



Division of Aging, Adult, & Behavioral
Health Services
P.O. Box 1437, Slot W241
Little Rock, AR 72203-1437
P: 501.686.9164
HUMANSERVICES.ARKANSAS.GOV

TO: Interested Parties

FROM: Rachael Veregge, Policy & Research Analysis Manager

DATE: July 31, 2023

RE: Public Comment Period

Attached is the Federal Fiscal Year 2024 Combined Substance Abuse and Mental Health Block Grant Behavioral Health Assessment and Plan application for the Division of Aging, Adult and Behavioral Health Services.

The public comment period for this grant application is August 1, 2020 through August 30, 2020.

Copies of the application can be found on our website: <https://humanservices.arkansas.gov/wp-content/uploads/Draft-FFY-2024-Combined-Application.pdf>

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

Arkansas

UNIFORM APPLICATION

FY 2024/2025 Combined MHBGSUPTRS BG
Application Behavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 07/31/2023 12.08.03 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID FJYALXB1EL42

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

Agency Name Arkansas Department of Human Services

Organizational Unit Division of Aging, Adult and Behavioral Health Services

Mailing Address Post Office Box 1437 Slot W-241

City Little Rock

Zip Code 72203-1437

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

First Name Tom

Last Name Fisher

Agency Name AR Department of Human Services, Division of Aging, Adult and Behavioral Health Services

Mailing Address PO Box 1437 Slot W-241

City Little Rock

Zip Code 72203-1437

Telephone (501)231-8919

Fax

Email Address Thomas.Fisher@dhs.arkansas.gov

State CMHS Unique Entity Identification

Unique Entity ID FJYALXB1EL42

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

Agency Name Arkansas Department of Human Services

Organizational Unit Division of Aging, Adult and Behavioral Health Services

Mailing Address Post Office Box 1437 Slot W-241

City Little Rock

Zip Code 72203-1437

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

First Name Jay

Last Name Hill

Agency Name AR Department of Human Services, Division of Aging, Adult and Behavioral Health Services

Mailing Address PO Box 1437 Slot W-241

City Little Rock

Zip Code 72203-1437

Telephone 501-686-9981

Fax 501-686-9182

Email Address jay.hill@dhs.arkansas.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☐ Yes ☐ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

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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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov> [sam.gov]
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

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.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov> [sam.gov]
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: ARKANSAS

Name of Chief Executive Officer (CEO) or Designee: JAY HILL

Signature of CEO or Designee¹: Jay Hill

Title: DAABHS DIVISION DIRECTOR

Date Signed: JULY 17, 2023
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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.

Please upload your state’s Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov> [sam.gov]
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

Name of Chief Executive Officer (CEO) or Designee: JAY HILL

Signature of CEO or Designee¹: Jay Hill

Title: DAABHS DIVISION DIRECTOR Date Signed: July 17, 2023
mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

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

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

Name

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the [Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NOT FINAL

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

Overview of Behavioral Health & Substance Abuse Prevention and Treatment in Arkansas

The Division of Aging, Adult and Behavioral Health Services (DAABHS) 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. utilizing block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). DAABHS is a division within the Department of Human Services (DHS). DHS serves an umbrella agency that includes nine Divisions responsible for providing social, health, and human services to citizens of Arkansas, including individuals with mental illness, individuals who are developmentally disabled, the elderly, adjudicated youth, and at-risk children and families.

The provision of block grant funded substance abuse services is facilitated agreements with seven (7) substance abuse treatment providers and thirteen (13) prevention providers covering the state. The DAABHS fulfills its responsibility for the provision of public mental health services by operating a 220-bed psychiatric facility, the Arkansas State Hospital (ASH), and a 290-bed skilled nursing facility, the Arkansas Health Center (AHC), utilizing state general revenue, Medicaid, and other local funding streams. The provision of block grant funded mental health services is facilitated through contracting services with twelve (12) local, private, nonprofit Community Mental Health Centers (CMHCs). For those persons without any insurance coverage, basic counseling level services are funded with state general revenue dollars through twenty-two (22) therapeutic counseling services contractors across the state to ensure easy and quick access as well as four (4) crisis stabilization units in different areas of the state that provides an alternative to psychiatric hospitalization or emergency room visits for persons in crisis or who encounter law enforcement due to their psychiatric condition. Each contracted provider of behavioral health services is expected to assess the diversity of their region and population served. Based on this self-assessment, providers are expected to assure that staff are trained on the specific treatment needs, cultural and ethnic differences, and disparities within their community while providing behavioral health services to fill in the gaps not covered by the Outpatient Behavioral Health Services (OBHS) program operated by the Division of Medical Services (DMS), the state Medicaid Authority, a division within DHS.

Background on Behavioral Health Services in Arkansas

Arkansas Act 433 of 1971 authorized the creation of a Division of Mental Health Services (DMHS) and this division was part of the Department of Social and Rehabilitative Services, later renamed the Department of Human Services (DHS) through Act 383 of 1977. This act also resulted in the transfer of operations of two of the State operated Community Mental Health Centers (CMHCs) and responsibility of providing CMHC services statewide to DHS. [Act 1717 of 2003](#) renamed the DMHS to the Division of Behavioral Health Services (DBHS) and transferred the Alcohol and Drug Abuse Prevention Program (ADAP) from the Department of Health to the new DBHS.¹ The DBHS was combined with the AR DHS Division Aging, Adult to become DAABHS. In April 2023 the AR DHS created a new Office of Substance

¹ History and Organization DHS-Div of Behavioral Health
https://www.dfa.arkansas.gov/images/uploads/budgetManuals/0710_dhs_behavioral_health_2005.pdf, accessed July 7, 2023.

Abuse and Mental Health combining AR Medicaid funded behavioral health services and the funding that is under the DAABHS to have focus on behavioral health services for Arkansans.

In [Act 944 of 1989](#), the Legislature specified that mental health centers and clinics must establish and maintain a community support program. Community Support Funds (CSF) were reallocated from institutional programs to the community in development of community-based alternatives to ASH, allowing individuals with serious and persistent behavioral illness to reside in the community. The community was designated as the point of responsibility, accountability, and authority for overall treatment for the adults with serious mental illness (SMI) and children and adolescents with serious emotional disturbance (SED). CSF were provided for client outreach, assistance in meeting basic needs and entitlements, crisis intervention and stabilization along with supportive services including supportive housing, supportive work, and behavioral health care. The CMHC was the designated leader to ensure these individuals have the community resources, including social resources, to feel secure and safe in the community. These community resources include local acute hospitalization for indigent adults who need psychiatric hospitalization.

Also passed in [1989 was Act 911](#). This Act pertains to the evaluation, commitment and conditional release of individuals acquitted of a crime when found not guilty by reason of mental disease or defect. The defendant is evaluated by a forensic psychologist or psychiatrist to determine if the defendant is fit to proceed with trial. If found not fit to proceed with trial, the defendant may be committed to the Arkansas State Hospital for inpatient treatment until restoration of fitness to proceed is achieved or a conditional release order is authorized. This allows the state to continue to monitor the individual for up to five years. Licensed social workers monitor the individual for compliance with the terms of his/her conditional release.²

As Medicaid coverage has changed over the years, through the expansion of the Child Health Insurance Program, referred to as ARKids First in January 2014, now includes families up to 142% federal poverty level and the Medicaid expansion for healthy adults referred to as the Arkansas Health and Opportunity for Me (ARHOME) program (formerly Arkansas Works) aged 19-64 up to 133% federal poverty level. With over half of Arkansas children enrolled in the ARKids and over 350,000 adults being insured through ARHOME, the population with no payor source for mental health services has changed, thus behavioral health service continuum has also changed.

Prior to the Behavioral Health Transformation in Arkansas in July 2018, behavioral health services in Arkansas were provided by 13 CMHCs, 53 Rehabilitative Services for Persons with Mental Illness (RSPMI) Providers and around 30 Licensed Mental Health Practitioners (LMHPs) at any given time. When the moratorium on adding new providers was lifted, the number of outpatient behavioral health agencies (OBHAs) (formerly RSPMI providers) Independently Licensed Practitioners (ILPs) (formerly LMHPs) certified as Medicaid behavioral health providers serving Arkansas Medicaid members dramatically increased. Currently there are 399 BHAs and 399 ILPs in Arkansas. In 2017 special language was removed from Arkansas statutes identifying specific CMHCs by name as state funded behavioral health providers. In 2019 the CMHC providers were procured by a competitive bid process.

Since the initial behavioral health transformation, DHS has continued to undergo additional changes to how behavioral health services are delivered in Arkansas, which includes the implementation of a Medicaid 1915(i) state plan amendment to enable the state to provide home and community-based

² Encyclopedia of Arkansas, [Act 911 of 1989 - Encyclopedia of Arkansas](#), accessed July 7, 2023.

services for individuals identified as Seriously Mentally Ill (SMI) or Seriously Emotionally Disturbed (SED) through a functional assessment and moved the population into an organized care model. The organized care model is a model of managed care that is 51% owned by Arkansas Medicaid providers and is called the Provider-led Arkansas Shared Savings Entity (PASSE). In this model, provider-led organizations integrate physical health services, behavioral health services, and specialized home and community-based services as authorized by Medicaid program. The first PASSE members were enrolled in Care Coordination beginning February 1, 2018, and as of March 2019, the PASSEs are responsible for the total management of attributed clients. As managed care organizations, the PASSEs reimburse Arkansas Medicaid enrolled providers to deliver behavioral health and other services and the CMHCs are some of those (but not the only) providers who contract with the PASSEs. The evolution of the continuum of care does not diminish the work of the CMHC providers which have been the focus of the mental health block grant funds in past years. Further, the DAABHS contracted providers must ensure they utilize contracted funds as the payor of last resort and to assist its clients to enroll in the healthcare coverage programs for which the client may be eligible.

More specifically, the CMHC providers are the designated Single Point of Entry (SPOE) for all adults in a region whose destination is ASH as well as the single point of access for acute inpatient psychiatric hospitals for clients for acute care hospitalization when these services are medically necessary. Shifts in admissions to ASH include most of the admissions being part of the forensic system and allowable Medicaid reimbursement utilizing a 15-day Institution of Mental Disease waiver through the PASSE program. The CMHC providers will utilize mobile crisis screenings as assessments when individuals present in crisis within their region. Each provider must also respond to the crisis and offer crisis intervention and stabilization, as well as other services, to prevent hospitalization, prevent further deterioration, and meet behavioral health needs of the client. Other community services provided include working with the court systems to provide forensic evaluations establishing whether individuals are competent to engage in the legal system. If the individual is not deemed competent, then the provider must provide outpatient services to help that client regain competency. CMHCs must maintain local behavioral health and community resource directory to ensure public information and education is widely available. An ongoing, at least monthly basis, public information campaign to educate the local community with information about available services, hours of operation, clinic contact information and how to access agency services including crisis services. Each CMHC must have a consumer council which allow consumers an opportunity to develop a strong and unified voice to influence and improve agency policy decisions, further develop the consumer-led initiatives, impact local service development, and forge proactive alliances with community resources.

DAABHS provides funding for the purchase of local acute care (psychiatric) hospital beds for adults who have no other funding source to pay for a psychiatric crisis situation. The funds are distributed through the CMHCs and are based on census data. CMHCs 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 contracted CMHCs to deliver services to individuals that are Seriously Mental Ill or Seriously Mentally Ill with co-occurring substance abuse disorders, and who are homeless or at imminent risk of becoming homeless. There are currently three (3) CMHCs providing PATH services which include outreach, housing match services, assessment, and assistance with SSI/SSDI application.

DAABHS continues to ensure behavioral health care is available to children and youth throughout the state. Outpatient behavioral health services are available through certified community providers and as such, must comply with State requirements that meet nationally accepted standards for delivering services. DAABHS recognizes that to successfully treat children and youth, their family and community involvement is essential. To support this belief, DHS supported System of Care (SOC) initiatives for more than nine (9) years. DAABHS was awarded a SAMSHA grant called the System of Care Implementation and Expansion Grant in October 2014 to September 2019. The purpose of this grant was to provide funding to build capacity in workforce development, continuing education, resource development, and technical assistance to professionals and family members. Many successes have been accomplished through this grant to date. Some of those include development of curriculums, trainings and certifications for Family Support Partners, Youth Support Partners and Infant and Early Childhood clinicians.

With the implementation of the PASSE, the bulk of services for children and adults with SED/SMI who have Medicaid are now managed by these organizations. Those without Medicaid are served through state contracts funded by the mental health block grant. Each PASSE has the flexibility to develop, implement and reimburse for creative service solutions that ensure appropriate care in the least restrictive setting. In addition, each PASSE is mandated to ensure access to all services covered under the Medicaid State Plan. One of the most critical pieces of this transformation involves the requirement of all PASSE beneficiaries to receive Care Coordination. Care Coordination includes development of the person-centered service plan (PCSP). The PCSP assures continuity of care across all services and all service providers. At a minimum, the PCSP includes health education and coaching, coordination between healthcare providers for diagnostics, ambulatory care, and hospital services, assistance with social determinants of health, promotion of activities focused on the health of a client and their community, and community-based medication management. The PASSE Care Coordinator is responsible for assisting the member with moving between service settings and must ensure care takes place in the least restrictive setting. A new Medicaid service has been developed to address the needs of beneficiaries who are moving from treatment in residential settings or to avoid treatment in residential settings. The service is called Intensive In-Home and state American Rescue Plan funds are being used to train providers in the Family Centered Treatment model using a team approach to support families.

In 2019, DAABHS implemented new contracts funded solely by state general revenue. The Therapeutic Counseling Services contracts ensure rapid access to basic level counseling services (an initial mental health evaluation/diagnosis, individual, group, family, multi-family, and psychoeducation services). Twenty-two (22) providers ensure coverage across all seventy-five counties. These contracts only cover persons without health insurance coverage for these services if they are medically necessary.

Substance Abuse Prevention and Treatment Background

DAABHS 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, DAABHS distributes federal funds from the Substance Abuse Prevention and Treatment Block Grant (SABG). DAABHS provides oversight for 100 treatment providers, with eight (8) of those funded by DAABHS to provide substance use disorder prevention, treatment, and recovery services throughout the State utilizing block grant funding. All contracted substance abuse providers in Arkansas are nationally accredited, as required by the licensure standards and are also in the contract language. 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.

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

Treatment and services needed by pregnant and women with dependent children are different from others in treatment. Specialized Women's Services (SWS) programs are family treatment programs. The programs assist mothers in becoming loving, effective parents as well as confident women in recovery. Residential Treatment is tailored to meet the women's needs in a structured and non-judgmental environment. The goal is to reduce the harmful effects of alcohol and other drugs on both the mother and unborn fetus allowing for healthier and drug free babies. Mothers learn to live life without alcohol and other drugs to become successful parents. SWS programs are unique in that the children enter residential settings with mothers, allowing for each family member's needs to be explored and supported without the added stress of separation. SWS Residential Treatment Services include Screening; Assessment; Comprehensive Treatment Planning; Treatment services that address physical health, trauma, developmental concerns, emotional issues, parenting and life skills; Individual, group and family counseling; Case management; and Discharge Planning. The children in care with their mothers are assessed and receive comprehensive physical and mental health services as determined by the assessment.

The Medicaid expansion population of adults can access the full continuum of SUD services through their insurance plan and work will begin on analysis of how this will allow a shift in the current use of block grant funds to determine a population of individuals who are not covered, or services not covered.

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 DAABHS provides the funding and 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) providers that assess and provide treatment referral services within the 75 counties in Arkansas.

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 DAABHS in forming a statewide infrastructure to develop knowledge, skills and abilities within communities to address substance abuse 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.

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 systems, 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, including for 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 data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System (URS)**, and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding¹* in developing this narrative.

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Footnotes:

NOT FINAL

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

The US Census Bureau reports that as of July 1, 2022 the population of Arkansas is estimated to be 3,045,637. Of the 75 counties in Arkansas, 55 are considered rural. Children in Arkansas, those 18 years of age and younger, comprise 22.9% of the state's population while the those 65 and older, comprise 17.8% of the population. The male to female ratio is fairly even in Arkansas with females having a slightly higher ratio at 50.6%. The most predominant race and ethnic origins in the state are individuals who are white and non-Hispanic or Latino (71.0%). The largest minority group are individuals who are African American (15.6%). Arkansans aged 25 and older who were high school graduate or higher represented 87.7% of the population and 24.3% had received a bachelor's degree or higher. The median household income was \$52,123 from 2017-2021. The percentage of Arkansans living below the poverty level in 2021 was 16.3%.¹

America's Health Ranking 2022 Annual Report ranks Arkansas 48th in the United States in overall health. Some reported strengths include a low prevalence of excessive driving (14.2% compared to 17.3% nationwide). Drug deaths (deaths per 100,000) are lower in Arkansas (18.5%) compared with the US over all (27.9%). Challenges Arkansans can work on include high prevalence of cigarette smoking. Arkansas ranks 33rd in e-cigarette usage among adults 18 and older (7.2% compared to 6.7% nationwide). While smoking tobacco in adults 18 and older ranks 48th in the nation (21.1% compared to 14.4% nationwide). Arkansas ranks 45th in the nation for non-medical drug use in adults 18 and older (19.1% compared to 15.5%).² Arkansans have a higher prevalence of common chronic conditions such as high cholesterol, hypertension, obesity, arthritis and depression. The Centers for Disease Control reports that as of 2022, heart disease, cancer, COVID-19, chronic lower respiratory disease, and accidents are the top five causes of death in Arkansas, which can be exacerbated by alcohol, tobacco, and other substances.³

The 2021 Arkansas State Epidemiological Outcomes Workgroup's Annual Profile of Substance Use⁴ provides a report on substance abuse in Arkansas prepared by the University of Arkansas for Medical Sciences (UAMS) for the Arkansas Department of Human Services (DHS), Division of Aging, Adult and Behavioral Health Services (DAABHS) to provide a demographic breakdown of population, education, economy and health to highlight the past successes and areas of focus for the future. Findings from this report, summarized as follows, are used to target areas of improvement:

Tobacco and E-Cigarette Usage

- The rates of current cigarette and smokeless tobacco use among Arkansas youth continued to decline and, in 2020, were lower than national rates among Arkansas 8th, 10th and 12th grade students.
- In 2019, a higher percentage of Arkansas adults currently smoked cigarettes relative to U.S. adults; however, current cigarette use continued to decline at a great rate over time among Arkansas adults.

¹ U.S. Census Bureau. Quick Facts: Arkansas. <https://www.census.gov/quickfacts/AR>. Accessed July 6, 2023.

² American's Health Rankings. 2022 Annual Report, State Summary: Arkansas. americashealthrankings.org Accessed July 6, 2023.

³ National Center for Health Statistics, Centers for Disease Control and Prevention. [Arkansas \(cdc.gov\)](https://www.cdc.gov/arkansas) Accessed July 6, 2023.

⁴ Bollinger M, Thostenson J, Porter A, Oliveto AH (2022) Arkansas State Epidemiological Outcomes Workgroup: 2020 Arkansas State Epidemiological Profile of Substance Use. Little Rock: Psychiatric Research Institute, University of Arkansas for Medical Sciences. [SEOW-2021-Annual-Profiles-Report-Part-1.pdf](https://www.seow-2021-annual-profiles-report-part-1.pdf), Accessed July 6, 2023.

- E-cigarette use among Arkansas women during the three months prior to pregnancy as well as last three months of pregnancy declined from 2016 to 2019, but was consistently higher than among U.S. pregnant women.

Alcohol Use

- The prevalence of lifetime alcohol use is lower among Arkansas youth relative to their U.S. counterparts. Since 2015, current alcohol use among Arkansas adults has remained stable and lower than national rates.
- The prevalence of binge drinking has remained relatively stable over time and rates are only slightly lower among Arkansas relative to U.S. adults. The prevalence of heavy drinking showed a slight increase from 2015 to 2019 with prevalence among Arkansas adults only slightly lower than among U.S. adults.
- Rates of driving under the influence during the past year decreased slightly among Arkansas relative to U.S. drivers, but a higher percentage of Arkansas drivers reported driving under the influence than their U.S. counterparts.

Marijuana Use

- Lifetime and current marijuana vaping among Arkansas youth was lower than among their U.S counterparts in 2020.
- From 2017-2018 to 2018-2019, the prevalence of past-year marijuana use decreased slightly among Arkansas young adults while increasing slightly among Arkansas adults aged 26 years or older.
- In 2018-2019, fewer Arkansas adults have used marijuana currently or in the past year compared with the national average.

Prescription Drug & Heroin Use

- In 2020, Arkansas seniors reported lower prevalence of lifetime prescription drug use but a slightly higher prevalence of lifetime heroin use, relative to their U.S. counterparts.
- Current prescription drug use has continued to decline among Arkansas 10th and 12th grade students but remained the same or increased among 8th and 6th grade students, respectively.
- U.S. drug overdose deaths continue to increase with at least 3 out of 5 deaths involving synthetic opioids such as fentanyl, fentanyl analogs, methadone or tramadol.
- Arkansas had the second highest opioid prescription rate in 2019. At the same time, a lower than national average rate of opioid-related overdose deaths is noted, which may be attributable to the underreporting of opioid-related deaths.

Other Drug Use

- Current inhalant or hallucinogen use remained relatively stable over time, while over the counter, cocaine, and methamphetamine use showed slight decreasing trends from 2015 to 2020.

- Lifetime and current bath salts use have been increasing from 2015 to 2020 and were more prevalent than over-the-counter drug use in 2020.
- The rate of cocaine use among adults in Arkansas is lower than that for U.S. adults. Among adults in the state, cocaine use is higher among those aged 18-25.
- Use of methamphetamine is higher among Arkansas adults compared with the national rate but is at 1.0% statewide and highest among those aged 18-25 (1.1%).
- Arkansas adults reported lower past-year illicit drug use than nationally in 2018-2019. These data suggest that many regions – the majority of which are more rural – have more problematic alcohol use than other parts of the state should consider more focused or intensive alcohol use prevention strategies.

With the changes made to the public behavioral health system in Arkansas, many gaps in service coverage are now being addressed through a more robust Medicaid program that allows for expanded behavioral health services and outpatient substance use disorder services. It is DAABH's intention to implement a more formal needs assessment in the near future once these new programs have been in place for a period of time. This will allow Arkansas to have a better picture of gaps in our new behavioral health system.

Regular conversations are being held with providers and stakeholders to discuss their perception of identified gaps and potential solutions to assist with assurances of service availability during the meantime. While many gaps have services are now being addressed or are under development, DAABHS still has identified the following unmet service needs and/or gaps in the behavioral health system:

- Transitional services for youth entering adulthood.
- Mobile crisis response with a state hub.
- Home and community-based services across the state are needed to replace clinic-based services.
- Step down services for children/youth leaving psychiatric residential facilities.
- Incorporating multiple data systems that do not interface with one another and cross multiple Divisions within DHS.

Arkansas has identified needs and gaps in the behavioral health services as it relates to COVID19:

- **Workforce shortages** – Arkansas has an overall shortage of licensed professionals and COVID-19 has only exacerbated the situation. Particularly hard hit is the southern half of the state where it is much more difficult to recruit and retain professional staff. Behavioral health providers serving that area of the state note difficulty replacing licensed positions when a staff member retires, changes employers, or moves out of the area. There are fewer private behavioral health providers in these rural areas than in the more urban central and northwestern parts of the state. Fewer students intern in these rural areas as they are further away from the universities and recruiting individuals living in other states or more urban areas of Arkansas is a hard sell. Enhancing the numbers and stability of the workforce in these underserved areas is crucial.
- **Peer Support Specialists** – Identifying, training and mentoring peer support specialists would assist in providing essential care and faster access to services in this underserved area. Arkansas plans to utilize the MHBG COVID-19 Supplemental Funds to train, certify, supervise, and employ peer specialists to increase access to the behavioral health system for those in need. Use of peers will better serve the

SMI/SED population who have been negatively impacted by the isolation and struggles of the pandemic to access and continue services.

- **First Episode of Psychosis** – Another area of concern is the small number of clinicians trained in the evidence-based first episode of psychosis (FEP) models. While Arkansas has in the past trained clinicians in these models, many have retired, moved, or changed their practice leaving only a minimal workforce with these skills. Arkansas is working with NAVIGATE to develop some general training for clinicians. Additionally, we'll do additional work with NAVIGATE on Coordinated Specialty Care programs and want to work on integrating FEP/EMSI knowledge into primary care settings.
- **Forensic Restoration** – Many states are experiencing increase in the number on individuals found Incompetent to Stand Trial (IST) and having to undergo competency restoration. These individuals are often incarcerated. In May 2023, Arkansas had 300 individuals court ordered to receive restoration services. Sixty-one (61) percent of those individuals were incarcerated. The Arkansas State Hospital (ASH) is an Inpatient Psychiatric Hospital that is accredited to deliver short term psychiatric treatment to stabilize individuals experiencing a mental health crisis before returning them to their community. In addition to being costly to send individuals to the restoration program at ASH, it is also not always the appropriate setting. Alternative placement and treatment options are needed for those individuals' undergoing restoration that do not meet the clinical criteria for admission to ASH. It is critical to diversify and expand the forensic continuum of care and decrease the focus of all forensic services on one facility. DAABHS has worked with the Governor's office to devise a plan for a secured restoration program that will provide streamlined competency restoration services to individuals who are incarcerated. Individuals in this program will require intensive treatment and psychoeducation to prepare them to stand trial but will not require the acute services of ASH. This program will also work to significantly minimize the length of time for restoration, which allows for relief from backlog within the courts and the forensics system. Most importantly, this program will provide a defendant with clinically appropriate treatment in a timely manner. Moreover, DAABHS clinical forensics team has worked to divert individuals into appropriate care within the current system in attempt to place people in treatment settings that align with their behavioral health needs. This work includes collaborating with community providers, law enforcement, the PASSEs, and the courts to get people into treatment and out of jail, when appropriate.
- **Crisis Continuum Development** – Arkansas used Centers for Medicaid and Medicare Services (CMS) Home and Community Based Services American Rescue Plan (ARP) funding to develop a statewide mobile crisis response system proposal. A request has been made for state ARP funding to provide startup funding to build out a state hub as well as one year of operational funding to stand up the new system. The state will use this to integrate this system with the existing 988 system being administered by the AR Department of Health and the Community Mental Health System supported crisis system and the AR Medicaid funded crisis services through community ambulance and new Triage/Treat/Transport services for ambulance.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Preventing Overdose

Priority Type: SUP, SUT

Population(s): SMI, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

To prevent overdose in the state of Arkansas

Strategies to attain the goal:

Decrease naloxone saves in the state of Arkansas on college campuses.

Educate college students regarding opioids, overdose, disseminating and administering naloxone by training and distributing educational materials.

Participation in the Arkansas College Network for community activities annually.

Partnering with prevention representatives of that region to reduce the need for opioid overdose saves.

Review state policies for medication distribution

Review claims data for prescriptions for naloxone

Assist with creation of naloxone saturation map and data tracking

Partner with harm reduction agencies to track distribution numbers and administrations

Track medication distribution, training, and administrations created by Act 811 with reporting to Arkansas Drug Director after initial provision of medication to high schools and colleges

Consider novel agents and integrate reversal agent neutral language into policy

Create databases to track above metrics and set baseline of currently achieved goals across multiple funding streams

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand access to opioid reversal agents

Baseline Measurement: Baseline measurement-set September 30, 2023 based on survey numbers.

First-year target/outcome measurement: Increase naloxone saves by 3% from baseline (September 30, 2024) based on information reported to DHS from AFMC Database

Second-year target/outcome measurement: Increase naloxone saves by 5% from baseline (September 30, 2025) based on information reported to DHS from AFMC Database

Data Source:

AFMC Database

Description of Data:

Self reported via QR code and website, fields below.

The data will be collected via a link or QR code that is connected to AFMC's database. The survey Naloxone Reporting Tool will appear. It covers:

- Source of Naloxone (grant)
- Date of administration
- Time of administration
- Street address of administration
- Zip code of administration
- County of administration
- Who gave the naloxone?
- Agency Report Identifier (Case Number, etc.)
- First name of person who administered naloxone
- Last name of person who administered naloxone
- Number of doses administered

- Location of administration
- Outcome of administration
- Was the client referred to a medical professional post administration
- Was the clients referred to substance abuse treatment services (given treatment referral card)?
- Substance used
- Age
- Race
- Ethnicity
- Gender
- Education
- Occupation
- Comments

Once this form is filled out then AFMC will collect the information and report out to us each week. If there is a discrepancy, then they investigate it to resolve this. This tracks the numbers of overdose reversals among all the data points on the survey.

Data issues/caveats that affect outcome measures:

Saves are self reported

Priority #: 2

Priority Area: Integrating Behavioral and Physical Health Care

Priority Type: SUT, MHS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

To integrate behavioral health into primary care using the collaborative care model in Arkansas

Strategies to attain the goal:

Collaborate with the Arkansas Behavioral Health Integration Network, revise Medicaid manuals and policies to support reimbursement for the model, collaborate with regional clinics and federally qualified health centers to pilot the model.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implement SBIRT in clinics for all clients and provide training and reimbursement

Baseline Measurement: Determine number of clinics who provide counseling services currently through Medicaid claims by counseling codes in primary care offices

First-year target/outcome measurement: Increase the number of clinics who integrate counseling into primary care by 3% from baseline.

Second-year target/outcome measurement: Increase the number of clinics who integrate counseling into primary care by 5% from baseline.

Data Source:

Medicaid claims

Description of Data:

tracking of clinics who provide BH services in PC offices

Data issues/caveats that affect outcome measures:

possible reporting issues

Priority #: 3

Priority Area: Strengthening the Behavioral Health Workforce

Priority Type: SUP, MHS
Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Expanding professional and paraprofessional roles able to bill Medicaid reimbursable services, broaden Peer workforce across disciplines, and enhance how Peer services are administered with the goal of increasing funding sources and sustainability.

Strategies to attain the goal:

update policies and procedures, expand provider types, support training initiatives, ensure education for those interested in hiring peers, collaborate with various insurance carriers to promote Peer services and their effectiveness, and obtain guidance from consultants about blending and braiding of resources to make sustainability a priority.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Implementation of evidence-based ACT teams
Baseline Measurement: Coordinate two training opportunities for ACT teams during 3rd and 4th quarters of SFY 2024
First-year target/outcome measurement: Complete initial training for at least 4 ACT teams by the end of SFY 2024.
Second-year target/outcome measurement: Schedule at least one additional training opportunity for new ACT teams and complete initial training for at least 4 additional ACT teams by the end of SFY2025.

Data Source:

Data will be tracked in conjunction with training entities selected by DHS.

Description of Data:

number of agencies committing to have ACT teams trained, number of teams undergoing training, number of teams completing initial training and entering consultation phase, number of fully certified teams.

Data issues/caveats that affect outcome measures:

Due to workforce issues we may not have the level of interest in getting ACT teams trained that we believe we need to provide services to those who need this level of care.

Indicator #: 2
Indicator: Expand career options and opportunities for trained and certified Peers
Baseline Measurement: Obtain baseline of Peers currently employed and working (paid or volunteer) as a Peer at agencies which intersect with SMI/SED populations at the end of the first quarter of SFY2024. Data will be compared with the current number of trained and certified Peers at Peer-in-Training, Core, Advanced, and Supervisor levels in the state.
First-year target/outcome measurement: Complete a state-wide survey to determine the number of paid and volunteer Peer positions working for agencies which may intersect with SMI/SED populations. Data will be compared with the current number of trained and certified Peers at Peer-in-Training, Core, Advanced, and Supervisor levels in the state.
Second-year target/outcome measurement: Increase employed or volunteer Peer positions (at any level) by 5%.

Data Source:

Data tracked by UALR/Mid-South & the Division of Provider Services and Quality Assurance, and the Recovery Unit.

Description of Data:

Data tracked by UALR/Mid-South & the Division of Provider Services and Quality Assurance regarding Peers in training, or who have been trained recently and completed certification processes. The Recovery Unit will track training development and completion, and the number of trainings requested, scheduled, and completed.

Data issues/caveats that affect outcome measures:

there might be some challenges with obtaining baseline data regarding agencies employing Peers in a paid or volunteer position.

Indicator #: 3

Indicator: Use funding for technical assistance to improve use of all funding sources to ensure the best use of existing workforce resources and to explore new options for building workforce in needed areas.

Baseline Measurement: During SFY 2024 Arkansas will be undergoing a needs assessment process and strategic planning on the most effective use of available resources.

First-year target/outcome measurement: An implementation plan will be finalized by the end of SFY2024 which will identify target areas and available resources to support the plan. This plan will include specific data points needing to be gathered, how they will be gathered and by whom, and how the data will be used to evaluate effectiveness.

Second-year target/outcome measurement: Our implementation plan will begin in SFY2025. Data will be reviewed by the end of SFY2025 to evaluate impact, effectiveness, and gaps.

Data Source:

Medicaid data, PASSE data, CMHC and/or other behavioral health provider data, plan/guidance developed by consultant company, strategic planning documents.

Description of Data:

Medicaid claims data, data on persons served under other funding sources, strategic planning documents, program evaluation documents.

Data issues/caveats that affect outcome measures:

accuracy of data and efficiency in obtain data we need.

Priority #: 4

Priority Area: Promoting resilience and emotional health for children, youth, and families

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

To implement evidence-based HCBS available to children and families/caregivers to decrease out-of-home placements and promote early intervention.

Strategies to attain the goal:

DHS will provide funding to support initial training, implementation, case consultation, and train the trainer programming for interested behavioral health providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand access to HCBS of Intensive In-Home Services focusing on the family unit by supporting training and implementation costs.

Baseline Measurement: establish baseline with newly trained teams in late 2023 to early 2024

First-year target/outcome measurement: increase number of trained teams by 4 in year one, and train-the-trainer by 2 individuals

Second-year target/outcome measurement: increase number of trained teams by 4 more in year two, and train-the-trainer by one additional trainer

Data Source:

Data will be tracked in conjunction with training entities selected by DHS.

Description of Data:

number of teams expressing interest in undergoing training, number of teams currently being trained, number of certified teams, number of trained trainers.

Data issues/caveats that affect outcome measures:

None identified at this time

Priority #: 5

Priority Area: Home and Community Based Services -Transitions

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Improve transitions processes and enhance/expand placement options for complex clients and reduce the recidivism rate in institutional settings

Strategies to attain the goal:

- Conduct statewide, multi-level stakeholder engagement interviews and surveys to gain input on barriers, current processes and recommended actions and policy and system improvements
- Identify HCBS transitions best practice models and conduct a resource and gap analysis and recommendations for transitions for complex populations
- Establish population-specific transitions processes
- Work with stakeholders to implement processes

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Recidivism Rate – Subacute/Psychiatric Residential Treatment Facilities (PRTF), Arkansas State Hospital (ASH)

Baseline Measurement: Information to be gathered based on 2023 data

First-year target/outcome measurement: 3% decline in institutional recidivism across populations and settings (from baseline)

Second-year target/outcome measurement: Additional 2% decline (from year 1) in institutional recidivism across populations and settings

Data Source:

Data from Managed Care Organizations (MCOs) including encounter data and data from Fee-For-Service Medicaid (claims and encounters for admissions and stays in Psychiatric Residential Treatment Facilities, Therapeutic Communities, Acute and emergency room settings); data on admissions and stays from the Arkansas State Hospital (ASH)

Description of Data:

Claims and encounter data collected through the state's MMIS and the Arkansas State Hospital

Data issues/caveats that affect outcome measures:

Having clean encounter data from MCOs

Priority #: 6

Priority Area: Enhancing Access to Appropriate Level of care for Forensic Involved Persons

Priority Type: MHS

Population(s): SMI, SED, BHCS

Goal of the priority area:

Develop and implement process improvement to ensure appropriate services occur in the appropriate level of care.

Strategies to attain the goal:

- Collaborate with CMHC to gather data related to services provided and success measures in specialty courts
- Engage CMHCs to enhance and expand community intervention and diversion through specialty courts
- Identify gaps in services with CMHCs and determine where services can be enhanced.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of persons diverted from ASH/Acute Hospitalization in comparison to baseline data in SFY2023

Baseline Measurement: Establish the baseline

First-year target/outcome measurement: Develop a data driven plan for specialty court diversions.

Second-year target/outcome measurement: Implement secured restoration program.

Data Source:

Procurement

Description of Data:

Procurement announcement, bids, performance measures, contract with vendor.

Data issues/caveats that affect outcome measures:

No issues known at this time

Indicator #: 2

Indicator: Implementation of justice involved peers in specialty courts to increase diversion efforts.

Baseline Measurement: Establish a program to place peers in specialty courts

First-year target/outcome measurement: by end of SFY 24 implement justice involved peers in at least 15 specialty courts.

Second-year target/outcome measurement: by the end of SFY 25 implement justice involved peers in at least 20 specialty courts.

Data Source:

DAABHS Recovery Unit monthly reports from justice involved peers Also receive monthly reports from the specialty court programs.

Description of Data:

Number served, demographic data, linkages to community resources

Data issues/caveats that affect outcome measures:

Challenge to educate the justice system on what peers can and cannot do. As reporting is new to peers, it may be a challenge to collect the data needed for monthly reports.

Indicator #: 3

Indicator: Engage CMHCs in identifying resources, barriers and solutions to increase the service array for forensically involved persons.

Baseline Measurement: Gather data related to the barriers common to forensically involved persons

First-year target/outcome measurement: Stakeholders will collectively identify 2 untapped resources and identify 2 solutions to the barriers identified in the baseline measurement.

Second-year target/outcome measurement: Implement solutions identified in first year target/outcome measurement.

Data Source:

Meeting minutes. Identification of resources currently available, resources to be developed, barriers and possible solutions.

Description of Data:

Identification of stakeholders present during the meeting as well as state staff, notes of progress of implementation, process maps, brainstorming activities.

Data issues/caveats that affect outcome measures:

Challenges scheduling meetings, meeting attendance, and limited resource availability.

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Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SUPTRS BG) ^a	J. ARP Funds (SUPTRS BG) ^b
1. Substance Use Prevention ^c and Treatment	\$9,670,515.00		\$0.00	\$10,882,752.00	\$1,945,399.00	\$0.00	\$0.00		\$0.00	\$0.00
a. Pregnant Women and Women with Dependent Children ^c	\$1,169,362.00									
b. Recovery Support Services										
c. All Other	\$8,501,153.00			\$10,882,752.00	\$1,945,399.00					
2. Primary Prevention ^d	\$4,041,388.00		\$0.00	\$3,000,000.00	\$0.00	\$0.00	\$397,439.00		\$0.00	\$0.00
a. Substance Use Primary Prevention	\$4,041,388.00			\$3,000,000.00	\$0.00		\$397,439.00			
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	\$721,676.00									
12. Total	\$14,433,579.00	\$0.00	\$0.00	\$13,882,752.00	\$1,945,399.00	\$0.00	\$397,439.00	\$0.00	\$0.00	\$0.00

^a The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

^b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

^c Prevention other than primary prevention

^d The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SUPTRS BG) ^a	J. ARP Funds (MHBG) ^b	K. BSCA Funds (MHBG) ^c
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention ^d											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) ^e		\$853,210.00									
4. Other Psychiatric Inpatient Care								\$722,933.00		\$416,234.00	
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			\$2,855,532.00		\$49,148,151.00	\$1,049,503.00	\$3,107,996.00				
8. Other 24-Hour Care					\$4,328,000.00						
9. Ambulatory/Community Non-24 Hour Care		\$6,825,790.00		\$6,293,057.00	\$20,660,649.00			\$6,144,934.00		\$3,329,865.00	
10. Crisis Services (5 percent set-aside) ^f		\$426,605.00								\$208,117.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately ^g		\$426,605.00						\$361,466.00		\$208,117.00	
12. Total	\$0.00	\$8,532,210.00	\$2,855,532.00	\$6,293,057.00	\$74,136,800.00	\$1,049,503.00	\$3,107,996.00	\$7,229,333.00	\$0.00	\$4,162,333.00	\$506,690.00

^aThe 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

^bThe expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

^cThe expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

^dWhile the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

^eColumn 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

^fRow 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

^gPer statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA’s National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA’s Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	5,000	39
2. Women with Dependent Children	15,000	561
3. Individuals with a co-occurring M/SUD	4,000	3,018
4. Persons who inject drugs	16,000	2,102
5. Persons experiencing homelessness	2,459	324

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

National Survey on Drug Use and Health: 2-Year RDAS (2018 to 2019) (<https://rdas.samhsa.gov/#/>) 1. Pregnant Women 2. Women with Dependent Children 3. Individuals with a co-occurring M/SUD 4. Persons who inject drug 5. Persons experiencing homelessness - 2022 Annual Homelessness Assessment Report (<https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf>) Additionally, since Arkansas had an issue with our TEDS reporting on our annual report, we are using the numbers from our data management system to report the aggregate number in need for the last SFY. If you need a different time period, please let me know.

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Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

FFY 2024			
Expenditure Category	FFY 2024 SUPTRS BG Award	COVID-19 Award ¹	ARP Award ²
1 . Substance Use Disorder Prevention and Treatment ³	\$9,670,465.00		
2 . Substance Use Primary Prevention	\$4,041,388.00		
3 . Early Intervention Services for HIV ⁴			
4 . Tuberculosis Services			
5 . Recovery Support Services ⁵			
6 . Administration (SSA Level Only)	\$721,676.00		
7. Total	\$14,433,529.00	\$0.00	\$0.00

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

³Prevention other than Primary Prevention

⁴For the purpose of determining which states and jurisdictions 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report 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 SUPTRS BG allotments to establish one or more projects to provide early intervention services 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

⁵This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A					B		
Strategy	IOM Target	FFY 2024					
		SUPTRS BG Award	COVID-19 Award ¹	ARP Award ²			
1. Information Dissemination	Universal	\$1,044,666					
	Selected	\$435,330					
	Indicated	\$96,145					
	Unspecified	\$0	\$0	\$0			
	Total	\$1,576,141	\$0	\$0			
2. Education	Universal	\$294,650					
	Selected	\$122,785					
	Indicated	\$27,118					
	Unspecified	\$0					
	Total	\$444,553	\$0	\$0			
3. Alternatives	Universal	\$160,718					
	Selected	\$66,974					
	Indicated	\$14,791					
	Unspecified	\$0	\$0	\$0			
	Total	\$242,483	\$0	\$0			
4. Problem Identification and Referral	Universal	\$26,786					
	Selected	\$11,162					
	Indicated	\$2,465					
	Unspecified	\$0	\$0	\$0			
	Total	\$40,413	\$0	\$0			
	Universal	\$937,521					

5. Community-Based Processes	Selected	\$390,681		
	Indicated	\$86,284		
	Unspecified	\$0	\$0	\$0
	Total	\$1,414,486	\$0	\$0
6. Environmental	Universal	\$160,718		
	Selected	\$66,974		
	Indicated	\$14,791		
	Unspecified	\$0	\$0	\$0
	Total	\$242,483	\$0	\$0
7. Section 1926 (Synar)-Tobacco	Universal	\$53,573	\$0	\$0
	Selected	\$22,325	\$0	\$0
	Indicated	\$4,930	\$0	\$0
	Unspecified	\$0	\$0	\$0
	Total	\$80,828	\$0	\$0
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	\$0	\$0	\$0
Total Prevention Expenditures		\$4,041,387	\$0	\$0
Total SUPTRS BG Award³		\$14,433,529	\$0	\$0
Planned Primary Prevention Percentage		28.00 %		

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

³Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

Footnotes:

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award ¹	FFY 2024 ARP Award ²
Universal Direct	\$2,678,632		
Universal Indirect	\$1,116,231		
Selected	\$246,524		
Indicated			
Column Total	\$4,041,387	\$0	\$0
Total SUPTRS BG Award³	\$14,433,529	\$0	\$0
Planned Primary Prevention Percentage	28.00 %		

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

³Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award ¹	ARP Award ²
Prioritized Substances			
Alcohol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Fentanyl	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prioritized Populations			
Students in College	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
LGBTQI+	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Persons Experiencing Homelessness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

FFY 2024					
Expenditure Category	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated ¹	D. COVID-19 ²	E. ARP ³
1. Information Systems		\$30,000.00			
2. Infrastructure Support	\$684,668.60	\$746,810.70			
3. Partnerships, community outreach, and needs assessment	\$9,547,369.40	\$3,056,577.42			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation		\$75,000.00			
7. Training and Education	\$160,103.00	\$133,000.00			
8. Total	\$10,392,141.00	\$4,041,388.12	\$0.00	\$0.00	\$0.00

¹Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

²The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

³The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:


Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY ¹ COVID Funds	FY ² ARP Funds	FY ³ BSCA Funds
.	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8. Total	\$	\$	\$	\$



Please wait while data loads...

¹ The 24-month expenditure period for the COVID-19 Relief Supplemental Funding Act (C-RSFA) is **September 1, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. If you have been approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

² The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

³ The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 thru October 16, 2024** and for the 2nd allocation will be **September 30, 2023 thru September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: <https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001>; <https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983>. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.¹ Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in an efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity, seriousness, and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

¹Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604. Available at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:
 - a) Adults with serious mental illness
 - b) Pregnant women with substance use disorders
 - c) Women with substance use disorders who have dependent children
 - d) Persons who inject drugs
 - e) Persons with substance use disorders who have, or are at risk for, HIV or TB
 - f) Persons with substance use disorders in the justice system
 - g) Persons using substances who are at risk for overdose or suicide
 - h) Other adults with substance use disorders
 - i) Children and youth with serious emotional disturbances or substance use disorders
 - j) Individuals with co-occurring mental and substance use disorders

In 2014 Arkansas became a Medicaid Expansions state. As a result, many more persons in the state became eligible for state assistance with obtaining health insurance coverage via Qualified Health Plans. Our expansion program, ARHOME (Arkansas Health and Opportunities for Me), had an enrollment of 342,267 persons as of January 2023, which amounts to about 30% of the state's total Medicaid population. www.healthinsurance.org also reports that as of September of 2022, Arkansans covered by Medicaid/CHIP was 1,020,344, and increase of over 463,000 since 2013.

Another crucial part of our transformation includes the development managed-care like organizations, called PASSEs (Provider-led Arkansas Shared Savings Entities). PASSEs serve Medicaid clients with complex behavioral health (BH) (i.e. SED/SMI), developmental, or intellectual disabilities (DD/ID). Persons are attributed to a PASSE by way of assessing functional deficit areas. These persons typically are not responding well to outpatient counseling services and need intensive home and community-based services, or services in residential/institutional settings. Those indicating the highest degree of deficits are assigned to one of four PASSEs. PASSEs are responsible for ensuring care coordination services, in addition to behavioral health services, and/or waiver services related to developmental/intellectual disabilities, along with primary care needs. PASSEs make sure that their members have access to all services covered under the current Medicaid State Plan, the Community Independence Waiver, the Community & Employment Supports Waiver, and services related to the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children/youth.

Within the last two years Arkansas has created a new provider type which we hope will boost community-based services for our BH, DD/ID, and dually diagnosed populations. Our Community Support System Provider (CSSP) type focuses on home and community-based services. CSSP providers can choose different levels of service provision from Base, to Intensive, to Enhanced. All services at the Base and Intensive Levels are home and community-based services. Providers at the Enhanced level also provide facility-based services, but they are also able to provide all services at the Intensive and Base levels as well.

Arkansas uses State General Revenue funding to ensure rapid access to Counseling services for anyone without health insurance coverage under our Therapeutic Counseling Services contract. This contract, with 24 different providers covering all 75 counties, requires our contractors to assist persons seeking services with getting enrolled for health insurance coverage if they are eligible and requires services be offered within seven calendar days of request.

Additional detail on efforts to increase access to services for:

a) Adults with serious mental illness

SMI adults can access services in a variety of ways. Approximately 340,900 are currently served through Qualified Health Plans which provide a full continuum of behavioral health and Substance Use Disorder services. Approximately 14,800 behavioral health adults are being served in the PASSE system at this time. Mental Health Block Grant (MHBG) and State General Revenue (SGR) funds are braided into Community Mental Health Center Contracts to ensure those without insurance coverage for necessary services have access to those services. Additional SGR funds cover Therapeutic Counseling Services contracts for those without any health insurance but who need mental health services. As stated above, this contract ensures rapid access, but also support to enroll in health insurance coverage if they are eligible. Social Services Block Grant (SSBG) funds are also available to ensure access to traditional and non-traditional services for those who are financially eligible.

Arkansas is using state-level American Rescue Plan funding to develop and Implement Assertive Community Treatment teams. We believe this is a gap in our continuum of services which, once fully implemented, will increase diversion from emergency rooms and law enforcement encounters.

We are also seeking assistance from consultants to assist us in developing a statewide crisis system that will serve all populations.

b) Pregnant women with substance use disorders

Our state has 5 catchment areas with 4 funded providers for specialized women's services. These programs can take a pregnant or parenting woman for up to 120 days with 2 dependent children. Exceptions can be made by the substance abuse treatment director for more children or for more time.

c) Women with substance use disorders who have dependent children

Women with substance use disorders with dependent children can be evaluated and placed into specialized women's services with their children. We also have funded faith-based programs that cater to women with children (i.e. Daughters of the Other Side).

d) Persons who inject drugs

Persons who inject drugs are priority for admissions into treatment services of any kind.

e) Persons with substance use disorders who have, or are at risk for HIV or TB

Our state program refers those providers who are offering medications for opioid use disorder (MOUD) guidance and reimbursement for testing for HIV and TB on intake and as necessary.

f) Persons with substance use disorders in the justice system

Our prisons will continue medications prescribed prior to entrance to the criminal justice system. Our Arkansas Community Corrections partner offers vivitrol inside the system and works with justice involved persons to continue care after release through Medicaid and partners with grant funding filling gaps if Medicaid is not available.

g) Persons using substances who are at risk for overdose or suicide

Our state has a standing order for naloxone, all Opioid Treatment Program clients are offered a prescription for naloxone. Intake assessments assess for suicide and require referrals to clinicians with that expertise.

h) Other adults with substance use disorders

All three forms of medication for Opioid Use Disorder (MOUD) are approved by Arkansas Medicaid.

i) Children and youth with serious emotional disturbances or substance use disorders

The Community Mental Health Center, Substance Use Treatment, and Therapeutic Counseling Service contracts also cover children/youth with SED or SUD issues, though most are Medicaid-eligible. Social Service Block Grant (SSBG) funds are also available to children and youth whose families meet those eligibility requirements. Recent figures indicate that 473,000 children are enrolled in traditional Medicaid and 34,100 of them are in a PASSE.

Arkansas is using state-level American Rescue Plan funding to develop and Implement Intensive In-Home Service teams. We believe this is a gap in our continuum of services which, once fully implemented, will increase diversion from emergency rooms and unnecessarily psychiatric hospitalizations.

Children and youth with substance use disorders are able to access buprenorphine and traditional outpatient services for substance use disorder if deemed necessary.

j) Individuals with co-occurring mental and substance use disorders

Arkansas Medicaid now covers substance use disorders treatment service being implemented on an outpatient basis, along with SUD detoxification which can take place in a hospital setting or a state-licensed residential substance use disorder treatment facility. With the newly approved inclusion of masters-level Licensed Alcohol and Drug Abuse Counselors (LADAC) as enrolled Medicaid service providers, along with other master's level Licensed Mental Health Practitioners working within their scope of practice, Arkansans are more often able to seek services from the same agency when co-occurring issues are present.

Clients who are co-occurring are able to seek services through our eight funded providers by catchment area and have a full array of services available through each provider or their sub-contractors as identified by memorandums of understanding with providers that offer services not offered by the funded provider.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The state's Medicaid agency is a division of the AR Department of Humans Services as is DAABHS. DAABHS staff work closely with the AR Medicaid in completing the provision of behavioral health services for AR Medicaid beneficiaries. AR Medicaid reimburses providers for a full continuum of Behavioral Health services for children/youth and adults including counseling services and home and community-based services for beneficiaries with Serious Mental Illness and Serious Emotional Disturbance. AR Medicaid and DAABHS staff members are currently working on the development of including a collaborative care model within primary care clinics to improve access and recently updated AR Medicaid Physician's Manual to allow physicians to hire licensed behavioral health professionals to provide services in clinics.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

- a) Access to behavioral health care facilitated through primary care providers
- b) Efforts to improve behavioral health care provided by primary care providers
- c) Efforts to integrate primary care into behavioral health settings

- a) Access to behavioral health care facilitated through primary care providers

The primary care providers are able to refer for behavioral health care and on-site care coordinators, peer recovery workers, or social workers are supportive to coordinate referrals. AR Connect Now is an online, 24/7 RN triage line with support from clinicians M-F 8-5 and Saturday 10-2. Their staff is available for resources and online mental health counseling within 7 days and is

able to refer to community providers after short-term counseling is complete or if services are not covered by insurance.

b) Efforts to improve behavioral health care provided by primary care providers

Primary care providers have outreach from our partner, the Arkansas Foundation for Medical Care (AFMC) and have provider representatives that provide on-site support and a quarterly information packet. This packet has included information about medications for opioid use disorder, AR Connect Now services, and referral sources.

c) Efforts to integrate primary care into behavioral health care settings

Many of our funded providers have integrated primary care into behavioral health through CCBHC grant support. Seven of our Community Mental Health Center contractors have been awarded CCBHC grants.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

In general, adults and children are determined to be SMI or SED by way of assessment of functional deficits. Those with the highest degree of deficits are attributed to one of four PASSEs. All persons in a PASSE automatically have care coordination services to ensure behavioral health, substance use disorder, developmental/intellectual disabilities, and/or their primary care needs are met. Individuals needs and service arrays are documented on a Person-Centered Service Plan (PCSP) which is developed in conjunction with the individual, and his/her guardian or caretakers when appropriate. The PCSP also includes goals and objectives identified by the individual. All PCSPs are individualized based upon identified issues. For instance, an adult with co-occurring behavioral health and substance-use disorder treatment needs will be inclusive of services for behavioral health and substance use disorder needs. A child with behavioral health and developmental disabilities may have a plan which reflects behavioral health treatment services, physical therapy, speech therapy, and personal care services.

a) Adults with SMI

Our most complex adults with Medicaid and attributable to our managed care organizations receive Care Coordination services. Adults with less complex needs are also able to receive care coordination under Therapeutic Counseling Service (funded with state general revenue) contracts and Community Mental Health Center contracts (funded by block grant dollars and state general revenue).

b) Adults with SUD

Care coordination is provided to adults with substance use disorders by our funded providers that provide the full array of services through their internal structures and memorandums of understanding with providers who offer services not offered by the funded provider. The assessment and coordination of the best level of care for the patient is offered by the funded providers, regardless of insurance status.

c) Children and youth with SED or SUD

Our most complex children with Medicaid and attributable to our managed care organizations receive care coordination services. Children with less complex needs are also able to receive care coordination under Therapeutic Counseling Service (funded with state general revenue) contracts and Community Mental Health Center contracts (funded by block grant dollars and state general revenue).

Adults and children are determined to be SMI or SED by way of assessment of functional deficits. Those with the highest degree of deficits are attributed to one of four PASSEs. All persons in a PASSE automatically have care coordination services to ensure behavioral health, substance use disorder, developmental/intellectual disabilities, and/or their primary care needs are met. Individuals needs and service arrays are documented on a Person-Centered Service Plan (PCSP) which is developed in conjunction with the individual, and his/her guardian or caretakers when appropriate. The PCSP also includes goals and objectives identified by the individual. All PCSPs are individualized based upon identified issues. For instance, an adult with co-occurring behavioral health and substance-use disorder treatment needs will be inclusive of services for behavioral health and substance use disorder needs. A child with behavioral health and developmental disabilities may have a plan which reflects behavioral health treatment services, physical therapy, speech therapy, and personal care services.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Since 2019, Medicaid has covered an array of mental health and substance abuse treatment services which are provided on an outpatient basis for youth and adults. Our service providers are encouraged to utilize existing evidence-based and age-

appropriate assessment tools for all persons who seek services. For instance, some providers utilize the American Society of Addiction Medicine (ASAM) criteria, Screening, Brief Intervention, and Referral to Treatment SBIRT), the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), the Columbia, and the Patient Health Questionnaire (PHQ-9). The screening and assessment tools drive placement in the appropriate level of care and determine if there is a need for additional referrals. Overall processes are the same for youth and adults, though the assessment tool may vary depending on age.

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

None is needed at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)¹, [Healthy People, 2030](#)², [National Stakeholder Strategy for Achieving Health Equity](#)³, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 [Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴.

Collecting appropriate data are 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 status⁵. 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 populations⁶. 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, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

¹ https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf

² <https://health.gov/healthypeople>

³ <https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf>

⁴ <https://thinkculturalhealth.hhs.gov/>

⁵ <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

⁶ <https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf>

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, sexual orientation, gender identity, and age?

- a) Race ☒ Yes ☐ No
- b) Ethnicity ☒ Yes ☐ No
- c) Gender ☒ Yes ☐ No
- d) Sexual orientation ☐ Yes ☒ No
- e) Gender identity ☒ Yes ☐ No
- f) Age ☒ Yes ☐ No

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? ☒ Yes ☐ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☒ Yes ☐ No
4. Does the state have a workforce-training plan to build the capacity of M/SUD 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? ☒ Yes ☐ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ☒ Yes ☐ No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ☐ Yes ☒ No
7. 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

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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 M/SUD systems and services. The [National Center of Excellence for Integrated Health Solutions](#)¹ offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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. SAMHSA's Evidence Based Practices Resource Center (EBPRC) 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. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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 General², The New Freedom Commission on Mental Health³, the IOM, NQF, and the [Interdepartmental Serious Mental Illness Coordinating Committee](#) (ISMICC)⁴.

One activity of the EBPRC⁵ was 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."⁶ SAMHSA and other HHS federal partners, including the 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 M/SUD 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁷ are best practice guidelines for the SUD treatment. SAMHSA 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](#))⁸ was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. Each KIT 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

¹ <https://www.thenationalcouncil.org/program/center-of-excellence/>

² United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

³ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

⁴ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁵ <https://www.samhsa.gov/ebp-resource-center/about>

⁶ <http://psychiatryonline.org/>

⁷ <http://store.samhsa.gov>

⁸ <https://store.samhsa.gov/?f%5B0%5D=series%3A5558>

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

We have a plan to contract with Guidehouse to assist DHS with reviewing our current Community Mental Health Center (CMHC) providers and contracts as a piece of our entire Behavioral Health system to help us identify gaps which indicate targeted areas which can be filled by our CMHC contractors. The CMHC contractors will be a part of the discussion about how to best fill the identified gaps using their existing infrastructure.

As previously mentioned, Arkansas will also be implementing several evidence-based programs to broaden our continuum of services for children/youth and adults. We are undergoing rate comparisons for Assertive Community Treatment and Intensive In-Home services with the plan to enact either per diem or monthly rates for each person actively involved in these programs.

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

None at this time

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
CBTp	12
Navigate	12
IRT	12

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
853221	853221

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Medicaid currently covers all individual services which might be provided to a person within the ESMI/FEP population for persons enrolled in one of our Provider-led Arkansas Shared Savings Entity (PASSE), which are managed care-like organizations. These services would include outpatient individual therapy, pharmacological management, psychoeducation, supported employment/education, crisis services which would include acute psychiatric hospitalization, etc.). Qualified Health Plans (QHP) cover counseling-level services at this time, and would cover residential treatment services for SUD, or acute psychiatric hospitalization. All services are currently being billed on a fee-for-service basis.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Currently, 10% of the regular Mental Health Block Grant funding (not COVID/ARPA funding) is divided among the Community Mental Health Centers (CMHC). With this funding, the CMHCs are expected to perform outreach and education in the community, support all needed services if there is no payor source, and ensure some training opportunities for staff providing services. Although DAABHS directly funded trainings in past years, we have not done so in the past five or six years and this has led to having a limited trained workforce for this population. *Many of our previously trained workforce are now in supervisory positions with a limited number still providing direct care services.

5. Does the state monitor fidelity of the chosen EBP(s)?

☐ Yes ☒ No

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

☒ Yes ☐ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Our current Community Mental Health Center (CMCH) contracts require twice monthly outreach efforts to educate a broad range of community-based entities (churches, probation, jails, law enforcement, community service groups, etc.) about ESMI/FEP and available services, along with the critical need to get that person connected with evidence-based treatment services rapidly. We think the implementation of the NAVIGATE's FEP 101 course will also assist educating newer clinicians about this population and their unique needs.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

As a part of our overall behavioral health system evaluation, guidance on how to best incorporate evidence-based trainings and implementation specific to the ESMI/FEP population will guide us in making some revisions to our current plans.

We've also considered a state-wide media campaign but have been cautious about this plan considering our work-force issues and the limited amount of fully trained clinicians competent in evidence-based interventions for this population.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Schizophrenia, Schizophreniform, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder with Psychotic Features, Major Depression with Psychotic Features, and Unspecified Schizophrenia Spectrum Disorder. We do understand that NAVIGATE advises narrowing this list.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

We do not have exact figures for Arkansans experiencing a FEP as these are not tracked across all payor sources. However, most sources estimate prevalence rates of 1.5 to 3.5 percent of people will meet criteria for psychosis at any given time. In SFY22, our CMHCs reported serving approximately 1100 unique individuals believed to be experiencing their first psychotic break and who were between the ages of 15 and 34 at the time of first contact.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

As stated above, we will be using a consulting firm who will assist us in developing the most practical avenue for outreach and engagement of those with a first episode of psychosis. With the addition of integrating with primary care services, we expect our early identification to expand.

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

During conversations with NAVIGATE consultants Arkansas received a significant amount of helpful suggestions about implementation. We would continue to seek their guidance about implementation when the state is ready to proceed with our Coordinated Specialty Care pilot program.

Footnotes:

NOT FINAL

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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 team 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, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems <https://ncapps.acl.gov/home.html> with a systems assessment at https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf

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.
Regarding the entire behavioral health system in Arkansas, Behavioral Health Agencies and Community Support System Providers, also Medicaid providers, are required to be nationally accredited through Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), The Council on Quality and Leadership (CQL), or Council on Accreditation (COA). These accrediting entities require a plan of care. Additionally, those persons with Provider-led Shared Saving Entity (PASSE) membership attribution are required to have a Person-Centered Service Plan (PCSP) created by the PASSE Care Coordinator collaboratively with the beneficiary and their identified supports. The Care Coordinator is mandated to engage all service providers, the PASSE member, and any caregivers or natural supports in the development of the PCSP. State contracts specifically related to ensuring behavioral health services for persons without insurance, or without a payor source for a medically necessary behavioral health services, require the collaborative development of a plan of care. Persons receiving fee-for-service Medicaid funded counseling level services require a Primary Care Physician referral for behavioral health services and this referral services as the plan of care.
4. Describe the person-centered planning process in your state.
All plans and updates to plans are required to be developed in collaboration with the person receiving services, and their caretakers, when appropriate, as evidenced by signatures on the document. Plans are to be written in plain language which can be understood by the person receiving services. Most agencies include direct quotes from their clients within the document when it comes to identifying specific treatment goals and objectives. Persons receiving services receive copies of their plans.
5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's [A Practical Guide to Psychiatric Advance Directives](#))?"
Community Mental Health Center contracts encourage special attention to persons who are repeatedly involve in re-occurring crises to provide individualized supportive services, including the development of a Psychiatric Advance Directive (PAD) once the crisis situation is stabilized or resolved. Guidance on PADs is also located on the DHS website.
Please indicate areas of technical assistance needed related to this section.
None at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 M/SUD 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 SUPTRS BG 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 SMI and children with SED and SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. 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 M/SUD 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:

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 program requirements, including quality and safety standards? ☒ Yes ☐ No

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

Pursuant to Arkansas Code Annotated 19-11-1010 and 19-11-267, the selected contractor must comply with performance-based standards. The contractor must comply with all statutes, regulations, codes, ordinances, licensure, or certification requirements applicable to the contractor or to the contractor's agents and employees, and to the subject matter of the contract. Failure to comply must be deemed unacceptable performance. The Division of Aging, Adult, and Behavioral Health Service's (DAABHS) Office of Substance Abuse and Mental Health (OSAMH) continues to update contract deliverables and damages to be imposed for non-compliance to include corrective action plans, financial penalties and up to contract termination. OSAMH is working to develop more robust monitoring and auditing practices related to quality of services and to ensure that MHBG funds are the payor of last resort. OSAMH has implemented use of state general revenue contract dollars to provide case management services to ensure enrollment with an insurance carrier where appropriate. Additionally, Community Mental Health Center contracted providers are mandated to ensure insurance enrollment when they interact with consumers reporting no insurance coverage.

Please indicate areas of technical assistance needed related to this section

Arkansas is still working to identify the best use of set-aside funds specific to our Early Serious Mental Illness population. A part of this work will involve a complete review of our current Community Mental Health Center system of care to identify more efficient and effective use of their resources across the state. OSAMH has a contract with Guidehouse to complete this review of

services and provide guidance on next steps.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

7. 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 Consultation](https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf)⁵⁶ 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.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

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?
3. 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.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification and Referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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) ☐ Yes ☐ No
 - a) ☒ Data on consequences of substance-using behaviors
 - b) ☒ Substance-using behaviors
 - c) ☒ Intervening variables (including risk and protective factors)
 - d) ☐ Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - a) ☒ Children (under age 12)
 - b) ☒ Youth (ages 12-17)
 - c) ☒ Young adults/college age (ages 18-26)
 - d) ☒ Adults (ages 27-54)
 - e) ☒ Older adults (age 55 and above)
 - f) ☒ Cultural/ethnic minorities
 - g) ☒ Sexual/gender minorities
 - h) ☒ Rural communities
 - i) ☐ Others (please list)

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

- a) ☐ Archival indicators (Please list)
- b) ☐ National survey on Drug Use and Health (NSDUH)
- c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)
- d) ☒ Youth Risk Behavioral Surveillance System (YRBS)
- e) ☒ Monitoring the Future
- f) ☐ Communities that Care
- g) ☒ State - developed survey instrument
- h) ☒ Others (please list)

Arkansas Collegiate Substance Use Assessment
Arkansas Prevention Needs Assessment

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

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

To help define needs and assess priorities.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ☐ Yes ☒ No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

Please see attached Arkansas Strategic Prevention Plan

7. Does your state integrate sustainability into the assessment step? ☒ Yes ☐ No

a) If yes, please explain in the box below.

Please see attached Arkansas Strategic Prevention Plan

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ☒ Yes ☐ No
 a) If yes, please describe.
 Arkansas Prevention Certification Board
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ☒ Yes ☐ No
 a) If yes, please describe mechanism used.
 Department of Health Prevention Technology Transfer Center
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No
 a) If yes, please describe mechanism used.
 Substance Abuse Prevention Skills Training
4. Does your state integrate the National CLAS Standards into the capacity building step? ☐ Yes ☒ No
 a) If yes, please explain in the box below.
5. Does your state integrate sustainability into the capacity building step? ☒ Yes ☐ No
 a) If yes, please explain in the box below.
 Please see attached Arkansas Strategic Prevention Plan
 b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary 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 SUPTRS BG? ☒ Yes ☐ No ☐ N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
 - b) ☒ Timelines
 - c) ☒ Roles and responsibilities
 - d) ☒ Process indicators
 - e) ☒ Outcome indicators
 - f) ☒ Cultural competence component (i.e., National CLAS Standards)
 - g) ☒ Sustainability component
 - h) ☐ Other (please list):
 - i) ☐ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG 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 SUPTRS BG primary prevention funds? ☒ Yes ☐ No
 - a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Strategic Prevention Framework (SPF) is a planning model promoted by Substance Abuse and Mental Health Services Administration (SAMHSA) to support coordinated, comprehensive, data-driven planning and accountability. Designed to

be long-term and evolutionary in nature, the resulting plan should build on knowledge and experience over time, and lead to measurable outcomes and system improvements. There are five (5) steps of the SPF developed to organize prevention strategies and objectives for change:

Five Steps:

Assessment: What is the problem?

Capacity: What do you have to work with? What are your human resources?

Planning: What works, and how do you build upon success?

Implementation: Put a plan into action – deliver evidence-based interventions as needed.

Evaluation: Examine the process and outcomes of interventions. Is it succeeding?

All Applicants should utilize this five-step process in the organization of their prevention strategies and objectives for change, and as a guide in the development of a Comprehensive Community Prevention Plan (CCPP). These steps, if implemented well, will strengthen the coalition and enhance their risk assessment when applying for funds. The five steps of the SPF are guided by two central principles: Cultural competence – the ability of an individual or organization to interact effectively with members of diverse population groups. Sustainability - the process of developing funding streams other than from grants and building an adaptive and effective system that enhances and maintains desired long-term results.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ☒ Yes ☐ No
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need response from Lynetta
8. Does your state integrate the National CLAS Standards into the planning step? ☐ Yes ☒ No
- a) If yes, please explain in the box below.
need response from Lynetta
- b) If no, please explain in the box below.
na
9. Does your state integrate sustainability into the planning step? ☒ Yes ☐ No
- a) If yes, please explain in the box below.
See attached Arkansas Strategic Prevention Plan.
- b) If no, please explain in the box below.
na

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification and Referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
Clearinghouse, material and media
 - b) Education:
Education for youth and families
 - c) Alternatives:
Youth leadership activities
 - d) Problem Identification and Referral:
 - e) Community-Based Processes:
Coalition building

- f)** Environmental:
SYNAR, local enforcement of policies and laws

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? ☐ Yes ☒ No

a) If yes, please describe.

4. Does your state integrate National CLAS Standards into the implementation step? ☐ Yes ☒ No

a) If yes, please describe in the box below.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? ☒ Yes ☐ No

a) If yes, please describe in the box below.

See attached Arkansas Strategic Prevention Plan

b) If no, please explain in the box below

NOT FINAL

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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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.

Evaluation

1. Does your state have an evaluation plan for substance use primary 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 SUPTRS BG 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 SUPTRS BG funded prevention services:

- a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☒ Heavy use

- c) ☒ Binge use
- d) ☒ Perception of harm
- e) ☒ Disapproval of use
- f) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ☐ Yes ☒ No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

See attached Arkansas Strategic Prevention Plan

6. Does your state integrate sustainability into the evaluation step? ☒ Yes ☐ No

a) If yes, please describe in the box below.

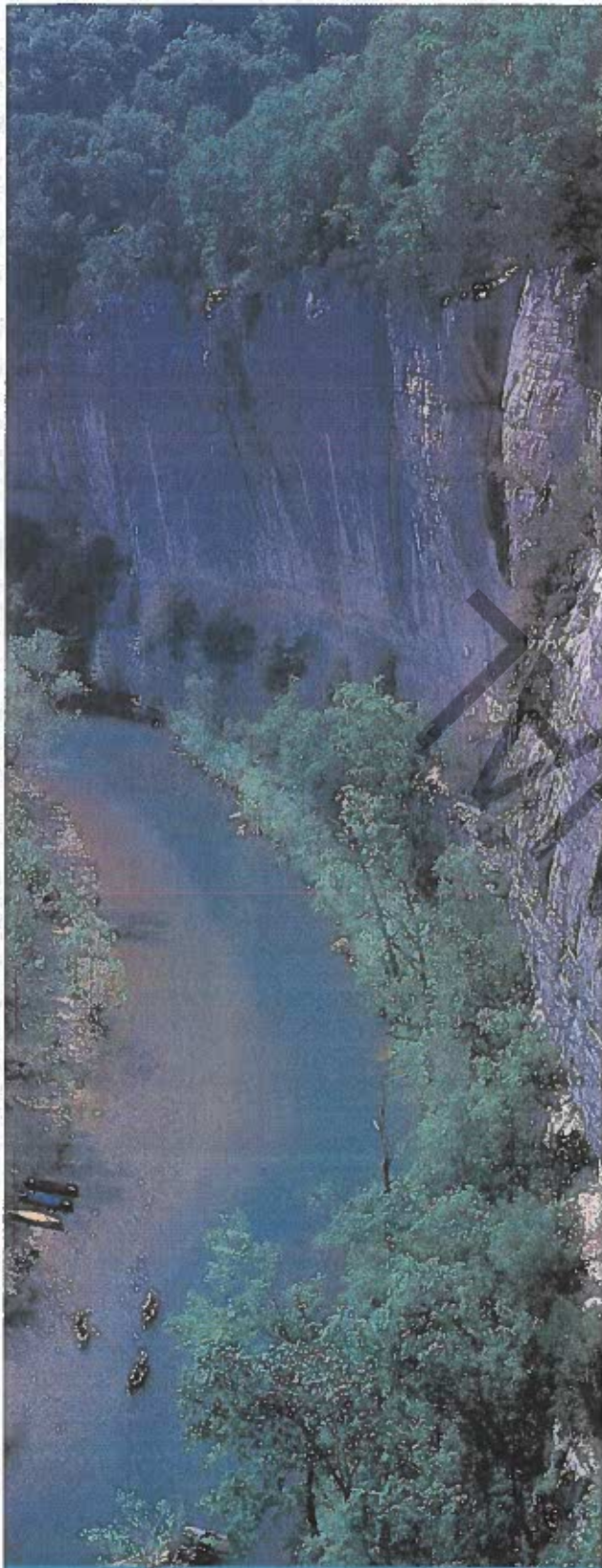
See attached Arkansas Strategic Prevention Plan

b) If no, please explain in the box below.

NOT FINAL

Footnotes:

NOT FINAL



ARKANSAS STRATEGIC PREVENTION PLAN

SFY 2019-2023

Strategic Five Year Plan



MidSOUTH CENTER FOR

PREVENTION AND TRAINING

NOT FINAL

A special thank you to the members of the Strategic Prevention Planning Committee for research, developing report narrative, editing and proofreading on this updated strategic prevention plan. Your contributions are greatly appreciated.

OFFICE OF THE STATE DRUG DIRECTOR

This Five-Year Arkansas Strategic Prevention Plan has been designed to help ensure Arkansans are healthy, safe, and able to enjoy a high quality of life free from substance misuse and is based on the knowledge that a continuum of care, beginning with prevention, is needed to effectively address the needs of individuals, families and



communities affected by substance abuse and addiction. Guided by the shared principles of collaboration, community responsiveness and cultural competence, and informed by the proven effectiveness of prevention services, the plan sets forth a five-year guide to strengthen prevention efforts within and across communities and create more opportunities for early intervention.

The Arkansas Drug Director executes a mandate to serve as the coordinator for development of an organizational framework to ensure that alcohol and drug programs and policies are well planned and coordinated.

In service to that duty, the Arkansas Drug Director looks forward to working with the many local, state, and federal stakeholders who contributed to the development of this plan and to ensuring the effective implementation of their recommendations. This office remains committed to building on this foundation, improving our efforts, and further reducing the negative impacts of substance misuse on the lives of Arkansans.

Pictured above, Arkansas State Drug director, Kirk Lane

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF AGING, ADULT AND BEHAVIORAL HEALTH SERVICES

VISION

Arkansas citizens are healthy, safe, and enjoy a high quality of life

MISSION

The Division of Behavioral Health Services provides leadership and devotes its resources to facilitate effective prevention, quality treatment, and meaningful recovery

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INTRODUCTION

BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH: PREVENTION WORKS!

This document is an update to two previous prevention plans - the Arkansas 2010 Prevention Plan and Prevention for a Healthy Arkansas: Strategic Plan for Five Years (2012). The document was developed with funding from the Substance Abuse Block Grant (SABG) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP). Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) is the Single State Agency (SSA) designated to oversee the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant in Arkansas. The Arkansas Alcohol and Drug Abuse Coordinating Council give final approval of the Arkansas Strategic Prevention Plan.

Arkansas's DAABHS promotes activities that improve the quality of behavioral health practices and services and strives to increase opportunities to maintain wellness for all Arkansans. It is one of the Divisions within the Arkansas Department of Human Services. DAABHS administers, oversees, and coordinates the State's behavioral health system to address the prevention and treatment of mental health, substance abuse, and problem gambling disorders.

DAABHS provides funding and contract management to the University of Arkansas Little Rock/MidSOUTH Center for Prevention and Training, who in-turn subcontracts with a variety of providers to ensure substance abuse prevention services are available to Arkansas citizens. For the purpose of seamless services delivery and reporting, the state is divided into thirteen (13) Prevention Regions. Each Region has a Regional Prevention Provider (RPP), staffed by Regional Prevention Representatives (RPRs), that offers training and technical assistance to community partners regarding prevention needs and solutions. MidSOUTH also subcontracts with other local, statewide, and out of state contractors to provide prevention services.

Arkansas's Five Year Strategic Prevention Plan will support DAABHS's overarching strategic goals and will focus statewide prevention efforts on a selection of data driven prioritized set of indicators, with results of activities that can be measured over time to demonstrate the success of state initiatives. These priorities are aligned with those of the Substance Abuse Block Grant (SABG). The plan will guide prevention prioritization, decision-making, and policy development at the state, region, and community level. DAABHS/MidSOUTH will collaborate with regional and community partners to enhance current capacity and plan for and develop newer systems and infrastructures to meet with current and emerging changes in substance abuse prevention service delivery. This work will strengthen, expand, and sustain systems and infrastructure at all levels.

DAABHS/MidSOUTH recognizes that substance abuse is a pervasive and complex social and public health issue that affects individuals of all ages; defies social, cultural, or economic categorization; and spans organizational boundaries.

Accordingly, no single agency, organization, or individual can effectively prevent or reduce substance abuse, but rather that effective prevention requires a targeted, coordinated and multi-disciplinary response.

Under the auspices of the Coordinating Council, DAABHS/MidSOUTH will work with agencies and organizations across the state with a stake in substance abuse prevention to enhance prevention capacity and ensure broad participation in prevention activities.



The Arkansas Strategic Prevention Plan describes a public health approach that will guide state agencies, schools, community organizations, coalitions, networks, and families in working together to prevent not only children, but all age groups, from engaging in problem behaviors including substance abuse. The planning committee used the expertise and knowledge from multiple agencies and organizations as a foundation to work toward a more cohesive and collaborative system that coordinates and maximizes resources to fill gaps in services and address unmet needs.

The state partners who came together to develop this Arkansas Strategic Prevention Plan acknowledge the challenges associated with developing, implementing, and maintaining such a plan. Such challenges include competing agendas, priorities, perspectives, limited state resources, and interagency fragmentation of prevention services.

The partners also recognize that the Arkansas Strategic Prevention Plan provides a unique opportunity to advance prevention and coordinate prevention funds and resources. Long-term change will be realized by pursuit of a shared vision and common goals and objectives that improve the well-being of the state's citizens, rather than directly modifying structures and budgets.

There is also a recognition that the state partners may not be able to unanimously subscribe to each strategy proposed for the Arkansas Strategic Prevention Plan. However, the partners are unanimously committed to working within their respective agencies and with other partners to put forth and implement the elements of the Arkansas Strategic Prevention Plan.

This plan was created from a process that included the following:

- An assessment of Arkansas' substance abuse prevention needs from available data, and providers' recommendations;
- Several meetings by Strategic Planning Committee comprised of individuals from University of Arkansas Little Rock/MidSOUTH Center for Prevention and Training; Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS); and the Arkansas Drug Director's Office, and other behavioral health agencies. See a complete list of committee members in appendix iii;
- Examination of the recommendations made by a federal expert team that conducted the most recent system review of Arkansas' prevention program.



WHAT IS PREVENTION

Prevention is the promotion of constructive lifestyles and norms that discourage alcohol, tobacco and other drug (ATOD) abuse. It is a proactive process designed to empower individuals and communities to meet the challenges of life events and transitions throughout the lifespan by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

PROMOTE

Prevention requires multiple processes that involve people in a proactive effort to protect, enhance, and restore the health and well-being of individuals and their communities. It is based on the understanding that there are factors that vary among individuals, age groups, ethnic groups, and risk-level groups and geographic areas.

PREVENT

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. Hence, comprehensive prevention efforts should be designed to target many agencies and systems, and use multiple strategies in order to have the broadest possible impact.

PROTECT

RISK AND PROTECTIVE FACTORS

Many of the problem behaviors faced by youth – delinquency, substance abuse, violence, school dropout, and teen pregnancy – share many common risk factors. Thus, reducing those common risk factors will have the benefit of reducing several problem behaviors.

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 and protective factors that exist in multiple contexts:

Individual Context: 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:

Family Context: 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

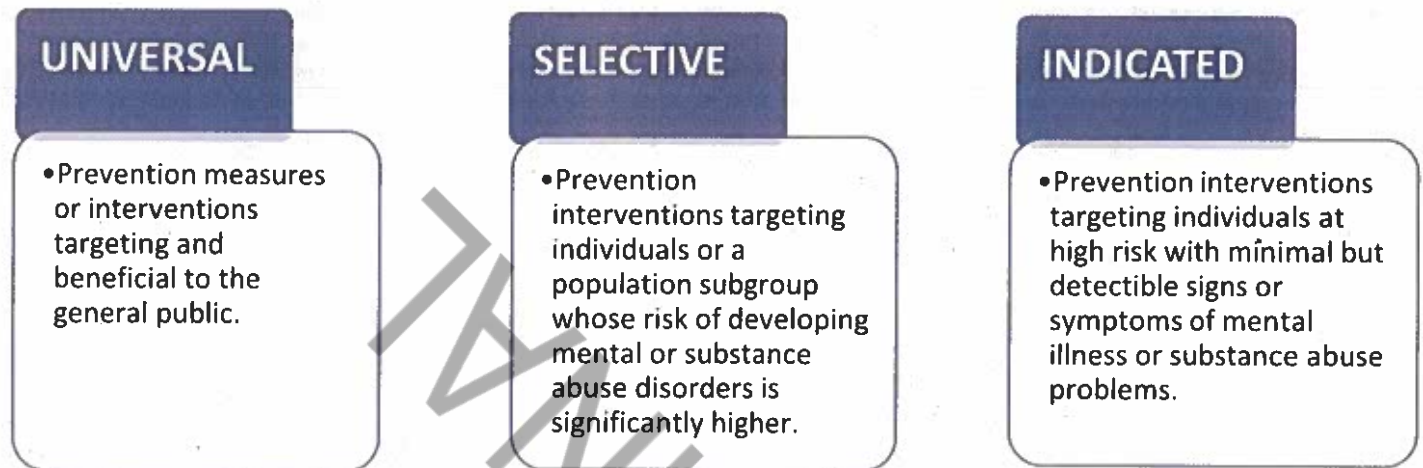
Community Context: In communities, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities

Societal Context: 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 a 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.



PREVENTION CATEGORIES

The overall goal for prevention is the development of healthy, responsible and productive citizens. To meet this goal, tailored prevention services must be made available through a variety of providers and strategies that target diverse groups (Institute of Medicine). Prevention efforts designed for specific populations are:



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 classes, 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.

Examples of selective interventions include:

- Group counseling.
- Social/emotional skills training for youth in low-income housing developments.

INDICATED: These interventions target individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to a DSM IV diagnosis¹).

Examples include:

- Programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

STRATEGIC PREVENTION FRAMEWORK

The Arkansas Strategic Prevention Plan is designed around elements that are part of a major prevention initiative of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP).

The Strategic Prevention Framework (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 theories 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 is also designed to include cultural competency and sustainability. All of these elements will guide state and local organizations to establish partnerships and implement systems to coordinate prevention resources.

These elements comprise a strong and viable state prevention system and include:

- **Assessment** – Determines needs, resources and causes of community issues.
- **Capacity** – Development of skills and knowledge for community members to address issues.
- **Planning** – Determines the best practices, strategies and action plans to be used to address issues.
- **Implementation** – The actual work done to address the issue.
- **Evaluation** – Reviews the process of implementation and determines if goals were met.

CENTER FOR SUBSTANCE ABUSE PREVENTION'S STRATEGIES

The Center for Substance Abuse Prevention's (CSAP) six strategies:

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.*

Education: This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress and problem-solving, and interpersonal communication. 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.*

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.*

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.*

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.*

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.*

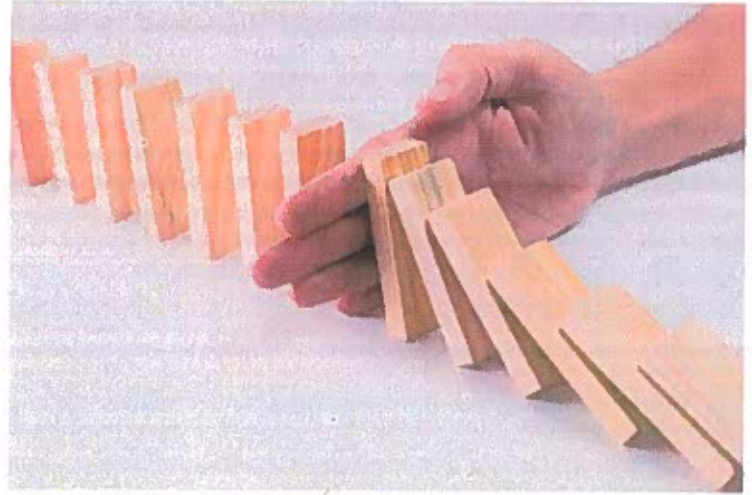
GUIDING PRINCIPLES FOR PREVENTION

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, 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.

GUIDING PRINCIPLES FOR PREVENTION

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 individual, the family, the community and the broader environment.
8. Systems of prevention services work 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. 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 the 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 chances 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.

GOALS AND OBJECTIVES



Implementation of prevention activities to achieve the goals and objectives of this plan will be guided by the CSAP strategies, Institute of Medicine's (IOM) prevention categories and prevention principles. All aspects of implementation will follow the Strategic Prevention Framework.

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. Most of the goals set for the 2012 Strategic Prevention Plan were either met or mostly met (see List of 2012 goals and progress in appendix i and ii).

The overall goal of this plan is to provide primary substance prevention providers and other behavioral health stakeholders with skills to reduce risk factors and increase protective factors on a range of substance use behaviors and to provide a roadmap on enhancing prevention infrastructure at local and state levels.

The indicators to be measured are:

- Past 30-day usage: This is a measure of the current use of substances among middle and high school students.
- Lifetime use: This indicator measures usage of a substance at least once in the student's lifetime, and is the best measure of youth experimentation with alcohol, tobacco and other drugs.
- Perception of risk: Increased perception of risk is a protective factor that measures likelihood of not using a substance. Likewise, decreased perception of risk increases the likelihood of usage.
- Past 2-weeks binge drinking: This measures excessive alcohol consumption.

MidSOUTH will be responsible for implementing and evaluating these measures with oversight from DAABHS. MidSOUTH will collaborate with regional prevention providers, prevention contractors, community coalitions and other prevention stakeholders to meet the identified goals and objectives of this plan.

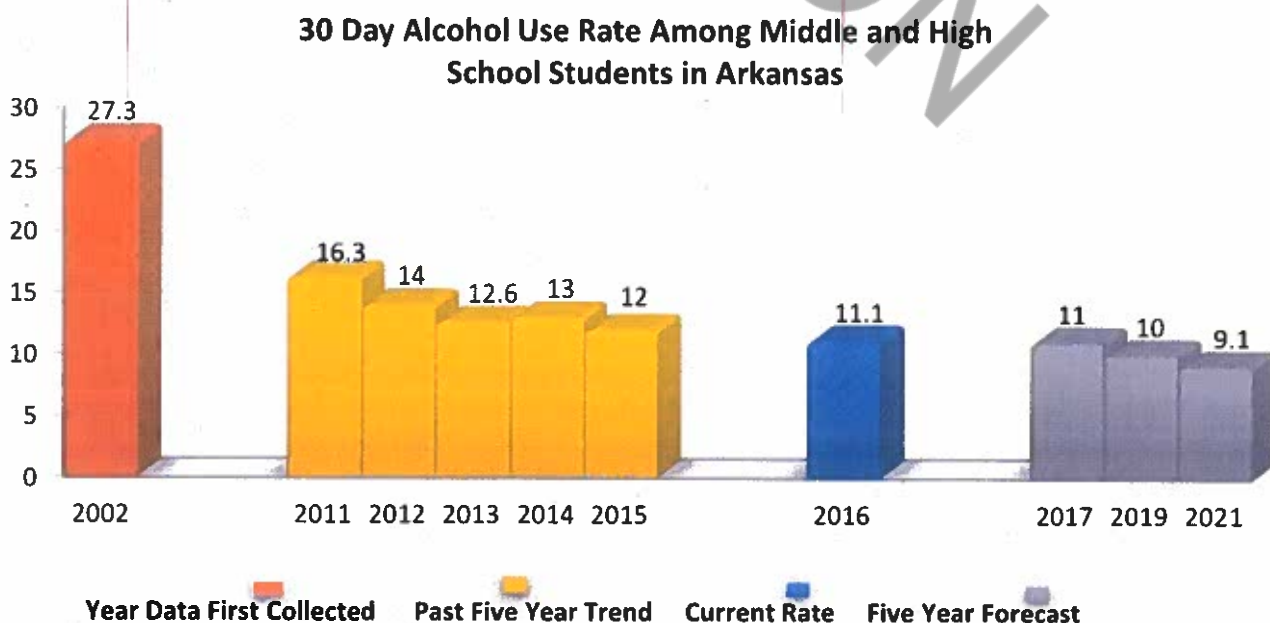
The following goals and objectives have been identified for the SFY 2019 to SFY 2023 Strategic Prevention Plan.

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.1: Lower the reported 30 day alcohol usage rate among middle and high school students according to the Arkansas Prevention Needs Assessment from 11.1% in 2016 to 9.1% by 2021.

Year	2002	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	27.3	16.3	14	12.6	13	12	11.1	11	10	9.1

Table 1 / Exhibit 1: Archival, past five years, current and forecasted 30 day alcohol usage rate among middle and high school students in Arkansas



Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

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STRATEGIES

1. Disseminate Information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on how alcohol effects the body and brain development of youth.
2. Increase knowledge and skills by educating youth/parents on alcohol risks using evidence based substance abuse prevention curriculum, peer leadership programs, and parenting/family management classes.
3. Offer community alternative activities such as: drug free dances and parties, youth/adult leadership activities, community drop-in centers, and community service activities.
4. Provide prevention training to physical education (PE), counselors and health teachers who are primarily responsible for substance abuse prevention in classrooms.
5. Promote the establishment or review of alcohol use policies in schools, increase the perception of harm, and enforce community alcohol policies. *Example: Social Host laws.*
6. Partner with community coalitions, policy makers, and other stakeholders to change community norms towards alcohol usage.
7. 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.
8. Identify youth who have indulged in illegal/age-inappropriate use of alcohol (indicated population) in order to assess if their behavior can be changed through educational avenues.
9. Partner with law enforcement and local policy makers to enforce social host law to reduce hosting underage drinking parties in their communities.

ACTION TIMEFRAME

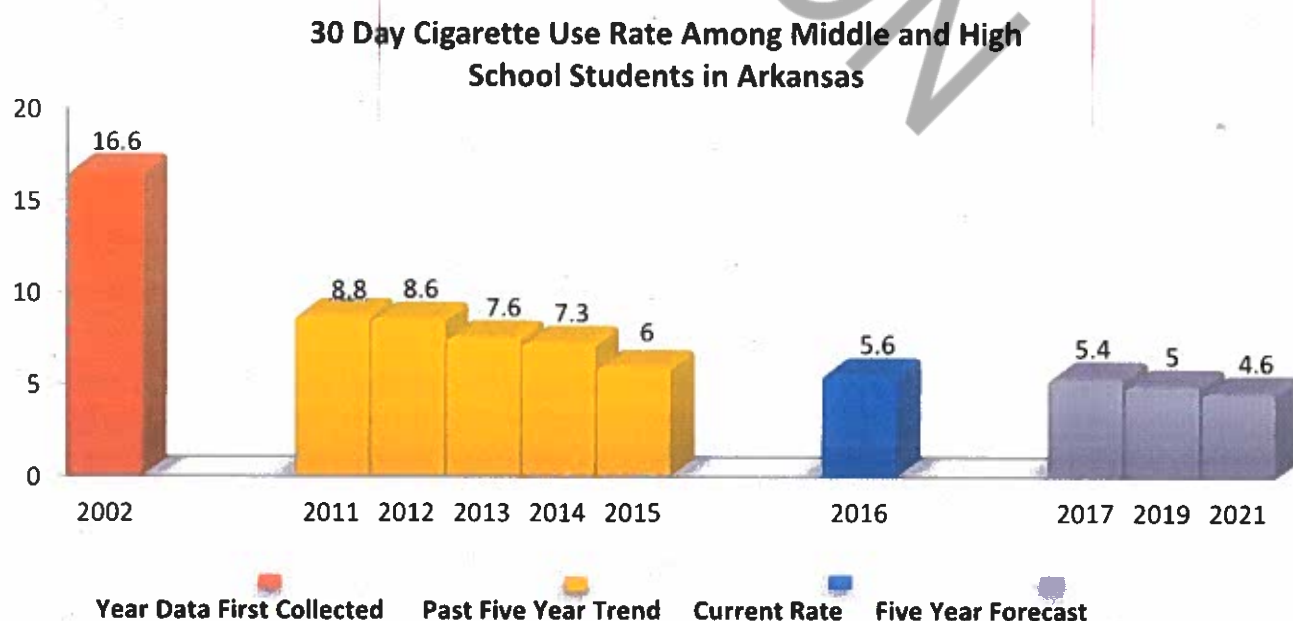
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate Information.	Disseminate Information.	Disseminate Information.	Disseminate Information.
Provide prevention training to PE and health teacher.	Provide prevention training to PE and health teachers.	Partner with local policy makers and law enforcement to enforce host law.	Partner with local policy makers and law enforcement to enforce host law.
Partner with community coalitions, policy makers, and other stakeholders to change community norms towards alcohol usage.	Partner with local policy makers and law enforcement to enforce host law	Increase knowledge and skills by educating youth/parents on alcohol risks using evidence based curriculum.	Increase knowledge and skills by educating youth/parents on alcohol risks using evidence based curriculum.
Increase knowledge and skills by educating youth/parents on alcohol risks using evidence based curriculum.	Increase knowledge and skills by educating youth/parents on alcohol risks using evidence based curriculum.		

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.2a: Lower the reported 30 day cigarette usage rate from 5.6% in 2016 to 4.6% in 2021 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2002	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	16.6	8.8	8.6	7.6	7.3	6.0	5.6	5.4	5	4.6

Table2/Exhibit 2: Archival, past five years, current and forecasted 30 day cigarette usage rate among middle and high school students in Arkansas



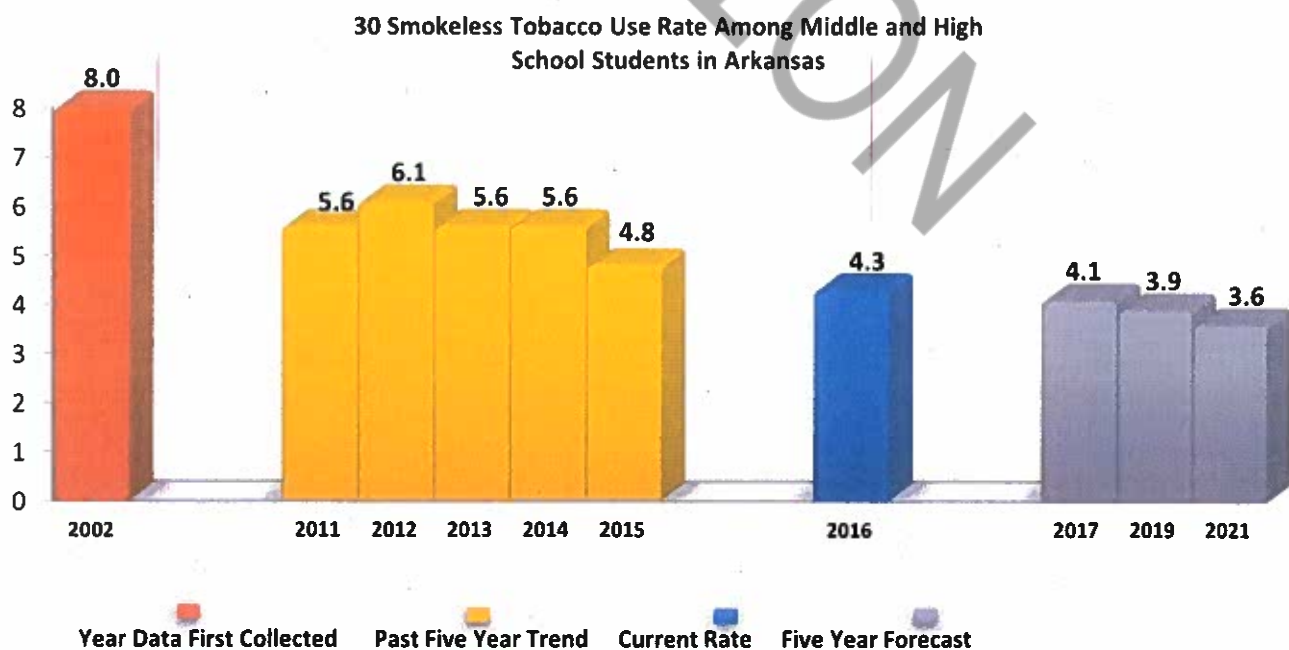
Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.2b: Lower the reported 30 day smokeless tobacco usage rate from 4.3% in 2016 to 3.6% by 2021 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2002	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	8.0	5.6	6.1	5.6	5.6	4.8	4.3	4.1	3.9	3.6

Table: Table3/Exhibit 3: Archival, past five years, current and forecasted 30 day smokeless tobacco usage rate among middle and high school students in Arkansas



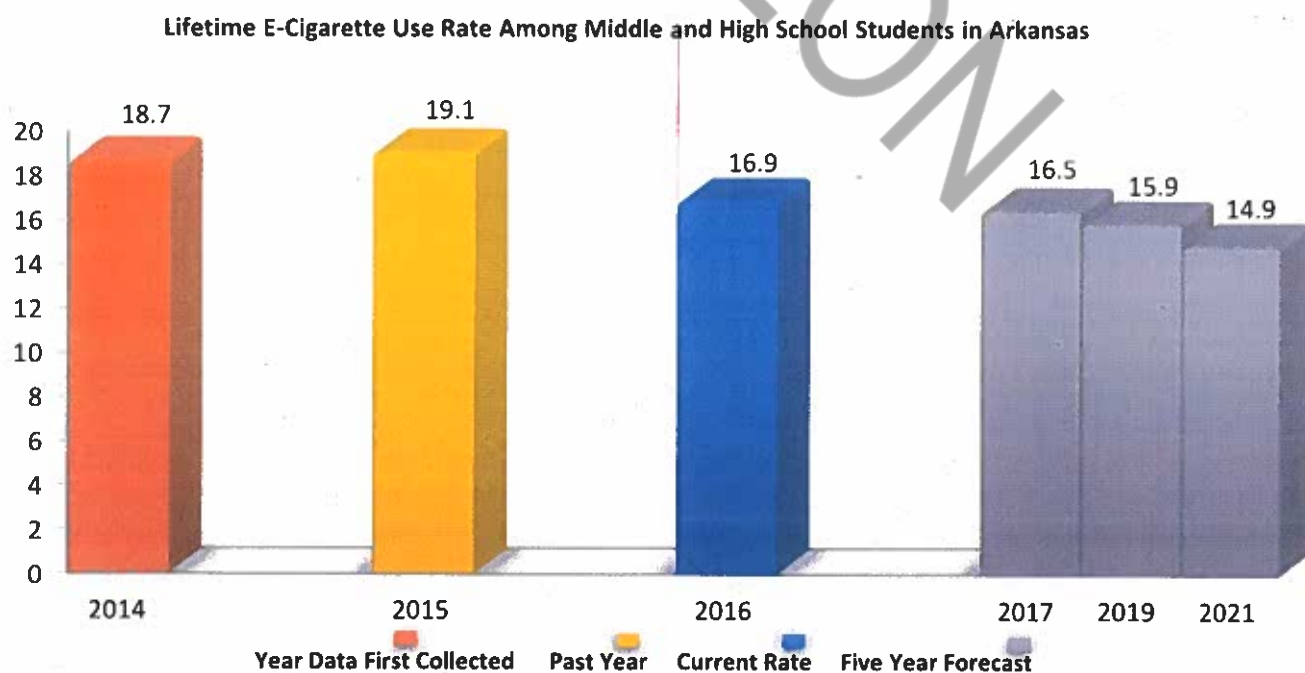
Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.2c: Lower the lifetime e-cigarette usage rate from 16.9% in 2016 to 14.9% in 2021 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2014	2015	2016	2017	2019	2021
Rate (%)	18.7	19.1	16.9	16.5	15.9	14.9

Table 4/Exhibit 4: Archival, past five years, current and forecasted lifetime e-cigarette usage rate among middle and high school students in Arkansas



Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

STRATEGIES

1. Disseminate information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on how tobacco/nicotine containing products affect the body and brain development of youth.
2. Increase knowledge and skills by educating youth/parents on tobacco/nicotine harms using evidence based substance abuse prevention curriculum, peer leadership programs, and parenting/family management classes.
3. Provide prevention training to school counselors, PE and health teachers who are primarily responsible for substance abuse prevention in classrooms.
4. Partner with community coalitions, policy makers, law enforcement and other stakeholders to change community norms towards nicotine and tobacco usage. *Example: promote tobacco free parks and workplaces and enforce laws against smoking in cars with young children present (ACT 811).*
5. Enhance coordination with Arkansas Department of Health Tobacco Prevention and Cessation Program, Arkansas Tobacco Control, Arkansas Chapter of American Lung Association, American Cancer Society, and other tobacco prevention stakeholders to provide tobacco prevention services in the communities through coordinated trainings.
6. Increase opportunities for youth to acquire prevention knowledge and skills so that they will become recognized as leaders and advocates for themselves and their peers.
7. Based on the Annual Synar Report, increase tobacco prevention efforts and resources to areas with higher tobacco retailer violation rates (RVRs).

ACTION TIMEFRAME

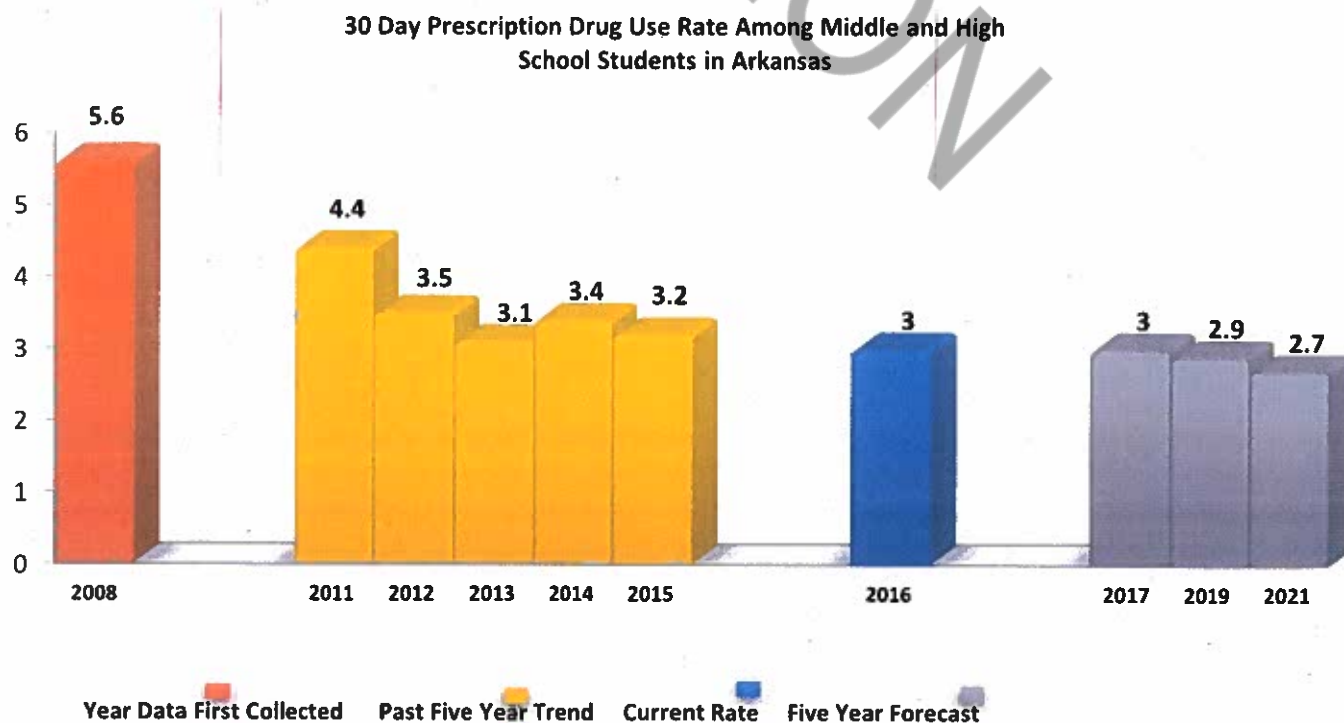
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.
Provide prevention training to counselors PE and health teacher.	Provide prevention training to counselors PE and health teacher.	Provide prevention training to counselors PE and health teacher.	Provide prevention training to counselors PE and health teacher.
Increase knowledge and skills by educating youth/parents on tobacco harms using evidence based substance abuse prevention curriculum.	Increase knowledge and skills by educating youth/parents on tobacco harms using evidence based substance abuse prevention curriculum.	Increase knowledge and skills by educating youth/parents on tobacco harms using evidence based substance abuse prevention curriculum.	Increase knowledge and skills by educating youth/parents on tobacco harms using evidence based substance abuse prevention curriculum.
Establish MOU's with ADH Tobacco Prevention and Cessation Program to provide tobacco prevention services in the communities through	Develop MOU with Arkansas Tobacco Control to leverage resources through coordination tobacco merchant trainings.		

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.3: Lower the reported 30 day rate for misuse of prescription drugs according to the Arkansas Prevention Needs Assessment from 3.0% in 2016 to 2.7% by 2021.

Year	2008	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	5.6	4.4	3.5	3.1	3.4	3.2	3	3	2.9	2.7

Table: Table 5/Exhibit 5: Archival, past five years, current and forecasted 30 day prescription drug usage rate among middle and high school students in Arkansas



STRATEGIES

1. Continue efforts by State Drug Director's office, Division of Aging, Adult, and Behavioral Health Services, Drug Enforcement Agency, Arkansas Health Department and law enforcement to raise community awareness through Monitor, Secure and Dispose campaign.
2. DAABHS/MidSOUTH will collaborate with Criminal Justice Institute to provide prevention and safe prescribers training to physicians and other healthcare providers for a greater understanding of the science of addiction and prescription drug issues related to over prescribing.
3. Partner with Criminal Justice Institute to provide training on Naloxone to all first responders, school resource officers, and other community stakeholders.
4. Provide prevention training to counselors, PE and health teachers who are primarily responsible for substance abuse prevention in classrooms.
5. Continue efforts to promote drug take back days and medicine drop boxes to reduce access to prescription drugs.
6. Encourage enforcement of prescription drug monitoring programs to reduce the overprescribing of medication and doctor shopping.
7. Expand the use and analysis of data of the Arkansas Prescription Monitoring Program (PMP).
8. Improve public health programs on prescribing i.e., how to speak to your provider, by using the MedHandBook.
9. Support research, prescriber education, and public education for non-opioid methods of pain treatments or alternative prescribing.

ACTION TIMEFRAME

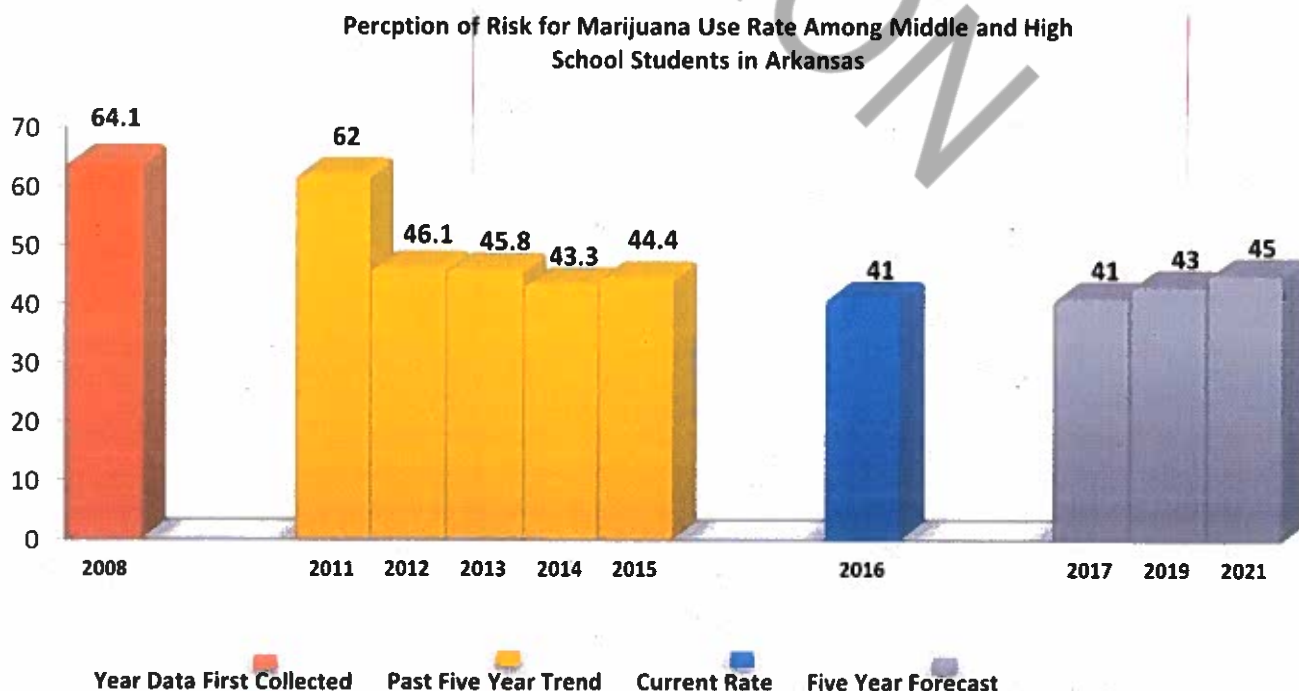
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.
Provide opioid abuse prevention training through MidSOUTH training academy.	Provide opioid abuse prevention training through MidSOUTH training academy.	Provide opioid abuse prevention training through MidSOUTH training academy.	Provide opioid abuse prevention training through MidSOUTH training academy.
Partner with Criminal Justice Institute to provide prescribers training.	Partner with Criminal Justice Institute to provide prescribers training.	Continue efforts to promote drug take back.	Continue efforts to promote drug take back.
Continue efforts to promote drug take back.	Continue efforts to promote drug take back.		
Coordinate with ADH to encourage prescribers use of prescription drug monitoring programs	Coordinate with ADH to encourage prescribers use of prescription drug monitoring programs		

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.4: Increase the reported perception of risk for marijuana use among Arkansas youth from 41% in 2016 to 45% by 2021 according to the Arkansas Prevention Needs Assessment.

Year	2002	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	64.1	62	46.1	45.8	43.3	44.4	41	41	43	45

Table 6/Exhibit 6: Archival, past five years, current and forecasted perception of risk for marijuana rate among middle and high school students in Arkansas



Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

STRATEGIES

1. Disseminate Information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on how marijuana effects the body and brain development of youth.
2. Increase knowledge and skills by educating communities on marijuana risks using evidence based substance abuse prevention curriculum, peer leadership programs, and parenting/family management classes.
3. Offer community alternative activities such as: drug free dances and parties, youth/adult leadership activities, community drop-in centers, and community service activities.
4. Provide prevention training to school counselors, PE and health teachers who are primarily responsible for substance abuse prevention in classrooms.
5. Promote the establishment or review of marijuana use policies in communities, increase the perception of harm, and enforce community marijuana policies. *Example: Dispensary and grower-free zones.*
6. DAABHS/MidSOUTH will partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.
7. Increase opportunities for youth to acquire prevention knowledge and skills so that they will become recognized as leaders and advocates for themselves and their peers.

ACTION TIMEFRAME

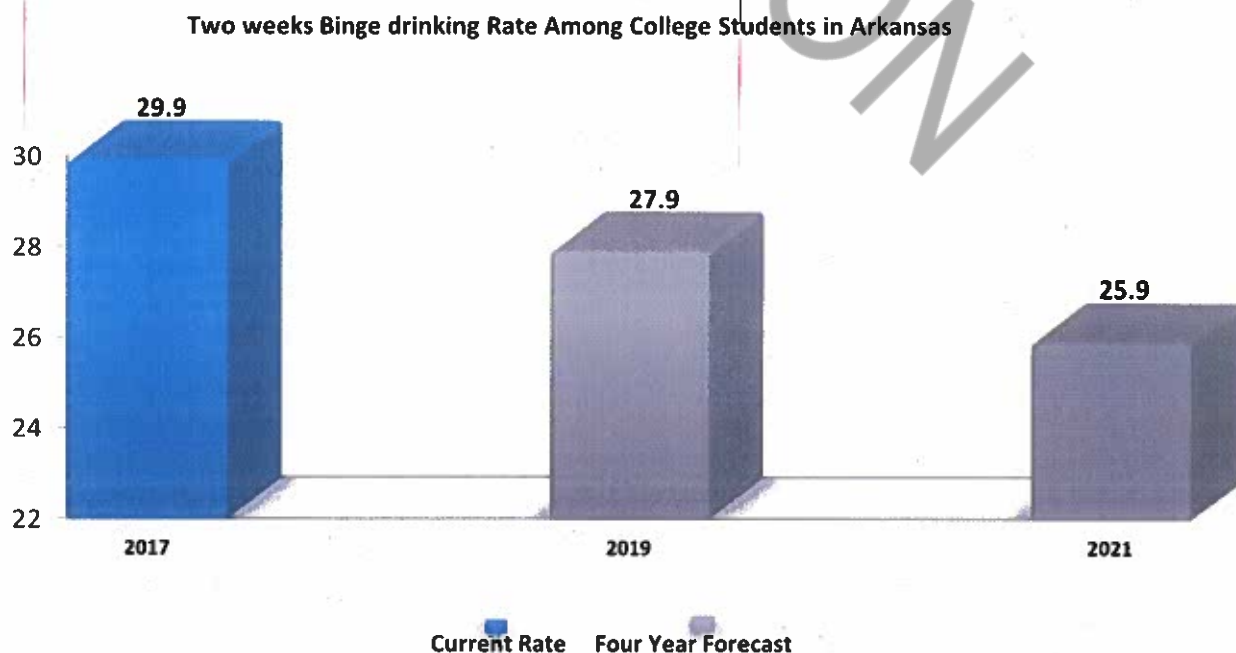
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.
Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.
	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.

GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

OBJECTIVE 1.5: Lower the reported past 2 week binge drinking rate according to the CORE survey from 29.9% in 2017 to 25.9% by 2021 among college students.

Year	2017	2019	2021
Rate (%)	29.9	27.9	25.9

Table 7/Exhibit 7: Current and forecasted 2 week binge drinking rate among college students in Arkansas



Source: CORE survey is available online at <http://core.siu.edu/>.

STRATEGIES

1. DAABHS/MidSOUTH will partner with community coalitions, policy makers, law enforcement and other stakeholders to change community norms and to enforce Social Host laws on college/university campuses.
2. Encourage collaborative efforts to increase number of colleges/universities that administer the CORE Survey.
3. Increase percentage of students participating in the CORE Survey.
4. Research prevention curriculum to be used statewide for incoming students on the awareness of the harmful effects of underage drinking and heavy drinking.
5. Encourage the establishment of collegiate recovery and prevention programs.
6. Promote student led wellness programs on college campuses.

ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Renew ACDEC contract.	Expand ACDEC program by recruiting more schools.	Promote student led wellness programs on college campuses.	Promote student led wellness programs on college campuses.
Expand ACDEC program by recruiting more schools.	Promote student led wellness programs on college campuses.	Collaborate with ACDEC to provide prevention trainings to college students.	Collaborate with ACDEC to provide prevention trainings to college students.
Promote student led wellness programs on college campuses.	Collaborate with ACDEC to provide prevention trainings to college students.	Partner with ACDEC and school policy makers to implement Social Host laws on university campuses.	Partner with ACDEC and school policy makers to enforce Social Host laws on university campuses.
Collaborate with ACDEC to provide prevention trainings to college students.			

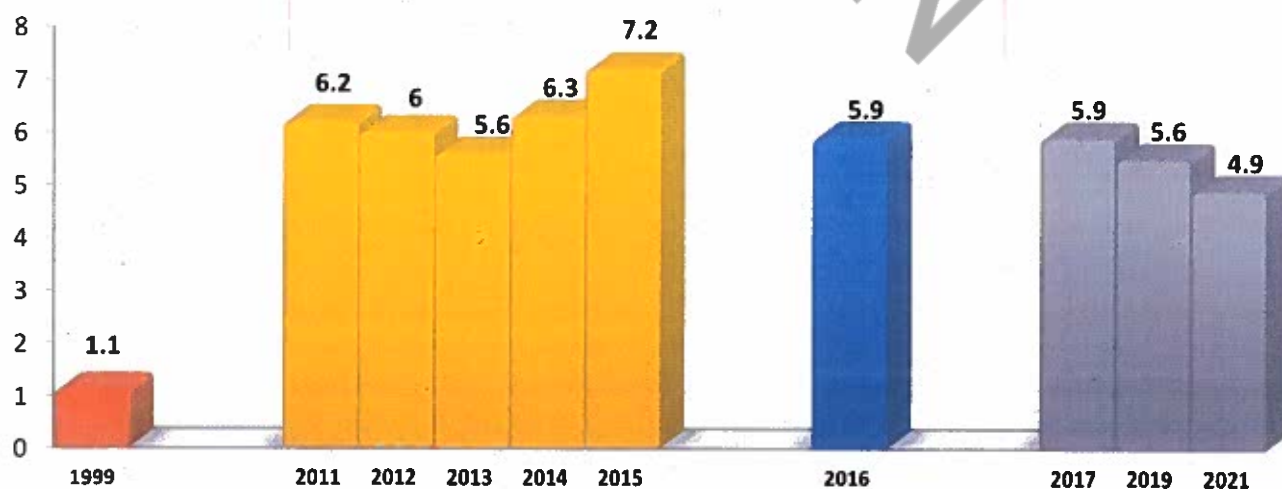
GOAL 2: Reduce the Opioid Overdose Death Rates in Arkansas.

OBJECTIVE 2.1: Lower the rate of intentional overdose deaths from drugs reported by the Henry J. Kaiser Family Foundation from 5.9% in 2016 to 4.9% by 2021.

Year	1999	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	1.1	6.2	6	5.6	6.3	7.2	5.9	5.9	5.6	4.9

Table 8/Exhibit 8: Archival, past five years, current and forecasted Opioid Overdose Death Rates in Arkansas per 100,000 Population (Age-Adjusted)

Opioid Overdose Death Rates in Arkansas per 100,000 Population



Year Data First Collected Past Five Year Trend Current Rate Five Year Forecast

Source: The Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/>

STRATEGIES

1. DAABHS/MidSOUTH will collaborate with University of Arkansas Criminal Justice Institute (CJI) to train physicians and other health workers on prescribing practices.
2. DAABHS/MidSOUTH will collaborate with CJI to identify high risk communities and develop awareness campaigns on the dangers of opioid drug abuse.
3. DAABHS/MidSOUTH will collaborate with CJI on Prescription Drug Overdose (PDO) and State Targeted Response to the Opioid Crisis (STR) Grants which aims to address the opioid crisis.
4. DAABHS/MidSOUTH will collaborate with Arkansas Department of Health Injury and Violence Prevention section to provide training on bullying, mental health first aide and suicide prevention.
5. Collaborate with Arkansas Department of Health Injury and Violence Prevention section to provide training on suicide screenings to community providers and promote awareness of suicide as a preventable health issue by developing a better understanding of the relationship between self-harm and mental health and substance abuse issues.
6. DAABHS/MidSOUTH will collaborate with LGBTQ groups to 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.
7. Encourage the establishment of collegiate recovery and prevention programs.

ACTION TIMEFRAME

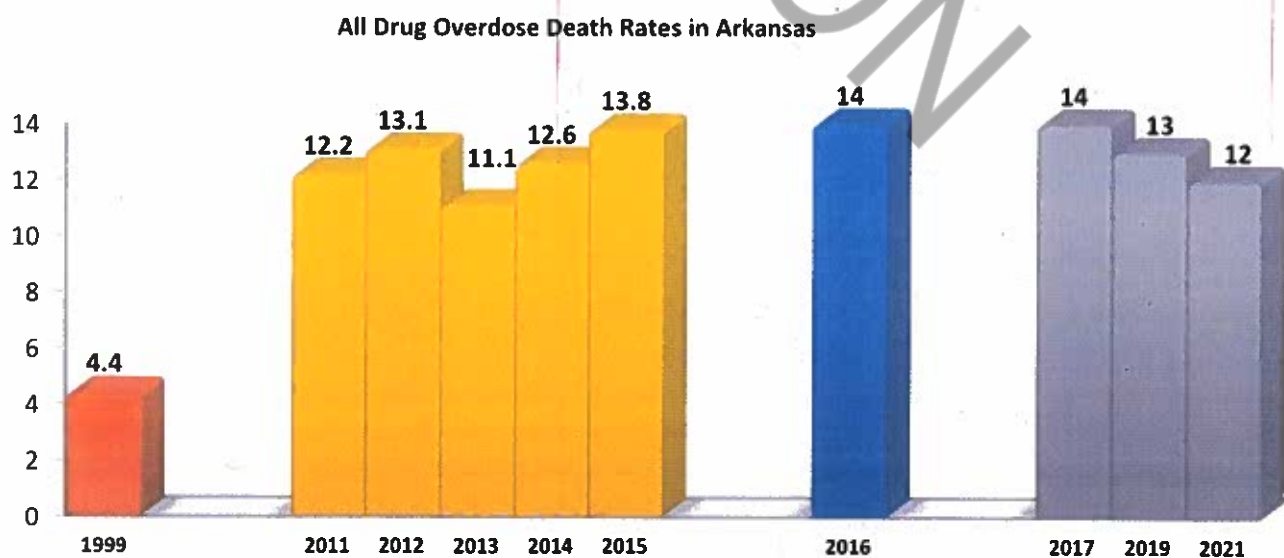
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Establish MOU's with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate suicide prevention trainings.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate bullying and suicide prevention trainings.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate bullying and suicide prevention trainings.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate bullying and suicide prevention trainings.
Collaborate with Criminal Justice Institute (CJI) to train physicians and other health workers on prescribing practices.	Collaborate with CJI to train physicians and other health workers on prescribing practices.	Collaborate with CJI to train physicians and other health workers on prescribing practices.	Collaborate with CJI to train physicians and other health workers on prescribing practices.
Collaborate with CJI to identify high risk communities for opioid drug abuse.	Collaborate with CJI to develop awareness campaigns on the dangers of opioid drug abuse.	Collaborate with CJI to develop awareness campaigns on the dangers of opioid drug abuse.	Coordinate with ADH Injury and Violent Prevention Section to administer LGBTQ and Veteran's surveys.
Include addiction and suicide prevention trainings to MidSOUTH CPT training schedules.	Coordinate with ADH Injury and Violent Prevention Section to develop LGBTQ and Veteran's surveys.	Coordinate with ADH Injury and Violent Prevention Section to administer LGBTQ and Veteran's surveys.	

GOAL 2: Reduce the Opioid Overdose Death Rates in Arkansas.

OBJECTIVE: 2.2: Lower the rate of all Drug Overdose Death Rates in Arkansas as reported by the Henry J. Kaiser Family Foundation from 14% in 2016 to 12% by 2021.

Year	1999	2011	2012	2013	2014	2015	2016	2017	2019	2021
Rate (%)	4.4	12.2	13.1	11.1	12.6	13.8	14	14	13	12

Table 8/Exhibit 8: Archival, past five years, current and forecasted *Opioid Overdose Death Rates* in Arkansas per 100,000 Population (Age-Adjusted)



Year Data First Collected Past Five Year Trend Current Rate Five Year Forecast

Source: The Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/>

STRATEGIES

1. DAABHS/MidSOUTH will collaborate with Arkansas Department of Health Injury and Violence Prevention section to disseminate suicide prevention materials at trainings, schools, health fairs, in the communities etc.
2. DAABHS/MidSOUTH will collaborate with Arkansas Department of Health Injury and Violence Prevention section to 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.
3. MidSOUTH will conduct trainings on bullying, mental health first aid and suicide prevention.
4. DAABHS/MidSOUTH will collaborate with Arkansas Department of Health Injury and Violence Prevention section to provide evidence-based trainings.
5. Develop Memorandum of Understanding between DAABHS/MidSOUTH and Injury and Violence Prevention section of Arkansas Department of Health.
6. Encourage Arkansas Collegiate Drug Education Committee (ACDEC) to establish collegiate recovery and prevention programs.

ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Establish MOU's between Arkansas Department of Health Injury and Violence Prevention section on collaborative efforts.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and conduct trainings on bullying and suicide prevention.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate bullying and suicide prevention trainings.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate bullying and suicide prevention trainings.
Collaborate with ADH Injury and Violence Prevention section to provide training on suicide screenings to community providers and promote suicide awareness.	Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials.	Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials.	Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials
Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials		Collaborate with ACDEC to establish collegiate recovery and prevention programs.	Collaborate with ACDEC to establish collegiate recovery and prevention programs.

GOAL 3: Strengthen and enhance Arkansas Prevention Infrastructure and leadership to manage, lead and sustain effective substance abuse prevention and behavioral health promotion programs and strategies.

OBJECTIVE 3.1: Enhance prevention infrastructure to systematically support Regional Prevention Providers (RPPs), Community Coalitions, and other state agencies and allied prevention partners in their efforts to reduce substance abuse and promote behavioral health outcomes.

STRATEGIES

1. Increase collaboration among organizations and agencies involved in prevention including, but not limited to, state and local government, elected officials, key stakeholders and the thirteen Regional Prevention Providers.
2. DAABHS/MidSOUTH will collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.
3. Design and implement training and technical assistance system that will enhance skills of providers to administer effective prevention services.
4. Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.
5. Build relationships with partners and community coalitions and clearly define roles and expectations for partners and communities.
6. Identify prevention champions in the legislature to advance prevention policies.

GOAL 3: Strengthen and enhance Arkansas Prevention Infrastructure and leadership to manage, lead and sustain effective substance abuse prevention and behavioral health promotion programs and strategies.

OBJECTIVE 3.1: Enhance prevention infrastructure to systematically support Regional Prevention Providers (RPPs), Community Coalitions, and other state agencies and allied prevention partners in their efforts to reduce substance abuse and promote behavioral health outcomes.

ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Enhance capacity of the Regional Prevention Provider system by increasing funding allocation.	Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.	Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.	Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.
Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.	Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.	Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.	Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.
Design and implement training and technical assistance system that will increase and enhance skills of providers to administer effective prevention services.	Develop/identify training curriculums and conduct TOTs.	Conduct training curriculums and conduct TOTs.	Conduct training curriculums and conduct TOTs.
Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.			
Establish County Prevention Taskforces.			

GOAL 3: Strengthen and enhance Arkansas Prevention Infrastructure and leadership to manage, lead and sustain effective substance abuse prevention and behavioral health promotion programs and strategies.

OBJECTIVE 3.2: Assist State agencies, organizations, and communities in using state and local data to conduct prevention needs assessments; selecting and implementing data driven prevention strategies/programs; and monitoring and evaluating effectiveness of prevention efforts.

STRATEGIES

1. Ensure increased statewide participation in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey and other identified prevention needs assessment efforts.
2. Increase collaboration among local and state partners to share information for the Risk Factors and Epidemiological State Profile data compilation.
3. Create a marketing plan to promote available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders

ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Ensure increased statewide participation in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey by recruiting more schools.	Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey.	Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey.	Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey.
Increase collaboration among partner agencies to share data.	Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.	Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.	Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.
Create marketing plan to promote available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.			

GOAL 3: Strengthen and enhance Arkansas Prevention Infrastructure and leadership to manage, lead and sustain effective substance abuse prevention and behavioral health promotion programs and strategies.

OBJECTIVE 3.3: Provide training and technical assistance to regional prevention providers and other behavioral health stakeholders.

STRATEGIES

1. DAABHS/MidSOUTH will conduct periodic assessments to determine training needs.
2. Provide year round prevention trainings and annual statewide prevention conference.
3. Prevention Certification/Workforce Development – Collaborate with the Arkansas Prevention Certification Board (APCB) to recruit more prevention providers into the certification process.
4. Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders to effectively plan, implement, evaluate and sustain prevention programs and strategies.
5. Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.
6. Develop/identify standardized prevention training to establish a common prevention knowledge base and shared interests across behavioral health sectors and disciplines.
7. Provide periodic trainings on Strategic Prevention Framework process and both SAPST and SAPST TOT with fidelity to providers and other prevention stakeholders.
8. Regularly evaluate community needs, successes, and challenges.
9. DAABHS/MidSOUTH will partner with Criminal Justice Institute to provide training on Naloxone to all first responders, school resource officers, and other community stakeholders.

GOAL 3: Strengthen and enhance Arkansas Prevention Infrastructure and leadership to manage, lead and sustain effective substance abuse prevention and behavioral health promotion programs and strategies.

OBJECTIVE 3.3: Provide training and technical assistance to regional prevention providers and other behavioral health stakeholders.

ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Conduct assessments to determine training needs.	Conduct assessments to determine training needs.	Conduct assessments to determine training needs.	Conduct assessments to determine training needs.
Provide year round prevention trainings and annual statewide prevention conference.	Provide year round prevention trainings and annual statewide prevention conference.	Provide year round prevention trainings and annual statewide prevention conference.	Provide year round prevention trainings and annual statewide prevention conference.
Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.	Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.	Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.	Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.
Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders	Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders	Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders	Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders
Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.	Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.	Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.	Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.
Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.	Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.	Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.	Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.

GOAL 4: Evaluate Arkansas' substance abuse prevention system.

OBJECTIVE 4.1: Collect and analyze process and outcome data to determine the ongoing effectiveness of prevention and behavioral health promotion programs and strategies implementations.

STRATEGIES

1. With guidance from the Arkansas Foundation for Medical Care (AFMC), the plan will be continuously monitored and evaluated periodically to determine if forecasted benchmarks are being met. The plan outcomes will be measured on a short term (2019), mid-term (2020) and long term (2022) basis by reviewing the usage rates for selected substances. This will entail a review of the outcomes by examining data sources for the trend of usage for the following indicators:
 - Past 30-day usage: This is a measure of the current use of substances among middle and high school students.
 - Lifetime use: This indicator measures usage of a substance at least once in the student's lifetime, and is the best measure of youth experimentation with alcohol, tobacco and other drugs.
 - Perception of risk: Increased perception of risk is a protective factor that measures likelihood of not using a substance. Likewise, decreased perception of risk increases the likelihood of usage.
 - Past 2-weeks binge drinking: This measures excessive alcohol consumption of college students.
2. Process data will be evaluated to determine infrastructure improvements, trainings, and partner outreach. Minutes and relevant documentation such as number of people trained, served and certified will be reviewed on a regular basis.
3. Develop Memorandums of Understanding between partner agencies to assure that all parties understand their respective roles.
4. Continue to fund and maintain the State Epidemiological Outcome Workgroup to provide state and county-level data to support substance abuse prevention planning and evaluation for the prevention system.

GOAL 4: Evaluate Arkansas' substance abuse prevention system.

OBJECTIVE 4.1: Collect and analyze process and outcome data to determine the ongoing effectiveness of prevention and behavioral health promotion programs and strategies implementations.



ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022
Continuously measure process and outcome data to determine if forecasted benchmarks are met.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.
Measure short-term outcomes by reviewing the usage rates for selected substances.	Measure mid-term outcomes by reviewing the usage rates for selected substances.		Measure long-term outcomes by reviewing the usage rates for selected substances.

DATA SOURCES

State Epidemiological Outcome Workgroup

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 populations. 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 online 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 <https://arkansas.pridesurveys.com/>.

Risk Factors for Adolescent Drug and Alcohol Abuse In Arkansas

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 resource for other fields, including treatment, youth services, etc. This report is posted online at <http://www.preventionworksar.org/>.

DATA SOURCES

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. More information on the CORE survey is available online at <http://core.siu.edu/>.

Monitoring the Future

Monitoring the Future is an ongoing study of behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 students in 8th, 10th, and 12th grades are surveyed. 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 <https://nsduhweb.rti.org/respweb/homepage.cfm>.

The Kaiser Family Foundation

Kaiser is a non-profit organization focusing on national health issues, as well as the U.S. role in global health policy. Unlike grant-making foundations, Kaiser develops and runs its own policy analysis, journalism and communications programs, sometimes in partnership with major news organizations.

KFF serves as a non-partisan source of facts, analysis and journalism for policymakers, the media, the health policy community and the public. More information on the KFF is available online at <https://www.kff.org/>.

APPENDIX i.

2012 Arkansas Prevention Strategic Plans Outcomes

Goal	Outcome Measured	Final Outcome
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.	30 day alcohol usage rate according to the APNA by 2016 was reported at 11.1%.	This represents a 5.2% decrease. Goal Surpassed by 2.1%
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.	30 day smokeless tobacco usage rate according to the APNA by 2016 was reported at 4.3%.	This represents a 1.3% decrease. Goal Not Met by 0.7%
	30 day cigarette usage rate according to the APNA by 2016 was reported at 5.6%.	This represents a 3.2% decrease. Goal Surpassed by 1.2%
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.	30 day prescription drugs usage rate according to the APNA by 2016 was reported at 3%.	This represents a 1.4% decrease. Goal Not Met by 0.9%
4. Lower the number of attempted suicide reported by the Arkansas Department of Health Injury Prevention from 1692 in 2010 to 1400 by 2016.	Information not available	Information not available

APPENDIX ii.

2012 Arkansas Prevention Strategic Plans Outcomes of Infrastructure Needs Identified

Infrastructure Needs Identified	Outcome
Need to source more funding from the state government and braiding of funds with other agencies.	<p>Prevention services did not receive funds from the state government. However, there has been increased coordination of services and braiding of funds, especially through trainings, with other agencies.</p> <p>Prevention services was able to secure the following discretionary funds from the Substance Abuse and Mental Health Services Administration (SAMHSA):</p> <ul style="list-style-type: none"> • Strategic Prevention Framework Partnership for Success grant (PFS) • Prescription Drug Overdose Grant (PDO) • State Targeted Response to Opioid Crisis Grant (STR)
Increase collaboration among behavioral health organizations	DAABHS and MidSOUTH have increased collaborations with other behavioral health agencies.
Restructuring of the technical assistance system at the regional/community level	<p>DAABHS remains the Single State Agency (SSA) with authority to oversee the Substance Abuse Block Grant (SABG).</p> <p>DAABHS has contracted the University of Arkansas Little Rock, MidSOUTH Center for Prevention and Training to manage the state's prevention program.</p> <p>The regions of service were restructured from 8 regions to 13 regions. MidSOUTH is also in contract with ACDEC.</p>
Comprehensive data management system	<p>WITS data management system was acquired by DAABHS and is currently being overseen by MidSOUTH.</p> <p>MidSOUTH and AFMC also developed a data reporting and analysis platform known as REDCap.</p>
Need for more behavioral health training and certification capacity	MidSOUTH currently conducts two (2) statewide prevention conferences. Also, year round trainings are conducted throughout the state.
Need for more prevention services staff at the state and local levels.	The contract with MidSOUTH has allowed for nine (9) additional prevention service staff to the three (3) staff housed at DAABHS for a total of twelve staff at the state level. Also, more staff has been added at the local level with the expansion of the regions from eight (8) to thirteen (13).

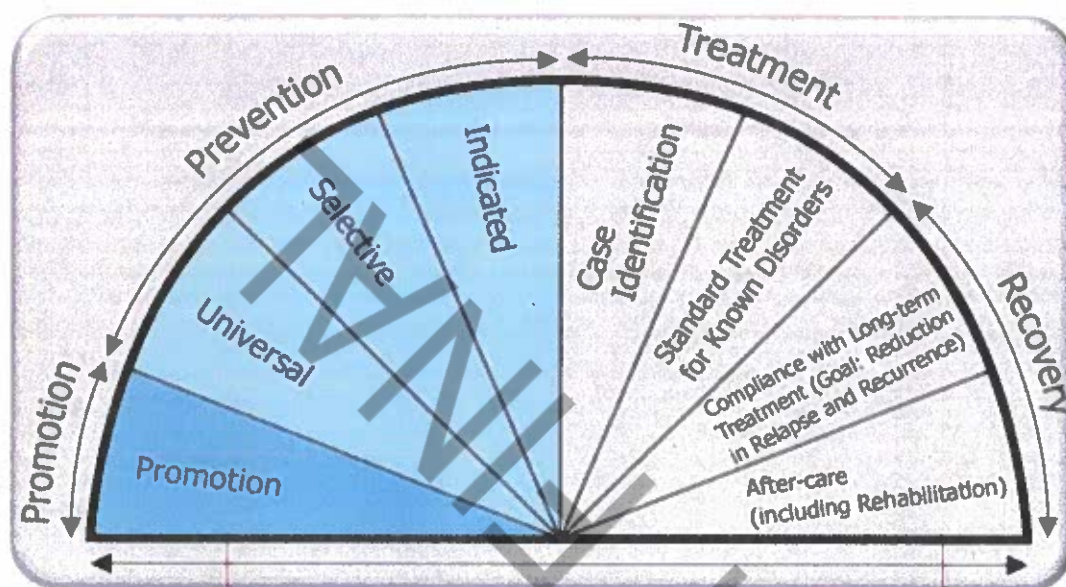
APPENDIX iii.

Arkansas Strategic Prevention Planning Committee Members

Name	Agency	Title	Email
Chuks Odor	UA Little Rock/MidSOUTH Center for Prevention and Training Lead: Strategic Planning Committee	Prevention Program Manager	CCOdor@midsouth.ualr.edu
Tenesha Barnes	Arkansas Department of Human Services	Early Intervention and Prevention Director	Tenesha.Barnes@dhs.arkansas.gov
Nelda Barnard	Arkansas Department of Human Services	Program Coordinator	Nelda.J.Barnard@asp.arkansas.gov
Steven Blackwood		Consultant	SRBlackwood@gmail.com
Gloria Gordon	Private Citizen	Consultant	gloria_gordon@sbcglobal.net
Megan Greenwood	Pulaski Technical College	ACDEC Representative	MGreenwood@pulaskitech.edu
Darla Kelsay	UA Little Rock/MidSOUTH Center for Prevention and Training	Substance Abuse Prevention Coordinator	d.kelsay@midsouth.ualr.edu
Kirk Lane	Arkansas Department of Human Services	State Drug Director	Kirk.Lane@asp.arkansas.gov
Jan Littleton-Caldwell	UA Little Rock/MidSOUTH Center for Prevention and Training	Assistant Director, MidSOUTH	JLCaldwell@midsouth.ualr.edu
Tiffani McAdoo	UA Little Rock/MidSOUTH Center for Prevention and Training	Partnership for Success Specialist	TLMcAdoo@midsouth.ualr.edu
Hayse Miller	Family Service Agency, Inc.	Region 9 Regional Prevention Representative	HMiller@fsainc.org
Sharron Mims	Arkansas Department of Human Services	Program Manager	Sharron.Mims@asp.arkansas.gov
Lisa Perry	Crowley's Ridge Development Council, Inc.	Region 4 Regional Prevention Representative	LPerry@crdcnea.com
Gigi Peters	UA Little Rock/MidSOUTH Center for Prevention and Training	Executive Director, MidSOUTH	GAPeters@midsouth.ualr.edu
Joycelyn Pettus	Arkansas Department of Human Services	Grants Analyst	Joycelyn.Pettus@dhs.arkansas.gov
Gina Redford	Arkansas Foundation for Medical Care	Manager, Analytical Services	Gina.Redford@afmc.org
Laurie Reh	Preferred Family Health Decision Point	Region 1 Regional Prevention Representative	LReh@decision-point.org
Johnny Riley	Bridging the Gaps	Executive Director	JohnnyRileyJr@gmail.com
Rosalie Shahan	UA Little Rock/MidSOUTH Center for Prevention and Training	Prevention Admin and Data Specialist	rsshahan@midsouth.ualr.edu
Kent Thompson	Arkansas Foundation for Medical Care	Supervisor, Program Evaluation	KThompson@afmc.org
Jill	T.O.U.C.H Coalition	T.O.U.C.H. Project Coordinator	Jill.Touch@gmail.com

APPENDIX iv.

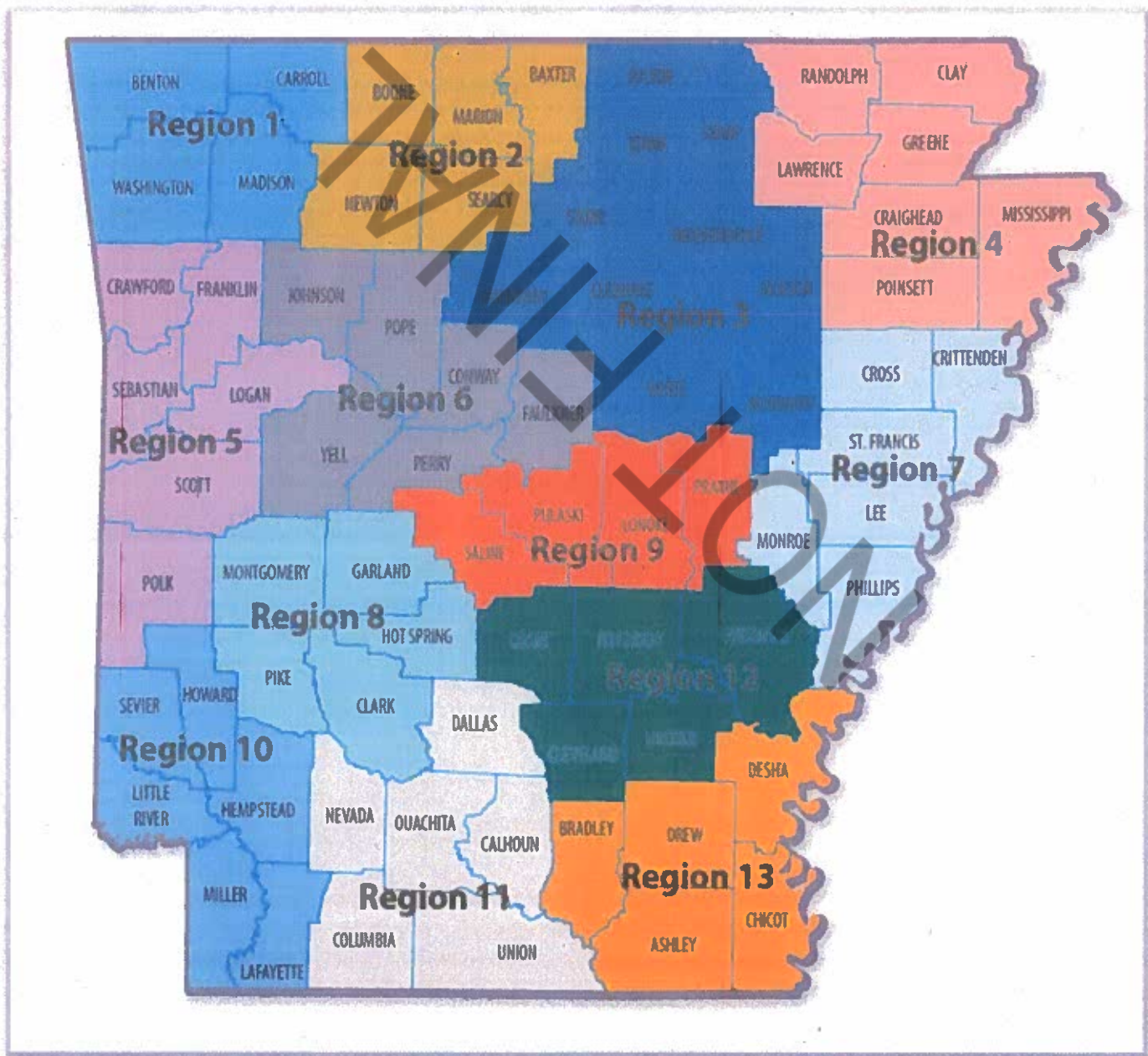
Continuum of Care

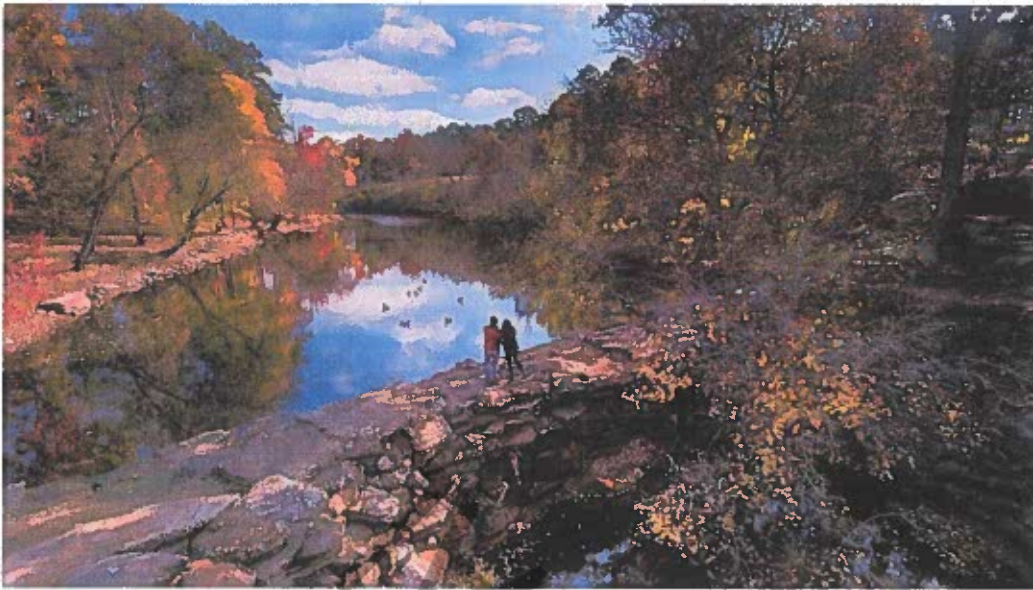


A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes the following components:

- **Promotion**—These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention**—Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment**—These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Recovery**—These services support individuals' abilities to live productive lives in the community and can often help with abstinence.

Arkansas Prevention Services Regions





Sources

1. Arkansas 2010 Strategic Prevention Plan.
2. Arkansas Prevention Needs Assessment (APNA) Survey. <https://arkansas.pridesurveys.com/>.
3. Arkansas Strategic Prevention Plan. Prevention for a Healthy Arkansas (12/31/2012).
4. Center for the Application of Prevention Technologies (CAPT). <https://www.samhsa.gov/capt/>.
5. Council on Alcohol and Drugs. <https://www.livedrugfree.org/>.
6. Institute of Medicine (IOM). Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities, March 2009.
<http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx>.
7. Kaiser Family Foundation. <https://www.kff.org/>.
8. Southern Illinois University Carbondale. Alcohol and Drug Survey for Higher Education.
<http://core.siu.edu/>.



NOT FINAL



Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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.

DAABHS ensures mental health and behavioral health care is available to children, youth, and adults throughout the state.

 - Outpatient mental health and substance use disorder services are available through certified community providers and as such, must comply with State and federal requirements.
 - PASSE members, as well as those without insurance or a payor source for needed services, can access a broader scope of rehabilitative services, which include Peer Support, Behavioral Assistant, Child and Youth Support Services, and Adult Life Skills Development.
 - Arkansas has developed a new home and community-based provider type called Community Support System Provider.
 - Aftercare Recovery Services provides a transitional service to assist individuals stepping down from a higher level of care and helps to promote and maintain community integration, and hopefully, fewer future hospitalizations.
 - Many counseling level of services are available by telehealth.
 - All Community Mental Health Centers are contractually mandated to have a clinic in every county in their region to improve access.
 - Counseling level services are more easily accessed and can be obtained from DHS certified Behavioral Health Agencies or Community Support System Providers at the Intensive/Enhanced level as well as Independently Licensed Clinicians who are enrolled as Medicaid providers.
 - Masters prepared Licensed Alcohol and Drug Abuse Counselors (LADAC) and Provisionally Licensed Master of Social Work clinicians are now able to provide Medicaid reimbursable services.
2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
 - a) Physical Health ☒ Yes ☐ No
 - b) Mental Health ☒ Yes ☐ No
 - c) Rehabilitation services ☒ Yes ☐ No
 - d) Employment services ☒ Yes ☐ No
 - e) Housing services ☒ Yes ☐ No
 - f) Educational Services ☒ Yes ☐ No
 - g) Substance misuse prevention and SUD treatment services ☒ Yes ☐ No
 - h) Medical and dental services ☒ Yes ☐ No
 - i) Support services ☒ Yes ☐ No
 - j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) ☒ Yes ☐ No
 - k) Services for persons with co-occurring M/SUDs ☒ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

For all persons in a PASSE, their assigned Care Coordinator provide coordination of services across all areas of need for their members, including their physical and mental health needs. Needs may also include housing or other types of supportive services.

As stated above supported employment for those with mental health issues, and housing are currently areas with gaps for our state.

3. Describe your state's case management services

Care Coordination from the assigned PASSE assists the individual in obtaining the best array of services to meet their needs and is available for children and adults. Additionally, case management is now a reimbursable service for persons accessing Counseling Level services under our state contracts. One of the primary tasks for case management is to ensure the individual gets access to available and appropriate healthcare insurance, but also other resources which positively impact the social determinants of health. As a part of the "Rural Life360 HOME" in the Arkansas Medicaid expansion program, a care coordinator will be assigned to all persons who have a social determinant of health need and a behavioral health need.

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

CMHC providers are contractually responsible for completing Single-Point of Access (SPOA) crisis screenings and services to all adults, youth, and children who are uninsured or underinsured and are not a member of a PASSE. Additionally, the CMHCs complete crisis screenings for all individuals in the custody of the Division of Children and Family Services (DCFS). For the DCFS population specifically, CMHC staff must provide crisis intervention services, in most cases within 2 hours, in a community setting which focuses on stabilization and prevents hospitalization when appropriate. Furthermore, CMHCs must include a safety plan and face-to-face follow-up within 24-48 hours of the initial crisis. Per contract, the CMHC emergency services staff must triage individuals in crisis into the least restrictive setting, which may include immediate outpatient treatment, crisis intervention and stabilization services, referral to detoxification program or other appropriate substance use disorder treatment services. For persons with re-occurring crises, the CMHC must re-evaluate previous crisis and safety plan(s) and revise or update plans using a collaborative approach to ensure safety and that behavioral health services are at an appropriate level of intensity, thus hopefully averting future hospitalizations. For those who are hospitalized, the vast majority are hospitalized in a community hospital and not the Arkansas State Hospital. The CMHC are financially incentivized to provide utilization management and expeditious aftercare services such that persons can be moved to community care as soon as safe and appropriate. The first outpatient appointment after a hospitalization is required to be within seven calendar days of hospital discharge.

Outside of our CMHC contracts, any Medicaid enrolled behavioral health provider is mandated to ensure crisis services are made available to their clients on a rapid basis.

Additionally, each PASSE is required to develop, implement, and maintain a 24/7 mobile crisis response. The contact information for each PASSE's crisis response is disseminated to all members upon enrollment and then each Care Coordinator includes a crisis plan in the Person-Centered Service Plan.

Using COVID Supplemental funding, we have two Mobile Crisis Pilots underway in the state, one in northeast Arkansas and a second in central western Arkansas. Both have struggled to have staffing at a level to allow for 24/7 responses on a consistent basis. However, both have regular meetings with their local law enforcement and work hard to communicate with a broad array of community stakeholders. Because these pilots are not working 24/7, we know that diversion efforts are not as complete as they will be, but we do believe they are positively impacted diversions rates to some degree.

Finally, our state currently has four Crisis Stabilization Units. They have been financially supported by a combination of State General Revenue and insurance reimbursement, including Medicaid, since the inception in 2019. The legislature has approved funding for a fifth unit in south Arkansas, where resources are desperately scarce. Originally, only CMHCs and Crisis Intervention-Trained officers were allowed to refer to the units. As of 2022, referrals are accepted from any entity, including self-and/or family referrals. In SFY 2021, the 4 current units served 2286 persons, in 2022 1,860 persons were served (1 unit was closed most of this year due to not having a behavioral health provider), and in 2023 a total of 2,317 persons were served.

We are excited to report that Arkansas is growing and diversifying our Peer Support workforce. In 2021 decisions were made to align training for all Peers to be inclusive of substance use disorder issues and mental health issues. Since that time, we have been working diligently to incorporate Peers into emergency rooms, jails, court rooms, and of course treatment locations. Federal funding has been accessed to develop Recovery Community Organizations and we are underway with working on increasing recovery housing options and getting those housing programs nationally accredited for quality control.

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

None at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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 M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	125,190	21,234
2.Children with SED	40,415	10,782

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.

Prior to 2017, the determination of whether an adult or child was Seriously Mentally Ill or Seriously Emotionally Disturbed was made by the behavioral health provider. In late 2017, Arkansas implemented a process whereas a 3rd party entity completes a functional assessment, called an Independent Assessment (IA), on Medicaid beneficiaries in need of, or already receiving behavioral health services. Based on the outcome of this IA, which is updated annually, Medicaid beneficiaries are attributed to a PASSE if they scored as a Tier 2 or Tier 3 category. An outcome of a Tier 2 or 3 indicates a person has complex behavioral healthcare needs, with Tier 2 being fairly moderate needs, and Tier 3 being designated as the highest-needs category. Individuals scoring a Tier 1 are not attributed to a PASSE, but are still able to access counseling level behavioral health services funded by Medicaid on a fee-for-service basis. Due to this significant change, the way Arkansas determines a person insured by traditional Medicaid to be SMI or SED is now determined by the outcome of the IA being a Tier 2 or Tier 3.

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

None at this time.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

- | | |
|--|---|
| a) Social Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Educational services, including services provided under IDEA | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Juvenile justice services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Health and mental health services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Establishes defined geographic area for the provision of services of such systems | <input checked="" type="radio"/> Yes <input type="radio"/> No |

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

None at this time

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

- a. Describe your state's targeted services to rural population. [See SAMHSA's Rural Behavioral Health page for program resources](#)

Arkansas is a primarily rural state with a few pockets of urban areas spread mostly across central and north western/north eastern areas of the state. In 2019, Arkansas required every Community Mental Health Center to open clinics in every covered county for their area to assist with limiting access barriers. Additionally, Arkansas increased the rates for Independently Licensed Mental Health Practitioners who wanted to become enrolled Medicaid providers which equalized reimbursement rates for agencies and the independent practitioners. This resulted in a massive increase in the number of providers for counseling level services. While many of these practitioners are located in urban hubs, there was also an increase in the number serving in rural areas. During the course of the pandemic, many services became allowable by telehealth. Arkansas has elected to continue liberal use of services by telemedicine which is helping those in rural areas, but also assists with workforce shortages. Federally Qualified Health Clinics and Rural Health Clinics can also provide behavioral health services, including telehealth services.

Finally, another recent change has also allowed primary care clinics to hire their own behavioral health clinicians to ensure integrated care services are more available to those in need.

- b. Describe your state's targeted services to people experiencing homelessness. [See SAMHSA's Homeless Programs and Resources for program resources](#)

Arkansas is a recipient of the Projects for Assistance in Transition from Homelessness (PATH) grant. Our PATH providers cover three different areas of the state, with one being exclusively urban, and in our capital city, and the other two providers cover a combination of urbanized and rural areas in the southwest and northeast areas of the state.

- c. Describe your state's targeted services to the older adult population. [See SAMHSA's Resources for Older Adults webpage for resources.](#)

Older adults with behavioral health issues have access to the same services as the general adult population. Nursing homes have been added as an allowable place of service for Medicaid. DHS also works with Senior Centers and AAA Centers through agency nurses to assure information regarding accessing services and emergency service numbers, including 988, are distributed to the older adult population.

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

None at this time.

NOT FINAL

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.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#).

Criterion 5

a. Describe your state's management systems.

Arkansas uses a significant amount of State General Revenue, Block Grant funding, and Medicaid dollars to ensure mental health services are available to all persons in need. Though Arkansas has undergone significant transformation over the last five years, we continue to evaluate our entire system for gaps and needs. Our Division of Aging, Adult, and Behavioral Health Services (DAABHS) is doing some reorganization for better use of DHS staff, but also to incorporate the Behavioral health staff, the Substance Use Treatment staff, Recovery staff, and the staff working for the Division of Medical Services who oversee our Provider-led Arkansas Shared Savings Entities under one area which will be known as the Office of Substance Abuse and Mental Health (OSAMH). With this new structure, we will be better able to coordinate multiple funding sources for behavioral health care needs for our citizens.

We are in the process of engaging our Community Mental Health Centers, Consumer Council Group, and other stakeholders in strategic planning meetings under the guidance of our consulting group. Based on the outcomes of those meetings, plans will be developed for moving forward and improving our forensic system, our crisis system, and our treatment programs. The goals identified in this application are general goals to address current gaps, but flexible enough that we can pivot and adjust based on the outcome of the strategic planning sessions.

Training for emergency health responders takes place in a few different ways. Since 2018 we have been working to expand the number of Crisis Intervention Trained (CIT) Law Enforcement Officers. Some of these specific trainings involve direct participation from our Crisis Stabilization Unit Directors. Other CIT trainings include guest speakers who are mental health professionals and/or persons with lived experience. A variety of grant initiatives are providing access to Mental Health First Aid to first responders, but also educators, medical professionals, and the broader public (not all initiatives are coordinated through DAABHS/OSAMH).

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Arkansas defines telemedicine using the information below:

Arkansas Medicaid provides payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider. Any other originating sites are not eligible to bill a facility fee.

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a client. Telemedicine includes store-and-forward technology and remote client monitoring.

Store-and-forward technology is the transmission of a client's medical information from a healthcare provider at an originating site to a healthcare provider at a distant site. An originating site includes the home of a client. Remote client monitoring means the use of electronic information and communication technology to collect personal health information and medical data from a client at an originating site that is transmitted to a healthcare provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring.

Arkansas Medicaid shall provide payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider. Any other originating sites are not eligible to bill a facility fee.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in person.

Professional Relationship

The distant site healthcare provider will not utilize telemedicine services with a client unless a professional relationship exists between the provider and the client. A professional relationship exists when, at a minimum:

1. The healthcare provider has previously conducted an in-person examination of the client and is available to provide appropriate follow-up care;
2. The healthcare provider personally knows the client and the client's health status through an ongoing relationship and is available to provide follow-up care;
3. The treatment is provided by a healthcare provider in consultation with, or upon referral by, another healthcare provider who has an ongoing professional relationship with the client and who has agreed to supervise the client's treatment including follow-up care;
4. An on-call or cross-coverage arrangement exists with the client's regular treating healthcare provider or another healthcare provider who has established a professional relationship with the client;
5. A relationship exists in other circumstances as defined by the Arkansas State Medical Board (ASMB) or a licensing or certification board for other healthcare providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.
 - a. A professional relationship is established if the provider performs a face-to-face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination. (See ASMB Regulation 2.8);
 - b. If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board (See ASMB Regulation 38 for these safeguards including the standards of care); or
6. The healthcare professional who is licensed in Arkansas has access to a client's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a client located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the client.

A health record is created with the use of telemedicine, consists of relevant clinical information required to treat a client, and is reviewed by the healthcare professional who meets the same standard of care for a telemedicine visit as an in-person visit.

A professional relationship does not include a relationship between a healthcare provider and a client established only by the following:

1. An internet questionnaire;
2. An email message;
3. A client-generated medical history;
4. Text messaging;
5. A facsimile machine (Fax) and Fax;
6. Any combination of the above; or
7. Any future technology that does not meet the criteria outlined in this section.

The existence of a professional relationship is not required when:

1. An emergency situation exists; or
2. The transaction involves providing information of a generic nature not meant to be specific to an individual client.

Once a professional relationship is established, the healthcare provider may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare provider is licensed or certified and in accordance with the safeguards established by the healthcare professionals licensing board.

Telemedicine with a Minor Client

Regardless of whether the provider is compensated for healthcare services, if a healthcare provider seeks to provide telemedicine

services to a minor in a school setting and the minor client is enrolled in Arkansas Medicaid, the healthcare provider shall:

1. Be the designated Primary Care Provider (PCP) for the minor client;
2. Have a cross-coverage arrangement with the designated PCP of the minor client; or
3. Have a referral from the designated PCP of the minor client.

If the minor client does not have a designated PCP, this section does not apply. Only the parent or legal guardian of the minor client may designate a PCP for a minor client.

Telemedicine Standard of Care

Healthcare services provided by telemedicine, including without limitation a prescription through telemedicine, shall be held to the same standard of care as healthcare services provided in person. A healthcare provider providing telemedicine services within Arkansas shall follow applicable state and federal laws, rules and regulations regarding:

1. Informed consent;
2. Privacy of individually identifiable health information;
3. Medical record keeping and confidentiality, and
4. Fraud and abuse.

A healthcare provider treating clients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. This requirement does not apply to the acts of a healthcare provider located in another jurisdiction who provides only episodic consultation services.

Telemedicine Exclusions

Telemedicine does not include the use of:

1. Audio-only communication unless the audio-only communication is in real-time, is interactive, and substantially meets the requirements for a health care service that would otherwise be covered by the health benefit plan:
 - a. Documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care after the contact;
 - b. Medical documentation is subject to the same audit and review process required by payers and governmental agencies when requesting documentation of other care delivery such as in-office or face-to-face visits;
2. A facsimile machine;
3. Text messaging; or
4. Email.

As we are unwinding from the Public Health Emergency, Arkansas plans to continue to allow a broad array of services to be performed by telemedicine to assist with access and overcome transportation barriers and workforce shortages.

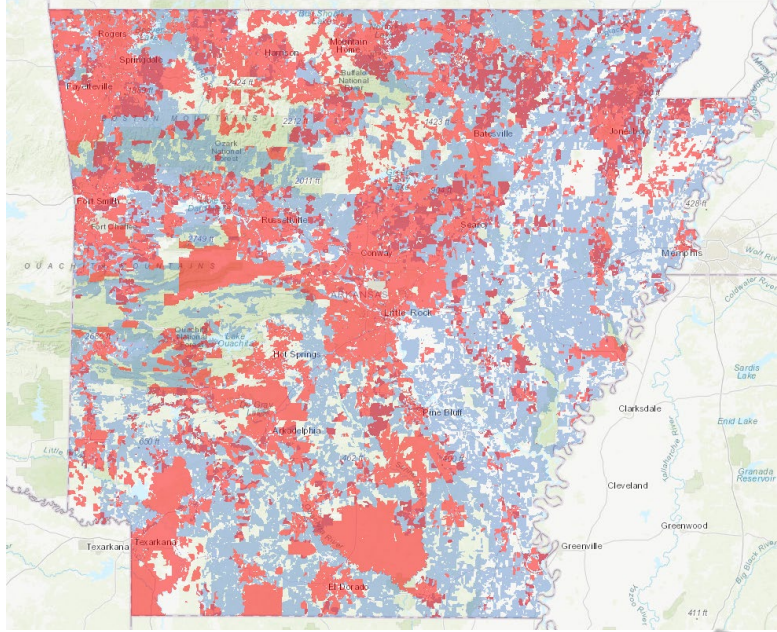
Our former Governor put a huge emphasis on improving broadband access across the state, one of which was related to services via telemedicine. Attached is a map of our state-wide coverage with red and blue areas now having coverage.

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

None at this time.

Footnotes:

NOT FINAL



NOT FINAL

RULE 2.8

8. **Requiring minimum standards for establishing Patient/Provider relationships. Provider is defined as a person licensed by the Arkansas State Medical Board. A Provider exhibits gross negligence if he provides and/or recommends any form of treatment, including prescribing legend drugs, without first establishing a proper Patient/Provider relationship.

A. For purposes of this regulation, a proper Patient/Provider relationship, at a minimum requires that:

1. A. The Provider performs a history and an “in person” physical examination of the patient adequate to establish a diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided, OR
B. The Provider has access to a patient’s personal health record, defined by ACA §17-80-401 *et seq.*, as relevant clinical information required to treat a patient, that is maintained by a Provider and uses any technology deemed appropriate by the Provider, including the telephone, with a patient located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the patient.
 1. A proper professional relationship does not include one established only by internet questionnaire, email message, patient-generated medical history, text message, facsimile, or any combination of these means.
- C. The Provider personally knows the patient and the patient’s general health status through an “ongoing” personal or professional relationship;
 1. Appropriate follow-up be provided or arranged, when necessary, at medically necessary intervals.
 2. A health record may be created with the use of telemedicine and consists of relevant clinical information required to treat a patient, and is reviewed by the healthcare professional who meets the same standard of care for a telemedicine visit as an in-person visit.

B. For the purposes of this regulation, a proper Patient/Provider relationship is deemed to exist in the following situations:

1. When treatment is provided in consultation with, or upon referral by, another Provider who has an ongoing relationship with the patient, and who has agreed to supervise the patient’s treatment, including follow up care and the use of any prescribed medications.

2. On-call or cross-coverage situations arranged by the patient's treating Provider.

C. Exceptions -- Recognizing a Provider's duty to adhere to the applicable standard of care, the following situations are hereby excluded from the requirement of this regulation:

1. Emergency situations where the life or health of the patient is in danger or imminent danger.

2. Simply providing information of a generic nature not meant to be specific to an individual patient.

3. This Regulation does not apply to prescriptions written or medications issued for use in expedited heterosexual partner therapy for the sexually transmitted diseases of gonorrhea and/or chlamydia.

4. This Regulation does not apply to the administration of vaccines containing tetanus toxoid (e.g., DTaP, DTP, DT, Tdap, Td, or TT) or inactive influenza vaccines.

NOT FINAL

RULE NO. 38: TELEMEDICINE

Requirement for all services provided by Providers using telemedicine:

1. A Patient/Provider relationship must be established in accordance with Rule 2.8 before the delivery of services via telemedicine. Provider is defined as a person licensed by the Arkansas State Medical Board. A patient completing a medical history online and forwarding it to a Provider is not sufficient to establish the relationship, nor does it qualify as store-and-forward technology.

2.L. A physician shall not issue a written medical marijuana certification to a patient based on an assessment performed through telemedicine. A Patient/Provider relationship established under Rule 2.8 may be utilized for medical marijuana recertification by telehealth. "Telehealth certification" means the electronic assessment of a patient by a provider in connection with an application for a registry identification card under the Arkansas Medical Marijuana Amendment of 2016.

M. Telemedicine does not include the use of audio-only electronic technology by a provider to renew a written certification that was previously issued to the same patient.

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

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 | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ii) Education | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iii) Brief Intervention | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iv) Assessment | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| v) Detox (inpatient/residential) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vi) Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vii) Intensive Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| viii) Inpatient/Residential | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ix) Aftercare; Recovery support | <input checked="" type="radio"/> Yes <input type="radio"/> No |

b) Services for special populations:

- | | |
|---------------------------------------|---|
| i) Prioritized services for veterans? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| ii) Adolescents? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iii) Older Adults? | <input checked="" type="radio"/> Yes <input type="radio"/> No |

NOT FINAL

Criterion 2

NOT FINAL

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ 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. Has your state identified a need for 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, and custody issues? ☒ 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.
- 1. Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs.
 - 2. Alcohol and Drug Abuse Prevention- Rules of Practice and Procedures
 - 3. Comprehensive Substance Abuse Treatment- Performance -Based Indicators

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement ☒ Yes ☐ No
 - b) 14-120 day performance requirement with provision of interim services ☒ Yes ☐ No
 - c) Outreach activities ☒ Yes ☐ No
 - d) Syringe services programs, if applicable ☐ Yes ☒ No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached ☒ Yes ☐ No
 - b) Automatic reminder system associated with 14-120 day performance requirement ☒ Yes ☐ No
 - c) Use of peer recovery supports to maintain contact and support ☒ Yes ☐ No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)? ☐ Yes ☒ No
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.
 1. Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs.
 2. Alcohol and Drug Abuse Prevention- Rules of Practice and Procedures
 3. Comprehensive Substance Abuse Treatment-Performance -Based Indicators

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? ☐ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers ☒ Yes ☐ No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment ☒ Yes ☐ No
 - c) Established co-located SUD professionals within FQHCs ☒ Yes ☐ No
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.

The Division of Aging, Adult and Behavioral Health Services, Substance Abuse Treatment does not monitor the Tuberculosis *TB). Our agency reaches out to the Arkansas Department of Health for this data.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have 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 such service delivery? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas ☐ Yes ☒ No
 - b) Establishment or expansion of tele-health and social media support services ☒ Yes ☐ No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ☐ Yes ☒ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? ☐ Yes ☒ No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☐ Yes ☒ No
3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ☐ Yes ☒ No

If yes, please provide a brief description of the elements and the arrangement

NOT FINAL

Criterion 8,9&10**Service 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 ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access ☒ Yes ☐ No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services ☒ Yes ☐ No
 - c) Establish a peer recovery support network to assist in filling the gaps ☒ Yes ☐ No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) ☐ Yes ☒ No
 - 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 ☒ Yes ☐ No
 - f) Explore expansion of services for:
 - i) MOUD ☒ Yes ☐ No
 - ii) Tele-Health ☒ Yes ☐ No
 - iii) Social Media Outreach ☒ Yes ☐ No

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? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ☒ Yes ☐ No
 - b) Establish a program to provide trauma-informed care ☒ Yes ☐ No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education ☐ Yes ☐ No

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)? ☐ Yes ☒ No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries ☐ Yes ☒ No
 - b) An organized referral system to identify alternative providers? ☐ Yes ☒ No
 - c) A system to maintain a list of referrals made by religious organizations? ☐ Yes ☒ No

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? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments ☒ Yes ☐ No
 - b) Review of current levels of care to determine changes or additions ☒ Yes ☐ No

- c) Identify workforce needs to expand service capabilities ☒ Yes ☐ No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background ☒ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements ☒ Yes ☐ No
- b) Training on responding to requests asking for acknowledgement of the presence of clients ☒ Yes ☐ No
- c) Updating written procedures which regulate and control access to records ☒ Yes ☐ No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: ☒ Yes ☐ 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? ☒ Yes ☐ 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.
- a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
Northeast Arkansas CMHC dba Mid-South Health Systems = Active Clients = 25; Recently Discharge Clients = 10
10th District Substance Abuse Program = Active Clients = 25; Recently Discharge Clients = 10
3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan ☒ Yes ☐ No
- b) Establishment of policies and procedures related to independent peer review ☒ Yes ☐ No
- c) Development of long-term planning for service revision and expansion to meet the needs of specific populations ☒ Yes ☐ No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? ☒ Yes ☐ 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)

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. Has your state identified a need for 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. Has your state identified a need for 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
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? ☒ Yes ☐ No
 - b) Mental Health TTC? ☒ Yes ☐ No
 - c) Addiction TTC? ☒ Yes ☐ No
 - d) State Targeted Response TTC? ☒ 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 that govern the Mental Health and Substance Use Disorder Programs.

If the answer is No to any of the above, please explain the reason.

NOT FINAL

Footnotes:

NOT FINAL

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF ALCOHOL AND DRUG
ABUSE PREVENTION**



**LICENSURE STANDARDS FOR
ALCOHOL AND OTHER DRUG
ABUSE TREATMENT
PROGRAMS**

REVISED 7/1/2022

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LICENSURE STANDARDS FOR
SUBSTANCE ABUSE TREATMENT PROGRAMS

AUTHORITY

The Department of Human Services (DHS), Division of DPSQA Provider Services and Quality Assurance (DPSQA) is vested by A.C.A. § 20-64-901 *et seq.* with the authority and duty to establish and promulgate rules for licensure of substance abuse treatment programs in Arkansas. All persons, partnerships, associations, or corporations establishing, conducting, managing, or operating and holding themselves out to the public as an alcohol and other drug abuse treatment program must be licensed by DPSQA, unless expressly exempted from these requirements. Programs administered by the Department of Defense, the Veterans Administration, acute care hospital-based alcohol and drug abuse treatment programs governed by § 20-9-201, § 20-10-213 and § 20-64-903, and persons exempted from licensure under Arkansas Code § 20-64-902 and § 20-64-903 are not required to be licensed by DPSQA, but may voluntarily seek licensure.

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is designated as the State Opioid Treatment Authority (SOTA) governing opioid treatment in Arkansas. Opioid Treatment Programs (OTPs) providing opioid treatment services shall comply with the applicable Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs including the specific standards for opioid treatment developed by DAABHS. Opioid treatment services shall comply with all applicable federal, state, and local laws and rules including those under the jurisdiction of the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the Drug Enforcement Administration (DEA) and the State Opioid Treatment Authority (SOTA)

As a condition of DPSQA licensure approval, , programs must comply with all laws and rules regarding alcohol or drug treatment, programming, services, accreditation, or education.

HISTORY

Act 644 of 1977 created the Arkansas Office of Alcohol and Drug Abuse Prevention (OADAP) and charged the office with the responsibility for developing and promulgating standards, rules for accrediting alcohol and other drug abuse prevention and treatment programs/facilities within the state.

Accreditation standards for alcohol and other drug abuse treatment programs were implemented in response to state and federal legislation, as well as the changing needs of the alcohol and drug abuse treatment programs. The first accreditation standards were adopted and implemented on January 1, 1983. Act 597 of 1989 delegated OADAP as the sole agency responsible for accrediting all alcohol and other drug abuse treatment programs. Revisions to the Accreditation Manual were promulgated on September 1, 1989. Act 173 of 1995 changed the accreditation process to a licensure process.

With the advent of the 1995 legislation, the Standards were promulgated and implemented as a Licensure Manual on July 1, 1995. The first Methadone Treatment Program Standards were developed and promulgated by OADAP on October 1, 1993. The Methadone/LAAM Treatment Program Standards were revised to include LAAM treatment on July 1, 1997. Subsequently LAAM treatment has been discontinued as a practice. More recently Buprenorphine has been recognized for use as an Opioid treatment. Thus, per designation of OADAP, the State Methadone Authority (SMA) has given way to the current designation of OADAP as the State Opioid Treatment Authority (SOTA) governing opioid treatment in Arkansas.

PURPOSE

The Licensure Standards for Substance Abuse Treatment Programs Manual are State issued rules governing the licensure process. The Manual includes:

- (1) Procedures for Licensure

- (2) Licensure Types
- (3) Substance Abuse Treatment Standards
- (4) Application for Licensure
- (5) Site Information Change Form
- (6) Incident Reporting Form

The Procedures for Licensure explains the licensure process for treatment programs, the Standards Review Team and other issues regarding licensure.

The Application for Licensure must be completed by all programs seeking licensure as an alcohol and/or other drug abuse treatment program in Arkansas prior to the on-site initial review. Separate licenses shall be issued for each physical site as indicated on the application.

An alcohol and other drug abuse treatment program must be in compliance with all applicable Standards in order for a program to obtain a license. Licenses shall be issued only for the premises and persons specified in the application and shall not be transferable.

No substance abuse program may be established, conducted, or maintained in Arkansas without first obtaining a substance abuse license as required by Ark. Code Ann. § 20-64-901 *et seq.*, DPSQA, and these licensing standards. The program shall not admit any clients until a license to operate has been issued.

All licenses issued hereunder are non-transferrable from one owner or proprietor to another, or from one site or location to another. Applicants for licensure or renewal of a substance abuse licensure shall obtain the necessary forms for initial or renewal licensure or to request re-licensure of the program after a change of ownership. The issuance of an application form shall not be a guarantee that the completed application will be acceptable, or that DPSQA will issue a license.

Questions concerning the licensure of alcohol and other drug abuse treatment programs in Arkansas may be directed to:

Mailing Address:

Department of Human Services
Division of Provider Services and
Quality Assurance
P.O. Box 8059, Slot S408
Little Rock, AR 72203

Physical Address:

700 South Main Street
Slot S408
Little Rock, AR 72203

Phone: 501-320-6283

Fax: 501-682-8540

<http://humanservices.arkansas.gov/about-dhs/dpsqa>

PROCEDURES FOR LICENSURE

Licensure is required of any individual, partnership, association or corporation operating or seeking to operate a substance abuse treatment program in the State of Arkansas. Upon promulgation of revisions to the standards, DPSQA will provide to each of the programs known to be operating within Arkansas, a copy of the newly issued Licensure Standards for Alcohol and other Drug Abuse Treatment Programs manual.

A schedule of the licensure process for each treatment program with the participation of the program under review will be developed by DPSQA. The entire licensure process for a program is shown below, with explanatory comments following.

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- Step 1
- a) Initial Application
 - b) a First time applicants seeking licensure shall submit a completed application for licensure for each site that will be providing substance abuse services to DPSQA.
 - c) b) Unlicensed alcohol and other drug abuse treatment programs will be notified by DPSQA of the need to make application for licensure.
- Step 2 Receipt by DPSQA of the program's completed application for licensure.
- a) First time applicants shall submit a non-refundable \$75.00 application fee for each site.
 - b) Currently licensed providers opening a new site must be fully licensed and shall be required to pay an additional \$75 application fee for each new site.
 - c) All currently licensed programs are required to pay an annual \$75.00 licensure renewal fee. Fees are due with the application or the application will not be processed.
- Step 3 DPSQA staff shall develop the schedule and requirements for the onsite review of the program and will inform the program of the impending review
- Step 4 DPSQA will provide written confirmation and notification to the program to include:
- a) Timetable developed in Step 1 – 3 above.
 - b) Members of the Standards Review Team for that program (see Standards Review Team Member selection process).
 - c) Notice of Requirement Form (form must be signed and returned to DPSQA prior to the start of the licensure review)
- Step 5 Formal on-site reviews by the DPSQA and Standards Review Team (SRT).
- Step 6 Compliance Notices developed by the SRT and their recommendations will be reviewed by DPSQA Certification and Licensing Office.
- Step 7 DPSQA The compliance notice will be sent to the program for a Plan of Correction (POC). The POC shall be completed by the provider, signed and returned to DPSQA within 15 days of receipt of the compliance notice..

- Step 8 Once the POC has been received and accepted, a decision will be made regarding the license to be given.
- Step 9 If the provider does not agree with the compliance notice, the provider may submit a reconsideration request to DPSQA. Instruction for the reconsideration is included in the compliance notice. DPSQA will respond to the program's reconsideration in writing.
- Step 10 Submission to DPSQA by the program, of a \$1,500.00 nonrefundable licensure review fee (for first time applicants only) due after the review. **NOTE: The formal license will only be issued upon receipt of payment of the licensure review fee.**

APPLICATION PROCESS FOR OPIOID TREATMENT PROGRAMS (OTP)

An OTP shall not operate in the State of Arkansas prior to completion of the application process. The following criteria must be met:

- a) Program has approval from the Drug Enforcement Administration (DEA) on file with DPSQA
- b) Program has approval from SOTA or the Co-SOTA.
- c) Program has approval from the SAMHSA's Center for Substance Abuse Treatment (CSAT).
- d) The program has received licensure as an Alcohol and Other Drug Abuse Treatment Program from DPSQA

NEW PROGRAMS COMMENCING OPERATION

Programs seeking licensure, or required to receive a licensure review, will complete all steps specified in the application process. DPSQA shall review standards applicable to programs that have not yet provided substance abuse treatment. If the program has met the requirements outlined below, DPSQA will issue a six (6) month operational permit.

1. Governing Board Authority and Procedures
2. Program Planning and Evaluation Processes
3. Employment and Personnel Practices
4. Program Services (to include applicable specialized services applied for)
5. Inspection of the Physical Plant
6. Articles of Incorporation/By Laws on file with the Arkansas Secretary of State
7. Board Minutes on file
8. Insurance Documentation
9. Evidence of current valid certifications of building, fire, safety and health inspections.
10. Policies and Procedures Manual
11. Client Handbook
12. All Clinical Forms
13. Admission and Intake Packet

Prior to expiration of the six (6) month operational permit, a formal review, with a Standards Review Team (SRT) will be performed to determine the program's level of compliance with all applicable standards. If the program under review is found to be in substantial compliance with all applicable standards, then DPSQA and the SRT shall recommend a one (1) year license.

STANDARDS REVIEW TEAM

The members of the Standards Review Team (SRT) for each program will consist of members who participate in the formal on-site review. DPSQA reserves the right to adjust the size of the SRT as appropriate to conform to the size and complexity of the program under review. The SRT ordinarily will be composed of representatives from:

- a) At least one team member from DPSQA. If more than one member, one member will be designated as “team leader”.
- b) At least one team member that meets the minimum requirements below. Representative(s) from other organizations or agencies may be selected as deemed appropriate by DPSQA.

The minimum requirements for at least one SRT Member are:

- a) A minimum of two (2) years experience in program administration and/or substance abuse treatment.
- b) The SRT member must not be a current or former employee (within the last 2 years) or client of the program to be reviewed.
- c) The SRT member must currently hold a license or certification that would allow the signing of comprehensive treatment plans as specified in the Standards.
- d) Peer Reviewer information will be forwarded for background check thirty (30) day's prior to a review at the Department of Corrections.

Note: A SRT member reviewing only administrative functions is not required to hold the credentials specified in item “c” above.

FORMAL LICENSURE REVIEW

The SRT shall make a formal on-site review optimally annually. The licensure review will include examination of program documents and records, client case records, interviews with staff and clients (in accordance with confidentiality laws), physical plant observations and interviews with various community agencies/individuals. The licensure review may include fiscal audits. Other sources may be used to determine compliance as applicable. DPSQA reserves the right to contact former clients and staff of the program under review to determine compliance with applicable standards.

Prior to the exit interview, there will be a meeting of the SRT members. During the meeting, each member will present his/her findings and recommendations on the area(s) assigned to him/her. All areas in terms of strengths, weaknesses, or deficiencies, as well as the decision of compliance on each applicable standard will be discussed and evaluated.

EXIT INTERVIEW

Following the SRT meeting, the SRT will meet with the Chief Executive Officer, Program Director or Clinical Director, and at least one (1) member of the Governing Board (if applicable). The team members will present the review findings. The purpose of this meeting will be to discuss and clarify the findings and recommendations noted by the team members. DPSQA will make the final determination as to whether licensure will be granted.

INSPECTION REPORT

Within fifteen (15) working days of the last day of the on-site review, a written report will be completed by the SRT team leader and forwarded to DPSQA for final review and enforcement (if applicable). .

LICENSURE REVOCATION

DPSQA may at its discretion revoke the operational permit of any program applying for licensure unable to meet compliance with the Standards for licensure. DPSQA may at its discretion initiate action to revoke the license of any program found not to be in full compliance with the Standards.

COMPLIANCE REVIEW

Per Federal Guidelines for Opioid Treatment Programs, Opioid Treatment programs will receive unannounced reviews by DAABHS, at least twice per year, to determine the program's ongoing compliance with opioid treatment specific standards.

GovConnect COMPLIANCE

All alcohol and other drug abuse treatment programs in Arkansas are required to report client-related data in accordance with the requirements of the current GovConnect. For acute care, hospital-based alcohol and drug abuse treatment programs, failure to report may result in notification to the Arkansas Department of Health, Division of Health Facility Services, of failure to comply with requirements of Act 25 of 1991. Licensure awarded automatically pursuant to Act 173 of 1995 shall not be affected by failure to report. For all other treatment programs, failure to report may result in the loss of DPSQA required licensure.

TYPES OF LICENSES

Six-Month Operational Permit

If the program seeking licensure is not currently licensed, DPSQA staff, along with any appropriate outside agencies, shall perform an initial licensure review of those Standards applicable to programs not currently licensed. If the program is in substantial compliance with all applicable Standards, as determined by DPSQA staff at the time of the review, then DPSQA will issue a six (6) month operational permit. No later than six (6) months after the according of the permit, a formal licensure review with a SRT will be performed to determine the program's level of compliance with all applicable standards. A one-time six (6) month extension of the operational permit will be considered for extenuating circumstances.

License

Following completion of a licensure review by an SRT, a license will be accorded to a program that previously held a six-month operational permit, if all applicable Standards are found to be in full compliance. These licenses do not expire until terminated at the closure of the facility, or at the discretion of DPSQA under these standards.

Corrective Action Plan:

If the program, at the time of the licensure review, is found to be out of compliance, an enforcement action may be prescribed by DPSQA at that time. This could include corrective action plan which will be developed by the program and submitted to DPSQA for approval. Other remedial enforcement actions may be prescribed at the discretion of DPSQA.

Probationary License

A license can be revoked at any time DPSQA determines (by licensure or compliance reviews), that a program is not in compliance with the licensure standards. A six-month probationary license will be accorded to allow the program to bring the program into full compliance with the Standards. The probationary license shall not exceed six months from the date of its issuance. Any programs issued a probationary license shall submit a corrective action plan to DPSQA within thirty (30) calendar days from receipt of the probationary license. Once in compliance, they will be accorded a new license, and continue to operate.

If the program fails to fully comply with applicable standards, during the probationary period, and fails to bring standards into full compliance prior to the end of the six-month period and formal licensure review, that would allow a new license, then the program will become non-licensed.

The program may request that the review be performed prior to the end of the probationary license. Programs with a probationary license shall not receive an extension.

Non-Licensed

Programs failing to comply with all applicable licensure Standards after the expiration of a six-month operational permit or a probationary license shall receive a non-licensed status. Programs receiving a non-licensed status shall not be allowed to operate as an alcohol or other drug abuse treatment program in the State of Arkansas. Programs receiving a non-licensed status shall wait a minimum of six (6) months before they can apply for a six-month operational permit.

CARF, JCAHO AND COA ACCREDITED PROGRAMS

Programs meeting the alcohol and drug abuse treatment standards of the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC) the Council on Accreditation (COA), or the American Correctional Association (ACA) shall receive DPSQA licensure as a licensed alcohol and drug abuse treatment program provided they have also met Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs as determined by DPSQA licensure review with emphasis on the following areas:

- (1) Treatment Plan development
- (2) Progress Note development
- (3) Treatment Plan reviews
- (4) Clinical Supervision
- (5) Health and Safety issues
- (6) Physical Plant requirements

The license shall be awarded by the office upon presentation by the program of evidence of accreditation by TJC, CARF, COA or ACA and verification of compliance of the above listed areas DPSQA. This subsection does not apply to opioid treatment programs operating in the State of Arkansas. All opioid treatment programs shall be licensed by DPSQA.

APPEAL PROCESS

If, for any reason, a program does not agree with the licensure decision, the program may appeal the adverse decision.

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. Written notification must be received by the Director of DPSQA no later than thirty (30) calendar days after the program's receipt of the licensure decision.

The appeal must contain:

1. A statement of the specific action which is being appealed.
2. The reason the licensure applicant believes the adverse action was incorrect.
3. The specific outcome requested.

When the written appeal is received, the Director of DPSQA or their designee will establish a date for the administrative hearing and notify the parties in writing. All hearings shall be conducted in accordance with the Arkansas Administrative Procedures Act codified at A.C.A. § 25-15-201 et seq.

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LICENSURE STANDARDS FOR ALCOHOL AND OTHER DRUG ABUSE
TREATMENT PROGRAMS

GOVERNING BODY (GB) - The governing body or legal owner of a program has the primary responsibility to create and maintain the organization's core values and mission via a well-defined and annually updated strategic plan which sets out authority over and responsibility for all programs. The authority shall ensure compliance with all applicable legal and regulatory requirements and supervise the recruiting of staff members that are competent and representative of the specific cultures and populations served. The governing body shall advocate for needed resources to carry out the mission of the organization and actively collaborate with the management staff to ensure the success of day to day operations. The program shall have written policies and procedures with supporting documentation for all of the following:

- GB1 There shall be a governing body or legal owner who has the ultimate authority for the overall operation of a program, which is one of the following as verified by the program's articles of incorporation:
- a. A public, non-profit organization; or
 - b. A private, non-profit organization; or
 - c. A private, for-profit organization; or
 - d. A foreign corporation authorized to do business in Arkansas
- GB2 Each program shall have a governing body or other responsible person that is accountable for the development of policies and procedures to guide the daily operations. If a program is governed by a board of directors, minutes and records of the board of director's meetings shall document that the program administrator has reported to the governing body or its designated representative a minimum of four times per year.
- GB3 Each program shall retain written documentation that describes the means by which the governing body shall maintain written documentation for all of the following:
- a. The election or appointment of its officers and members;
 - b. The orientation of new governing body members and any subsequent training;

- c. The appointment of committees as necessary to effectively discharge responsibilities;
- d. The scheduling of meetings; and
- e. Determination of quorum requirements; and, keeping minutes of all meetings;

GB4 The governing body shall hold meetings and keep minutes that include:

- a. Date(s);
- b. Names of the members attending;
- c. Summary of discussion;
- d. Actions taken;
- e. Target dates for implementation and recommendations;
- f. The minutes shall be signed by a member, as designated by the governing body; and
- g. The minutes shall be available to staff, persons served and the general public upon request (applies to non-profit organizations only).

The Legal Owner:

GB5 The legal owner for the organization shall:

- a. Delegate a Chief Executive Officer for the program that is not a member of the governing body (applies to non-profit organizations only);
- b. Prohibit any employee from being a voting member of the governing body;
- c. Delegate authority and responsibility to the Chief Executive Officer for the management of the program in accordance with established policy; and
- d. Perform an employment evaluation of the Chief Executive Officer at least annually.

- GB6 The legal owner shall:
- a. Maintain an authorized policy and procedures manual that describes the rules, principles, and guidelines that determine the substance abuse treatment program operations;
 - b. Review and update the policy and procedures manual as needed, but at least annually (as verified in the board minutes);
 - c. This policy and procedures manual shall be made available to the public upon request (applies to non-profit organizations only).
- GB7 The legal owner shall ensure compliance with all applicable legal and regulatory requirements and supervise the recruiting of staff member that are competent and representative of the specific culture and populations served. The legal owner shall advocate for needed resources to carry out the mission of the organization and actively collaborate with the management staff to ensure the success of day-to-day operation.

PROGRAM PLANNING/EVALUATION (PP&E) The program shall have written policies and procedures with supporting documentation for all of the following

PP&E 1 A program plan will be developed and approved by the governing body or legal owner which addresses outcome measures and includes:

- a. A written statement of the substance abuse treatment program goals and objectives;
- b. A written plan for implementation of the goals and objectives; and,
- c. An organizational chart that includes the structure including lines of authority, responsibility, communication, and staff assignments.

PP&E2 The Governing Body or legal owner will evaluate the plan annually based on the goals and objectives of the program. This includes operational definitions of the criteria to be applied in determining achievements of established goals, objectives, and a mechanism for:

- a. Assessment of the progress toward attainment of the goals;
- b. Documentation of program achievements not related to original goals;
- c. Assessing the effective utilization of staff and program resources;
- d. Documentation verifying the implementation of the evaluation plan; and
- e. Identify the results of the evaluation process.

FISCAL MANAGEMENT (FM) - The program shall have written policies and procedures with supporting documentation for all of the following

FM1 The Governing Body or legal owner shall oversee the management of a program which maintains a comprehensive written schedule of service fees and charges and which offers a reasonable payment plan that considers the clients' income, resources and dependents. This will be reviewed and approved annually by the governing body and shall be accessible to the public (applies to non-profit organizations only).

FM2 The Governing Body or legal owner shall ensure that the program has liability insurance that provides for the protection of the physical and financial resources of the program:

- a. To cover its clients, staff and general public;
- b. To include coverage of the building, equipment, and vehicles; and
- c. If part of a governmental agency, in lieu of liability insurance, the program has other proper means of protection for the items specified.

FINANCIAL EVALUATION (FE) - The program shall have written policies and procedures with supporting documentation for all of the following:

FE1 Each client shall receive a financial evaluation that includes all sources of income. The sources shall be verified and documented. Sources must include all household income (i.e., public assistance, retirement, social security and VA). If specific amounts are unavailable, averages or reasonable estimates may be used.

FE2 A client's insurance coverage shall be documented.

ADMINISTRATIVE OPERATIONS (AO) - The program shall have written policies and procedures with supporting documentation for all of the following:

AO1 Ownership Change. The program shall provide written notification to DPSQA at least thirty (30) calendar days prior to any change of name, ownership, location, control of the facility, or make major programmatic changes **using the Appendix 2.**

AO2 Access Policy. The program has a policy defining the program's areas that may be accessed by clients and visitors that includes medication areas, dispensing and food preparation areas.

AO3 Directory. The program shall maintain a log of all visitors to the program to protect client confidentiality in accordance with 42 CFR Part 2.

AO4 Tobacco Products. The program shall have a written policy and procedure prohibiting the use of any tobacco products within the facility in accordance with the Arkansas Clean Indoor Air Act of 2006. If the program provides a designated smoking area it shall be located a minimum of 25 feet from any entrance to the facility and shall not be in a common area that non-smoking individuals must transverse to gain access into the facility. In addition, the program shall prohibit the use of alcohol, tobacco and illicit drugs by staff which includes:

- a. Providing, distributing, or facilitating the access of tobacco products to clients;
- b. Use of tobacco products in the presence of clients or visitors; and
- c. Prohibits the public display of tobacco products by staff.

AO5 HIV/AIDS. The Program shall implement a written policy that states the Program shall not deny treatment to a person based on his or her actual or perceived serostatus, HIV related condition or AIDS.

AO6 Advertising. The Program shall not use incentives or rewards or unethical advertising practices to attract new clients. This shall not forbid the Program from rewarding clients that maintain exemplary compliance with program rules and their individualized treatment plans.

AO7 Privacy. The private counseling area used provides sufficient privacy to maintain confidentiality of the communication between counselor and client. A private meeting area shall be available for clients to meet with their legal representatives, service providers, family members or persons providing assistance in attaining treatment goals.

AO8 Emergency/Natural Disaster. The program shall develop written policies and procedures for continued safety and treatment of clients in the event of an emergency or natural disaster. Emergency policy and procedures are readily available to all staff; the program has a written internal disaster plan which includes the training of staff in disaster and evacuation procedures, a list of alternate resources and the monthly rehearsal of various disastrous scenarios or safety drills are documented.

AO9 Critical Care Referral. The program will have policies and procedures for referring clients for services needed at a critical care facility.

AO10 Workforce Safety. The program has implemented work practice controls and provided personal protective equipment to reduce exposure to bodily fluids through the normal performance of their duties.

AO11 Infection Control. The Program shall have written policies for infection control, which are in compliance with the Center for Disease Control and Prevention Guidelines.

AO12 STD Control. The program shall have policies and procedures describing the programs services for HIV/AIDS, Sexually Transmitted Diseases (STDs), Tuberculosis (TB) and Hepatitis to include:

- a. The provision of testing and treatment at the program or through a written referral agreement with a medical entity qualified to provide such services;
- b. Testing shall be available to all clients upon request;
- c. All testing shall be voluntary;
- d. All clients shall receive HIV/AIDS, STD, Hepatitis and TB education per admission; and
- e. documentation of all the above.

AO13 Client Handbook. The Client Handbook shall clearly state that the program shall not be held responsible for any medical costs incurred by clients or children occupying the program and transported to medical appointments. The provider's responsibility is limited to arranging for the clients to access these services and providing transportation for them.

AO14 Grievance Policy. The Program shall have a grievance policy which states that there is a reasonable, specific deadline for completing the grievance process. At the program level, once received, client grievances must be reviewed and a decision reached in accordance of the program's policies and procedures.

Grievances to be reviewed by the governing board shall be heard no later than the board's next scheduled meeting.

- AO15 The program will maintain a publicly listed or local telephone number.
- AO16 Hours of operation are scheduled to make services accessible to clients and the general public.
- AO17 There shall be no less than one (1) staff on duty at all times per twenty-five (25) clients, per physical site. (Not Applicable to Criminal Justice System).
- AO18 There shall be no less than one (1) treatment staff per twenty (20) clients during scheduled treatment activities.
- AO19 A counselor's caseload shall not exceed the 25 to one (1) client/counselor ratio in a residential setting.
- AO20 The program has at least one staff person present during operating hours who maintains a valid certification in First Aid, Cardio-Pulmonary Resuscitation (CPR) and Non-violent Crisis Prevention and Intervention (NCPI) or other nationally accredited, evidence-based behavioral management/crisis intervention model. All Specialized Women Services programs will have at least one staff person who is certified in child and infant CPR per shift. This documentation will be verified by the staff member's personnel record.
- AO21 The program has procured an agreement with a mental health provider licensed or certified in the State of Arkansas to provide consulting services for co-occurring treatment applicants or clients. The agreement must be updated every two years.
- AO22 The program maintains a comprehensive resource directory (updated every 2 years) of local community and government agencies within the service area which contains at least:
- a. The name and location of the resources; and
 - b. The type of services provided by the resource.
- AO23 The program shall develop a Quality Assurance committee that meets quarterly to identify programmatic issues necessary to develop and implement an appropriate plan of action to correct deficiencies.
- AO24 The program will provide written agreements to, or coordinate

introduction of, available resources and services through community and government agencies that will assist with specialized needs to maintain a continuum of client care.

These agreements shall include:

- a. The services the resource agrees to provide;
- b. The duration of the agreement;
- c. The procedures to be followed in making referral;
- d. A statement of conformity to federal, state, and program confidentiality requirements;
- e. Date, time, and signatures of both parties; and
- f. The agreements must be updated every two years.

AO25 Services are available to provide a variety of diagnostic and primary substance abuse treatment on both a scheduled and non-scheduled basis. Services provided by the program include, but are not necessarily limited to the following:

- a. Case management;
- b. Orientation to the program's operations and procedures;
- c. Screening of applicants for substance abuse treatment service for referral, or treatment purposes;
- d. Individual, group and family counseling sessions;
- e. Crisis intervention; and
- f. Interdisciplinary treatment services.

AO26 Residential services are provided seven (7) days per week, twenty-four (24) hours per day and provide;

- a. A minimum of twenty-eight (28) hours of structured treatment weekly
- b. A minimum of five (5) hours daily (Monday through Friday) and
- c. A minimum of three (3) hours daily on Saturday and/or Sunday.

(See Definitions Section for an explanation of “structured treatment.”)

AO27 Partial day treatment programs provide services at a minimum of four (4) hours per day and at least five (5) days per week and include at a minimum:

- a. Intake, individual and/or group therapy, psychosocial education, case management and one hot meal per day.
- b. Treatment services may include drug testing, medical care other than detoxification and other appropriate services.

AO28 Protocol for administrative discharge to include: threats of violence or actual bodily harm, disruptive behavior, sexual misconduct, loitering, sale, purchase or use

of drugs or alcohol, continued unexcused absences from counseling.

AO29 When a program determines to administratively discharge a client, the program shall provide a written statement containing:

- a. The reason(s) for discharge;

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- b. Written notice of his or her right to request review of the decision by the Program Director or his or her designee; and
- c. A copy of the appeal procedures.

AO30 GovConnect Compliance. All licensed substance treatment programs in the State of Arkansas must report client related data in accordance with the requirements of the current GovConnect , regardless of funding source.

HUMAN RESOURCES (HR) - The Governing Body shall ensure that the program has written personnel policies and procedures that apply to employees and those working under the supervision of individuals employed by the program (i.e., contracted workers, interns, volunteers, visitors). These shall include but not be limited to the following:

- HR1 Ensure compliance with all legal, ethical, and regulatory codes in accordance with Title VI/Title VII of the 1964 Civil Rights ACT and the Equal Employment Opportunities Commission (EEOC) (race, color, sex, religion, national origin, age or disability).
- HR2 Prohibiting harassment of any nature including that of race, color, religion, age, sexual orientation, physical or mental disability and unwanted sexual advances.
- HR3 The program shall designate an employee who will monitor the programs compliance with the Americans with Disability Act (ADA), and educate all staff.
- HR4 Consequences for unethical conduct and violations of the harassment policy

will include:

- a. Steps for reporting violations;
- b. Process for investigating allegations; and
- c. Disciplinary process for violations.

- HR5 A criminal background check shall be required for all staff that have direct contact with clients or client records. Results will determine eligibility for employment in accordance with program policies.
- a. Programs shall require a check of the adult maltreatment registry through the Department. Programs with children and adolescents involved shall also require a check of the child maltreatment registry through the Department .
 - b. Persons who have not resided in the State of Arkansas for at least five (5) years must also have an FBI background check through the Arkansas State Police.
- HR6 A program cannot employ any person currently receiving substance abuse treatment services or treatment related services. This also prohibits the use of clients to monitor the program. Such individuals can maintain employment by providing administrative services, janitorial, landscaping, and/or any other non-clinical tasks.
- HR7 Former substance abuse clients shall not provide direct treatment services for 12 months after their discharge from substance abuse treatment.
- HR8 An employee assistance program or provisions for referral to such services must be available.
- HR9 Employee grievance protocol which is reviewed, updated and approved annually by the governing body. Documentation of employee grievances shall be confidential and shall be stored separately from personnel records.
- HR10 Personnel shall meet all local, state, or federal legal requirements for their position. (e.g., licensing and certification)

- HR11 All non-certified or non-licensed staff, including volunteers, providing counseling and treatment related services, shall be registered with the Arkansas Substance Abuse Certification Board (ASACB). An exception is granted for those staff involved in an internship or practicum from another human services or behavioral discipline.
- HR12 Students or interns must be over the age of 18 and shall be supervised by a paid staff member and shall not be used to supplant direct treatment service employees.
- HR13 A Counselor in Training (CIT) shall provide evidence that a minimum of thirty (30) clock hours of continuing education is obtained per year toward the certification process.
- HR14 CITs providing direct treatment services must receive at least one hour of individual supervision or ninety minutes of group supervision weekly. Such supervision must be documented and must be performed by persons authorized to approve treatment plans, as specified in this manual.
- HR15 Policy includes a specific process for completion of a comprehensive evaluation of personnel performance on at least an annual basis for all staff.
- HR16 The process for evaluation of personnel performance requires a written report and requires documentation that the evaluation is reviewed with the employee.
- HR17 The program has established an appropriate staff development plan for all Employees, contractors, students, and volunteers within ninety (90) days from date of hire. The plan is to include:
- a. An orientation program for each staff person, which includes a documented review of the program's policies and procedures;
 - b. A training program based upon the identified strengths and areas of improvement of staff, volunteers (volunteers working less than ten hours monthly are exempt) and designated staff development representative. The needs are identified and documented at least annually. The plan must include staff signatures; and
 - c. Employee's signature.
- HR18 Personnel records will be kept on all employees, volunteers, and professionals contracted to provide direct treatment services that contain at least:

- a. Job descriptions and qualifications for all positions will be reviewed annually and will include:

- (1) , Education;
- (2) Experience;
- (3) Licensing and certifications relevant to the position;
- (4) Reporting supervisor's position;
- (5) Position(s) supervised; and
- (6) Duties and responsibilities.

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- b. Application/resume;
- c. License/certification, where applicable;
- d. Proof of Professional liability insurance (if required by license/certification)
- e. Documentation of a minimum of six (6) hours per year of ongoing continuing education units (CEUs) and /or training specifically to the position.
- f. Results of criminal background checks, if required for the position;
- g. A signed statement acknowledging receipt and compliance with the following:
 - (1) Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2);
 - (2) Health Insurance Portability and Accountability Act (HIPPA) (45 C.F.R. Parts 160 and 164);
 - (3) Client Rights as listed in these standards;
 - (4) Program Policy and Procedure Manual;
 - (5) Employee assistance plan;
 - (6) Emergency Policies;
 - (7) Organizational chart;
 - (8) Job Description; and
 - (9) Annual employee evaluation.

HR19 Employee records are stored in a secure and confidential place.

CLINICAL PROCEDURES (CP) - The program shall have written policies and procedures with supporting documentation for all of the following:

- CP1 State and federal rules governing confidentiality of alcohol and drug abuse client records and other client identifying information. Existing federal rules include the Health Insurance Portability and Accountability Act and 42 CFR, Part 2. Both rules provide for safeguarding files or other client identifying information from disclosure or access by unauthorized individuals, and require that records be maintained in a secure manner. DPSQA shall review records for the purpose of monitoring execution of the policies and standards required by these rules.
- CP2 Documentation shall not contain slang, technical jargon, or abstract terms.
- CP3 Errors in the treatment chart should never be corrected with “white-out” or marker; by pasting paper over the error, or by any other method, which would obliterate the original words. When an error is corrected, the original text must remain readable. A single line is to be drawn through the error, the correct information added with the date and initials of the person making the correction.
- CP4 No documentation shall be signed and dated prior to completion;
- CP5 The program's treatment services, lectures, and written material shall be appropriate to the clients served, age-appropriate and easily understood by clients.
- CP6 There is documentation of planned programs, consistent with the needs of the Clients and treatment services that also include social, educational, and recreational activities for all clients for daytime, evenings, and weekends.
- CP7 The program shall retain all documentation for at least six (6) years and shall ensure that all individual client records (both electronic health records (EHR) as well as paper records) are maintained and disposed of in a secure manner. The written policies and procedures shall ensure:
- a. The program exercises its responsibility for safeguarding and protecting loss, tampering, or unauthorized disclosure of information, and the file cabinets and files are marked “CONFIDENTIAL;”
 - b. Client case records are readily accessible to those individuals specifically authorized by program policy.
 - c. Content and format of client records are kept uniform;

- d. Entries in the client record are signed, dated and time noted;
- e. Client records which are part of an unresolved audit, investigation or other legal process shall be maintained for a minimum of six years or at least until the audit, investigation or other legal process is resolved;
- f. Forms in each client record are bound in such a manner to minimize accidental loss;
- g. Allergies and/or other serious conditions are "flagged" on the outside of the record;
- h. The program shall make records available to DPSQA upon request; and
- i. Each new admission, readmission or transfer admission is interviewed and the interview is documented in the client record.

CP8 The program has standardized screening protocol to determine applicants eligibility and appropriateness for admission to treatment.

CP9 The program has a uniform intake process and documentation shall include:

- a. The types of information to be gathered on all clients;
- b. Procedures to be followed when accepting referrals;
- c. Offering case management, withdrawal risk assessment, outpatient services, education, and referral to another licensed program when the program is at full capacity; and
- c. Procedures for the provision of emergency services (i.e., after hour admission, medical emergencies) and other special circumstances.

CP10 A client handbook is made available to all clients and a receipt must be in the client record. The client handbook shall include the following:

- a. A written statement of the services provided by the program and a description of the kinds of problems and types of clients the program can serve;
- b. A written statement describing admission and discharge procedures;
- c. A written statement describing living conditions and standards of behavior expected;
- d. The organization's client grievance process.

CP11 Personal Property Inventory shall be taken upon admission to a residential environment. Items of value shall be securely stored by the program at the request of the client. The inventory list will include the stored items, date received and returned, and signatures of staff and client. Alcohol or illicit drugs, or controlled substances shall be confiscated and disposed of properly (Phil will look into this).

CP12 The program shall provide a specialized plan for treatment by assessment and then addressing the specialized needs of each client of the program.

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CASE MANAGEMENT (CM) - The program shall have written policies and procedures with supporting documentation for all of the following:

- CM1 Arranging and facilitating for the provision of all services as documented in the treatment plan;
- CM2 Holding regular, and as needed, meetings with the client to monitor and reevaluate the individualized comprehensive treatment plan;
- CM3 Holding regular, and as needed, meetings with the program staff and others involved in the delivery of services to the client to monitor and evaluate progress;
- CM4 Maintaining records of other documentation of all services delivered to the client; and
- CM5 Developing an aftercare plan with the client prior to discharge.

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SCREENING AND INITIAL ASSESSMENT (SA) All clients in all programs shall receive an accurate and thorough assessment to determine the appropriate level of care and client needs. The program shall have written policies and procedures with supporting documentation for all of the following:

SA1 A pre-admission screening shall be used to determine a client's eligibility and appropriateness. It is to include:

- a. Substance Use history;
- b. Current detoxification level determination;
- c. Past psychiatric treatment;
- d. Past chemical dependency treatment;
- e. Significant medical history;
- f. Current health status;
- g. Current medications;
- h. Known food allergies;
- i. Known drug allergies;
- j. Current emotional state and behavioral functioning;
- k. Current living situation; and
- l. Current employment situation.

SA2 Documentation of client information and history is to include:

- a. Confirmation of identity;
- b. Name, address (street and number, town, county, state, zip), phone, current housing arrangements, guardianship (if applicable), photograph of client, social security number;
- c. Client's date of birth and sex;
- d. Name of referral source. Document if treatment was mandated by the referral source; if treatment was mandated, the complete address and telephone number of the referral source. Documented conditions of referral and/or information needs of the referral source;
- e. Emergency contact information;
- f. Types of problems experienced by the client that need resolution;
- g. Substance abuse history to include most recent use patterns (i.e. amount per type, route of administration) ages of first use per substance and age of regular and/or addictive patterns. Document any injection use;
- h. Document the client's family history to include current marital status, effect of substance use on current and past relationships, history of family members' use, any family members "in recovery"; names and ages of

dependents and who has custody of dependents while the client is in treatment;

- i. Client's highest grade completed, major (if applicable), effect of substance use on the client's educational process. The client's reading and writing levels must be evaluated when appropriate;
- j. Current/most recent vocations, any trained skills, effects of substance use on employment, adequacy of current employment;
- k. Legal history, which includes the dates and type of charges, arrests, convictions and sentences;
- l. Medical and health history to include chronic medical problems, significant medical/physical events, problems that could influence treatment, medical conditions that could prompt a crisis, special dietary needs, current medications (i.e. does client have sufficient supply during treatment), purpose of current medications, history of alcohol or other drug related conditions (i.e. blackouts, delirium tremens , etc.), at-risk behaviors (i.e. multiple sex partners, unprotected sex, etc.), pregnancy status, allergies. (i.e. allergies and/or other serious conditions are "flagged" on the outside of the record);
- m. Medication records for both prescriptions and over-the-counter medications. Drug type, dosage strength, how many, time/date of dispersion, which dispensed/witnessed dosing;
- n. Psychological/psychiatric treatment history to include dates of any treatment, type of problem(s), who provided treatment, outcome of treatment, any current psychotropic medications;
- o. Other relevant information to include military service (i.e. branch of service, dates of service, discharge status, highest rank, classifications, and any combat experience); copies of court or parole orders, and other information that will aid in assessing the client;
- p. A completed Addiction Severity Index (ASI) or other nationally accredited evidence-based assessment tool.;
- q. Re-admissions and transfers to another environment are clearly delineated;
- r. Summary of client problems and corresponding needs, as based on client information;
- s. Summary of the client's strengths and weaknesses, as based on the client information; and
- t. Based upon the assessment, each client will be assigned a Diagnostic and Statistical Manual for Mental Disorders (DSM), substance abuse

- disorder diagnosis, and code from the most current version of the DSM.
- u. Only staff authorized to approve comprehensive treatment plans as specified in this manual will assign the diagnosis code.
 - v. Counseling personnel registered as Counselors in Training with the Arkansas Substance Abuse Certification Board may assign the diagnosis provided the diagnosis is approved, in writing, by personnel

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authorized to sign comprehensive treatment plans. The diagnosis and code will meet the current substance abuse disorder criteria as per Diagnostic and Statistical Manual of the American Psychiatric Association.

SA3 An assessment to determine severity and environment placement to include a completed Addiction Severity Index (ASI) or other national accredited evidence-based assessment tool for adults or an equivalent assessment tool for adolescents is to be completed within seventy-two (72) hours of admission. When applicable, results of other tests or standardized assessments, including the American Society of Addiction Medicine (ASAM) patient placement criteria or other nationally recognized placement tool must also be included.

INITIAL TREATMENT PLAN - The program shall have written policies and procedures with supporting documentation for all of the following:

ITP1 The initial treatment plan is to be developed and implemented within twenty-four (24) hours, based on assessments that determined all immediate problems and needs such as; medical condition, nutrition, clothing, personal hygiene, legal issues and emergency contacts and the actions taken to meet those needs.

COMPREHENSIVE (MASTER) TREATMENT PLAN (CTP) The program shall have written policies and procedures with supporting documentation for all of the following:

CTP1 The comprehensive treatment plan is to be developed and implemented no later than seven (7) days from admission to residential services and partial day treatment and no later than twenty-one (21) days from admission to outpatient services and is to include:

- a. A clear and objective statement of the client's needs to be addressed;
- b. Clearly stated goals and objectives that the client is capable of understanding;
- c. The means of achieving each goal is documented;
- d. The method and frequency of treatment per goal or objective are documented;
- e. The projected date of completion, per goal, is documented;
- f. The staff person responsible for carrying out the treatment plan is specified; and
- g. The CTP is signed and dated by both the counselor and client.

CTP2 All comprehensive treatment plans are reviewed and approved by one of the following, as licensed or certified in the State of Arkansas:

- a. Advanced Certified Alcohol and Drug Counselor (ACADC),
- b. Certified Alcohol and Drug Counselor (ADC) As defined by the ASACB
- c. Certified Clinical Supervisor (CS) As defined by the ASACB
- d. Licensed Marriage and Family Therapist, (LMFT)
- e. Licensed Clinical Social Worker; (LCSW)
- f. Licensed Master Social Worker;(LMSW)
- g. Licensed Physician; Medical Doctor (MD)
- h. Licensed Psychologist; Doctor of Psychology (PhD)
- i. Licensed Professional Counselor;(LPC)
- j. Licensed Psychological Examiner;(LPE)
- k. Licensed Alcoholism and Drug Abuse Counselor;(LADAC)
- l. Licensed Associate Alcoholism and Drug Abuse Counselor;(LAADAC)
- m. Certified Criminal Justice Professional (applies to Arkansas Community Correction (ACC) and Arkansas Department of Correction (ADC) only;
- n. Certified Co-Occurring Disorder Professional –
- o. Licensed Associate Counselor (LAC)
- p. Advanced Practice Nurse (APN)

CTP3 The client's progress in meeting treatment plan goals is reviewed no later than every seven (7) days in the residential environment (unless clinically contra-indicated) and every ninety (90) days in an outpatient environment. The

(Not review must be approved by an individual specified in "CTP2" above;
Applicable to Criminal Justice System).

CTP4 The client's progress in meeting treatment plan goals will be assessed at the time of discharge.

PROGRESS NOTES (PN) The program shall have written policies and procedures with supporting documentation for all of the following:

- PN1 Progress notes shall contain the date and time the session began and ended; the purpose of the session; topics discussed; client behavior and response to the treatment provided during the session; significant events; and the name, signature, and title of the staff person conducting the session;
- PN2 Group and individual treatment session's progress shall be documented per session;
- PN3 Outpatient treatment is documented per session;
- PN4 Partial day treatment notes contain information required, but may be compressed into a single note, that addresses treatment provided on a per day basis.
- PN5 Residential treatment shall be documented at least daily.
- PN6 All clinical documentation must be individualized and specific to the client.
- PN7 Significant client events that fall within the provisions of the "Incident Reporting Policy", the administration of first aid to a client, and any client behavior that could lead to a disciplinary action, or any other event that could affect the client's treatment shall be documented as soon as possible after the event; The
- PN8 When a client refuses to divulge information and/or follow the recommended course of treatment, this refusal is noted in the client's record.
- PN9 When a client transfers from one program to another, the transferring program shall send copies of the transferring client's records to the licensed receiving program prior to admission. A Release of Information (ROI) shall be completed, signed, and maintained in the client's record prior to transferring the client's information.

AFTERCARE PLAN (AP) The program shall have written policies and procedures with supporting documentation for all of the following:

- AP1 The aftercare plan will be written one-week prior to target date of completion of treatment services;
The aftercare plan, implemented at discharge, shall minimally contain a summary of client needs not treated; established goal(s) that address the untreated needs; and the means by which the goals will be met;
- a. The staff person responsible for the aftercare plan is documented;
 - b. There is evidence of the client's participation in, and understanding of the treatment and aftercare planning process (i.e. client's signature); and
 - c. Upon request by the client, the program shall provide a copy of the plans to the client.
- AP2 Discharge Summary shall include, but not be limited to, the date, time, conditions of discharge, environmental change, client's perception of treatment offered, referrals made, a description of goals that have been met, services that were provided, date and signature, and credentials of staff.
- AP3 The program shall have written policies and procedures denoting protocol for discharging clients abruptly to ensure the safety and welfare of clients during discharge. Documentation for such discharges shall include:
- a. Reason for discharge;
 - b. Staff present at the time of discharge;
 - c. All actions taken by the program to remedy the situation to avoid discharge;
 - d. Notification of persons listed on emergency contact list;
 - e. Signed statement that personal property and medications have been returned to client upon discharge; and
 - f. The transportation arrangement assistance offered, available and the method ultimately taken.
- AP4 In the case where a client is discharged against medical advice, for non-compliance or in abstentia, the program shall document that the Aftercare Plan has not been developed for these specific reasons.

CLIENT CONFIDENTIALITY (CC) Confidentiality policies, procedures, and practices must comply with the current federal and state laws, guidelines and standards, including 42 CFR Part 2 and **HIPAA**. The program shall have written policies and procedures with supporting documentation for all of the following:

CC1 There are written policies and procedures for the protection of client's privacy regarding program visitors which require:

- a. The clients are informed in advance of scheduled visitations; and
- b. Visitations are conducted when they will minimally interrupt the client's usual activities and therapeutic programs.

CC2 A client's authorization shall be obtained before releasing information. A proper consent form must be in writing and contain the following items:

- a. The name or general designation of the program(s) making the disclosure;
- b. The name of the individual or organization that will receive the disclosure;
- c. The name of the client who is the subject of the disclosure;
- d. The purpose or need for the disclosure;
- e. A description of how much and what kind of information will be disclosed;
- e. The clients right to revoke the consent in writing, and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice;
- g. The program's ability to condition treatment, payment, enrollment or eligibility of benefits on the client agreeing to sign the consent, by stating either that the program may not condition these services on the client signing the consent, or the consequences for the client refusing to sign the consent;
- h. The date event or condition upon which the consent expires if not previously revoked;
- i. The signature of the client (and/or other authorized person); and
- j. The date on which the consent is signed.

CC3 The program has written procedures for responding to requests for confidential client information when presented with telephone inquiries; written inquiries; subpoenas; court orders; search warrants; arrest warrants; and for reporting child abuse.

CC4 Every authorization for release of information becomes part of the client's

permanent case record; and, according to HIPAA programs, must provide client with copies of all signed authorizations.

CC5 In a life-threatening situation or where an individual's condition or situation precludes the possibility of obtaining written consent, the program does allow for the release of pertinent medical information to the medical personnel responsible for the individual's care without a client or applicant's

authorization, and without the authorization of the Chief Executive Officer or their designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the individual.

CC6 In the event information has been released without the individual's authorization, the staff member responsible for the release of information enters the individual's case record all details pertinent to the transaction, including at least: the date the information was released; persons to whom the information was released; the reason the information was released; the nature and details of the information given.

CC7 The client or applicant is informed that the confidential information was released as soon as possible after the incident occurs.

CLIENT RIGHTS (CR) The program shall have written policies and procedures with supporting documentation for all of the following:

CR1 To inform all clients of their legal and human rights. At the time of admission, each client shall be informed of their rights in a language that they understands, and shall receive a written copy of these rights, which shall include:

- a. To be fully informed, as evidenced by a client's written acknowledgment, of the rights, responsibilities, and rules that apply to the client's conduct and the consequences of non-compliance;
- b. To the receipt of adequate and humane services, regardless of sources of financial support;
- c. To the receipt of services within the least restrictive environment possible;
- d. To receive an assessment that is used to develop an individual comprehensive treatment plan;
- e. To participate in the planning of his/her treatment plan and to treatment based on same;
- f. To a periodic staff review of the client's treatment plan;
- g. The right to access or amend their individual client record in accordance with the HIPAA laws.
- h. To an adequate number of competent, qualified, and experienced professional clinical staff to implement and supervise the treatment plan;
- i. To be informed of treatment alternatives or alternative modalities;
- j. To be encouraged and assisted throughout treatment to understand and exercise his/her rights as a client and a citizen, including:
 - (1) The right to report any cases of suspected abuse, neglect, exploitation of clients being served in the program, in accordance with applicable State law and abuse reporting procedures;
 - (2) The right to a grievance and appeal process; and
 - (3) The right to recommend changes in policies and services.
- k. To be informed regarding the financial aspects of treatment, including the consequences of nonpayment of required fees;
- l. To be informed of the extent to and limits of confidentiality, including the use of identifying information for central registry and/or program evaluation purposes;
- m. To receive a copy of consent for a release of confidential information after the form is signed by the client.
- n. To give informed consent prior to being involved in research projects.
- o. To not be used for the solicitation of funds or other contributions by the program.

- p. To communicate with family and significant others outside the program including:
 - (1) To conduct private telephone conversations with family and significant others, unless justified in the client's case record and explained to the client; and
 - (2) To send and receive mail in uncensored condition. Mail may be inspected in the presence of a staff member.
- q. To be informed if visitors are expected at the program; and
- r. Appeal treatment decisions made by staff in accordance with the programs grievance policy.

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PHYSICAL ENVIRONMENT (PE) - The program will apply these standards to all sites operated by the program regardless of ownership. The primary concern of the program should always be the safety and well-being of the clients and staff. The program shall have written policies and procedures with supporting documentation for all of the following:

- PE1 Programs are to ensure compliance with all local, state, and federal laws and rules regarding the condition and maintenance of its facility;
- PE2 Provide evidence of current valid certifications, which are maintained on site of all applicable buildings, fire and safety, health, and all other applicable inspections. All items of concern noted in these inspections shall immediately be addressed/corrected;
- PE3 Private residences shall not be used to provide treatment unless:
 - a. There is a separate entrance to areas in which services are rendered; and
 - b. Services are provided in an area used exclusively for treatment.
- PE4 Provides adequate physical facilities for the storage, processing, and handling of client records by means of suitable locked, secured rooms or file cabinets;
- PE5 Maintain a suitably stocked first aid kit(s), with contents as defined in the program's policies and procedures at all sites;
- PE6 Maintain fire extinguisher(s) that are accessible, in working order and have attached documentation of annual inspection;
- PE7 Evacuation routes are prominently posted throughout all facilities;
- PE8 All exits must be clearly marked;
- PE9 The programs telephone number(s) and actual hours of operation will be posted at all public entrances;
- PE10 Conspicuous warning signs must be posted at all public entrances informing staff, volunteers, clients, and visitors as to the following requirements:
 - a. No alcohol or illicit drugs are allowed in the facilities;
 - b. No firearms, or other dangerous weapons, are allowed in the facilities with the exception of law enforcement while in the performance of their duties; and
 - c. The use of tobacco is not allowed in the facilities.

PE11 A copy of compliance with law Title VI/Title VII of the 1964 Civil Rights Law

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shall be prominently displayed for the viewing public.

PE12 Programs must provide a safe and sanitary environment.

PE13 Residential facilities shall:

- a. Provide separate bedroom areas for males and females; adults and adolescents; (13 through 17 years of age)
- b. Provide separate bathroom facilities for males and females; adults and adolescents; (13 through 17 years of age)
- c. Provide adequate barriers such as structural separation to divide the population; as determined by the DPSQA
- d. Window coverings to allow for privacy;
- e. Sufficient lighting to avoid injury;
- f. Provide sufficient clean linens with covered storage; and
- g. Sleeping areas shall have at least:
 - (1) Fifty (50) usable square feet per person in single occupancy rooms;
 - (2) Forty-eight (48) usable square feet per person in multiple occupancy rooms;
 - (3) Individual storage for clothes and personal items; and
 - (4) Bedrooms used for detoxification must have single beds (no bunk beds allowed).

PE14 Adult clients shall remain separated from adolescent population during all times with the exception of mixed therapy sessions. Continuous monitoring shall occur during transition of mixed therapy sessions.

PE15 Plumbing must be:

- a. In working condition and to avoid any health threat; and
- b. All toilets, sinks and showers shall be clean and in working order.

PE16 There shall be at least one toilet, one sink, and one shower or tub per every eight (8) residential clients.

PE17 Laundry facilities shall be available in the facility or on a contractual basis.

When provided at the facility laundry rooms shall be kept separate from bedrooms, living areas, dining areas and kitchen.

- PE18 Storage will be least twelve (12) inches above the floor.
- PE19 A secure locked storage is available for client's valuables when requested.
- PE20 Separate storage areas are provided and designated for:
- a. Food, kitchen, and eating utensils;
 - b. Clean linens;
 - c. Soiled linens and soiled cleaning equipment; and
 - d. Cleaning supplies and equipment.
- PE21 When handling soiled linen or other potentially infectious material Universal Precautions are to be followed.
- PE22 Hazardous and regulated waste is disposed of in accordance with federal requirements.
- PE23 Poisons, toxic materials, and other potentially dangerous items shall be stored in a secured location.

MEDICATION (MD) - The program shall have written policies and procedures with supporting documentation for all of the following:

- MD1 The documentation of handling; administration; observation and self-administration; witnessed disposal process; medication errors, adverse reactions and use of medication. Chain of custody will be maintained at all times.
- MD2 Medication Errors and Adverse reactions are to be reported to DPSQA following the Incident Reporting Policy. DPSQA will receive follow-up reports throughout the programs process of investigation and bringing the incident to a close.
- MD3 A list of prescription medications and over the counter (OTC) medications to be kept in stock on units that dispense medication shall be developed. All medications shall be properly labeled in accordance with current applicable laws and rules pertaining to the practice of pharmacy.
- MD4 Both lists will be developed in conjunction with the program's physician who shall sign and date denoting his approval. Any future additions/deletions must follow the same procedure.
- MD5 The medication list shall be reviewed at least annually.
- MD6 Programs who do not employ or contract with a Medical Doctor shall not maintain stocked prescription medications.
- MD7 The program shall use an effective inventory system to track and account for all prescription medications.
- MD8 A system is in place to monitor and to dispose of all outdated medication in compliance according to the program's disposal policy.
- MD9 Medication orders may be given by telephone to licensed or registered nurse. The orders must then be signed by the authorizing physician ordering the medication within 72 hours.
- MD10 Medications shall be stored at appropriate temperatures based on the manufacturer's product inserts.
- MD11 Medications requiring refrigeration shall be stored in a locked compartment separate from food.
- MD12 External use medications in liquid, tablet, capsule, or powder form shall be stored separately from medications for internal use.
- MD13 Urine or blood samples shall not be stored with food or medicines.

- MD14 The program shall keep all prescriptions and non-prescription medications, syringes, and needles in locked storage.
- MD15 Medications, syringes, and needles shall be accessible only to staff who are authorized to provide medication.
- MD16 Used needles and syringes shall be placed in secure, rigid, puncture proof containers and disposed of according to OSHA's Hazardous Waste Standards.

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FOOD AND NUTRITION (FN) The program shall have written policies and procedures with supporting documentation for all of the following;

- FN1 If the program prepares meals on site, the program shall have a current food establishment health inspection as required by the Arkansas Department of Health.
- FN2 When meals are provided by a food service, a written contract shall be maintained and shall require the food service to have a current food establishment health inspection as required by the Arkansas Department of Health.
- FN3 A licensed dietitian or certified dietary manager shall approve menus and written guidelines for substitutions in advance.
- a. Approve a meal planning manual with sample menus and guidelines for substitutions;
 - b. Approve age appropriate menus and healthy food choices for children residing in SWS facilities;
 - c. Approve menus prepared by new staff before they plan meals independently;
 - d. Review a sample of menus served at least annually; and
 - e. Provide kitchen staff training as needed.
- FN4 The program shall provide modified diets to residents who medically require them as determined by a licensed dietitian or certified dietary manager. Special diets shall be prepared in consultation with a licensed dietitian or certified dietary manager.
- FN5 The program shall provide at least three meals daily, with no more than fourteen (14) hours between dinner and breakfast.
- FN6 Clients in a Partial Day Treatment setting shall be offered a minimum of one meal per day provided by the program.
- FN7 Outpatient programs shall allow a meal break after five consecutive hours of scheduled activities.
- FN8 All food shall be stored, prepared, and served in a safe, healthy manner according to USDA and FDA guidelines along with any local guidelines;
- FN9 Non-perishable items shall not be used that contain a sell by or use by date that has expired by more than two years.
- FN10 Perishable items shall not be used once they exceed their sell by date.

- FN11 Storage of items will be at least twelve (12) inches above the floor.
- FN12 All persons working in the kitchen or meal preparation environment shall wear hair coverings and gloves (this shall include beards).
- FN13 If menu planning and independent meal preparation are part of the client's treatment program, a licensed dietician or certified dietary manager shall provide training or approve a training program for staff who instruct and supervise clients in meal preparation.
- FN14 The program shall define duties in writing and have written instructions posted or easily accessible to clients.
- FN15 Clients in detoxification treatment shall not prepare meals.
- FN16 An adequate number of pots and pans based on the population served shall be provided for preparing meals. Eating utensils shall be free of chips or cracks.
- FN17 Each program shall have adequate refrigeration and storage space based on the population served. An adequately sized storage room shall be provided with adequate shelving. The storage room shall be constructed to prevent the invasion of rodents, insects, sewage, water leakage or any other contamination. The bottom shelf shall be of sufficient height (i.e. 12 inches) from the floor to allow cleaning of the area underneath the bottom shelf.
- FN18 Raw meat and eggs shall be separated from cooked foods and other foods when refrigerated. Raw meat is to be stored in such a way that juices do not drip on other foods.
- FN19 In programs that have a residential type kitchen, a five (5)-lb. ABC fire extinguisher is required in the kitchen. In facilities that have commercial kitchens with automatic extinguishers in the range hood, the portable five (5)-lb. fire extinguisher must be compatible with the chemicals used in the range hood extinguisher. The manufacturer recommendations shall be followed.
- FN 20 Refrigerator temperature shall be maintained at 41 degrees Fahrenheit or below, and freezer temperatures shall be maintained at 0 degrees Fahrenheit or below. Thermometers will be placed in each refrigerator and freezer.
- FN21 Hot foods should leave the kitchen (or steam table) above 145 degrees Fahrenheit and cold foods at or below 41 degrees Fahrenheit.
- FN22 Containers of food shall not be stored on the floor of a walk-in refrigerator, freezer, or storage rooms. Containers shall be seamless with tight-fitting lids and shall be clearly labeled as to content.
- FN 23 Food scraps shall be placed in garbage cans with airtight fitting lids and bag liners. Garbage cans shall be emptied as necessary, but no less than daily.
- FN 24 Leftover foods placed in the refrigerator shall be sealed, dated, and used or disposed of within 48 hours.

- FN 25 Personnel/staff/employees shall not use tobacco, in any form while engaged in food preparation or service, nor while in areas used for equipment or utensil washing, or for food preparation.

NOT FINAL

DETOXIFICATION SERVICES (DS) - Program providing detoxification services shall in addition to the General Standards meet the requirement of the standards listed in this section. The program shall develop, implement and have written policies and procedures with supporting documentation for all the following:

- DS1 The Regional Alcohol and Drug Detoxification Program will not admit any client under 18 years of age, belligerent, or with overriding medical conditions.
- DS2 While a client is in observation detoxification (with or without medical supervision), Medical Doctor(s), registered or licensed practical nurse or Regional Detoxification Specialists (RDS), must be present and specifically assigned to monitor the client on a twenty-four (24) hour basis.
- DS3 Clients in detoxification services will receive three (3) meals per day, with no more than fourteen (14) hours between any two (2) meals. Their meals will be served separately from other residential clients. If eating in a common area, they will receive their meal prior to or after other clients have vacated the area.
- DS4 Only an RDS, Medical Doctor, registered or licensed nurse are authorized to document progress notes, vital signs, fluid/food intake, withdrawal risk assessments and stabilization plans. All documentation is to include the authorized persons' signature and credentials.
- DS5 An RDS must hold current certifications in the following;
- a. Cardiopulmonary Resuscitation (CPR) or Basic Life Support (BLS);
 - b. First Aid (including naloxone training);
 - c. A nationally accredited, evidence-based behavioral management program, such as Nonviolent Physical Crisis Intervention (NPCI); and
 - d. Regional Alcohol and Drug Detoxification (RADD Training)
- DS6 All staff assigned to monitor detoxification clients shall know the signs and symptoms of withdrawal, the implication of those signs and symptoms; and emergency procedures, as defined in facility policy and procedure manual.
- DS7 Clients in detoxification services will have their vital signs taken upon admission and documented; and at least every two (2) hours thereafter, until within normal limits for eight (8) consecutive hours.

Exception: Once vital signs are within normal limits for eight (8) consecutive hours, they will be taken no less than every six hours. At this time, blood pressure, temperature and pulse may be omitted one (1) time per twenty-four (24) hour period; observation will continue as evidenced by documentation of reason for vital sign omission, client behavior observed and respiration count. (e.g. Vital signs completed at 10:00 p.m., description of behavior client exhibiting at midnight and resume vital signs at 2:00 a.m.);

- DS8 Observation detoxification, with or without medical supervision, will include:
- a. Gender separate sleeping areas with:
 - (1) One-level bed (no bunk beds);
 - (2) Individual storage for clothing and personal items;
 - (3) Window coverings to allow for privacy; and (4) Sufficient clean linen
 - b. Gender separate bathroom/shower areas with:
 - (1) Sufficient lighting so as to avoid injury;
 - (2) Plumbing in working condition so as to avoid any threat to health; and (3) Sufficient clean linen supply
- DS9 A complete set of vital signs will include blood pressure reading (systolic and diastolic), temperature, pulse and respirations.
- DS10 Once vital signs are within normal limits for eight (8) hours, they will be taken no less than every six (6) hours. There will be documentation in the client's case record verifying each vital sign taken during the client's stay in detoxification.
- DS11 Oral fluids and food shall be easily accessible to clients.
- DS12 There will be documentation of meals offered, consumed and/or refused; and the amount consumed or refused, every two (2) hours.
- DS13 There will be documentation of consumption of oral fluids indicating amount offered, consumed, or refused, every (2) hours.
- DS14 There will be documentation of reason for not offering nutrition. (e.g. client absent during meal time to see personal physician).
- DS15 Medication that is prescribed to an individual for withdrawal must be documented in the withdrawal risk assessment, stabilization plan and progress notes.
- DS16 A file will be maintained for each client, per admission; it will contain:
- a. Proof of client identity;
 - b. A signed Voluntary Admission Agreement; or,

- c. Involuntary Admission Agreement, as appropriate;
- d. Consent to Treat Agreement signed prior to admission;
 - (1) Must obtain signed, dated and timed consent, even if client is impaired by substance; and,
 - (2) Must obtain another signed, dated and timed consent once said substance no longer impairs client.
- e. The withdrawal risk assessment will be initiated on admission, completed and filed in the client record within four (4) hours of admission. If an emergency of the client's physical condition prevents documentation within four (4) hours, staff will explain the circumstances in the client record and obtain the information as soon as possible;
- f. Qualified staff member(s) (physicians, registered and/or licensed practical nurses or Regional Detoxification Specialists) will perform withdrawal risk assessment; it will include:
 - (1) Substance Use History;
 - (2) Current Detoxification Level Determination;
 - (3) Past psychiatric treatment;
 - (4) Past chemical dependency treatment;
 - (5) Significant medical history;
 - (6) Current health status;
 - (7) Current medications;
 - (8) Known food allergies;
 - (9) Known drug allergies;
 - (10) Current living situation;
 - (11) Current employment situation; and,
 - (12) Current emotional state and behavioral functioning.
- g. Completed and signed authorization(s) to release confidential information, as appropriate;
- h. Medication records, as appropriate (In programs utilizing MD's, LPN, LPTN and/or RNs); Clients must provide all previously prescribed prescription medications during admission. All previously prescribed prescription medications must be documented in client file including: type of medication, amount/dosage, route in which medication is administered, how often medication is taken, medical condition for prescription, prescribing physician and count of medication provided at admission.
- i. Personal Property Inventory, signed by staff or authorized agent, and client;
- j. Confirmation of client receiving and understanding of handbook;

- k. Confirmation of client receiving notice of Federal Confidentiality Regulations; to be signed when client is capable of rational communication;
- l. A staff person, authorized by the program, will identify the client's short term needs (based on the withdrawal risk assessment and medical history) and develop an appropriate detoxification plan (stabilization plan):
 - (1) An RDS, LPN, LPTN, RN or MD will sign the plan;
 - (2) The client will sign the detoxification plan, unless medically contraindicated; staff will explain the circumstances in the client record and obtain the signature as soon as possible;
 - (3) The completed and signed detoxification plan will be filed in the client record within eight (8) hours of admission;
 - (4) The program will review and, if necessary, revise the detoxification plan (stabilization plan) every twenty-four (24) hours or more often, should client need(s) change significantly;
 - (5) The program will implement the detoxification plan (stabilization plan) and document the client's response to interventions in the progress notes.
- m. Progress notes in detoxification will be documented every two (2) hours until stable for eight (8) hours (additional notes will be documented as appropriate) and will include:
 - (1) The client's physical condition observed by staff (signs);
 - (2) Client statements about the client's condition (symptoms);
 - (3) Client statements about their needs;
 - (4) The client's mood and behavior;
 - (5) Any medications that have been prescribed by the program's Medical Director (for programs utilizing medical staff), and
 - (6) Information about the client's progress or lack of progress in relation to detoxification (stabilization) goals.

DS17 Aftercare plans must document, at a minimum, referral to an ongoing counseling treatment or recovery services program.

ADOLESCENT TREATMENT (AT) - The program shall develop. Implement and have written policies and procedures with supporting documentation for all the following:

AT1 The program shall limit admissions to adolescents 13 through 17 years of age. The policies and procedures shall specify any exceptions to this requirement, and DPSQA must be notified and a waiver obtained prior to admission.

AT2 The program shall document and address the special needs (i.e., self-esteem, peer pressure education, decision making skills, use of leisure time ,etc. classes) of adolescents and protect their rights.

AT3 The program shall provide groups and activities for adolescents separate from adults.

NOT FINAL

- AT4 The program shall obtain consent for admission and authorization to obtain medical treatment at the time of admission for all clients under 18 years of age, unless adjudicated as an emancipated minor.
- AT5 Residential and day treatment programs shall have policies and procedures that govern access to client education as required by the Arkansas Department of Education.
- AT6 Residential programs shall allow regular communication between an adolescent client and the client's family and shall not arbitrarily restrict any communication without clear, written individualized clinical justification documented in the client record.
- AT7 Program staff that plan, supervise, or provide chemical dependency education or counseling to adolescents shall have the following:
- a. Qualified credentials for counselors; and
 - b. Direct care employees shall have documentation of continuing education in human adolescent development, family systems, adolescent psychopathology and chemical dependency and addiction in adolescents, and adolescent socialization issues. This may include in-service training.
 - c. Training specific to the clients served, such as: impact of substance abuse on children, identifying domestic violence; abuse, neglect, empowering the client and families to restore family functioning, development and age appropriate behaviors, parenting skills, self-esteem, peer pressure and bullying.
- AT8 Clients shall be under direct supervision at all times.
- AT9 In public places, clients shall be within eyesight at all times.
- AT10 Staff shall conduct and document visual checks at least once every hour. Bed checks will be made and documented every four (4) hours.
- AT11 All Incidents will be recorded and reported as appropriate.
- AT13 The program shall involve the adolescent's family or an alternate support system in the treatment process or document why this is not happening.
- AT14 The program shall prohibit adolescent clients from using tobacco products.
- AT15 The program shall prohibit tobacco products within the confines of any program housing adolescents.

SPECIALIZED WOMEN’S SERVICES (SWS) - Programs authorized by DPSQA to provide Specialized Women’s Services shall in addition to the General Standards meet the requirements of the standards listed in Specialized Women’s Services sections. The program shall address the specialized needs of the parent and include services for children. These services may be provided on the premises or through written service agreements with other providers. The program shall develop implement and have written policies and procedures with supporting documentation for all the following:

SWS1 Treatment shall include intensive primary treatment and clients must participate in at least thirty (30) hours of therapeutic services per week, including substance abuse group counseling, education, parenting, family reunification, and child development services.

SWS2 Job Skills:

- a. The program shall assure that clients attend G.E.D. classes (if applicable) , receive job training skills, or be employed.
- b. At a minimum, all clients shall register at the Employment Security Division (ESD); and
- c. At a minimum, all clients shall register at the Arkansas Department of Workforce Services. If employed the client shall receive a minimum of 15 hours per week of therapeutic services as determined by the client’s treatment plan.

SWS3 Parenting Skills:

- a. The program will assure all adult residents receive training in early child development and other parenting skills.
- b. These services may be provided on the premises or the clients may be transported to other locations.

SWS4 Children in the program shall receive age appropriate therapy as needed.

SWS5 All clients with children will attend and participate in parent/child interactive education either individual or group (1 hour minimum) per week.

SWS6 The program shall assess and document parent-child interaction weekly and any identified needs shall be addressed in treatment.

SWS7 Residential programs shall not accept dependents over the age of six (6), unless the program has prior written approval from DPSQA.

- SWS8 The program shall inform and educate pregnant clients of the Child Abuse Prevention and Treatment Act in accordance with state and federal laws.
- SWS9 Programs will provide training specific to the clients served, such as: substance abuse impact on children; identifying domestic violence; abuse; neglect; empowering the client and families to restore family functioning; child development and age appropriate behaviors; parenting skills; self-esteem; peer pressure; and bullying.
- SWS10 The program shall inform and educate pregnant clients of the dangers and effects that alcohol and illicit drug use has on the fetus.
- SWS11 Other education to be provided will include, but not be limited to, the topics of HIV/AIDS, STDs, TB, family planning, nutrition, sexual abuse and spousal abuse.
- SWS12 Family Education and Support:
- a. The program shall establish a family-counseling program for each client.
 - b. Family members shall receive basic drug abuse prevention information, and support skills, especially in relapse prevention, family dynamics and communication.
- SWS13 Aftercare: Prior to discharge the program shall be responsible for establishing an aftercare plan and will encourage the client to participate in support activities.
- SWS14 The program will provide access and referral to the fullest possible range of medical care for clients and children to include but not be limited to: Prenatal and postpartum health care; emergency health care; health screening; dental; well-child health care; screening in speech/language; hearing and vision; and verification of immunization records.
- SWS15 Childcare: The program shall ensure parents or qualified childcare providers directly supervise the children, at all times. The program is always responsible for providing oversight and guidance to ensure children receive appropriate care, when they are supervised by clients.
- SWS16 Childcare for residents with small children/day care will be provided either on the program's premises (by an authorized child care provider), or through a licensed day care center.
- SWS17 Child care shall be arranged for services delivered in the evenings, such as, an

AA meeting, or for an emergency. (Clients cannot provide this service).

SWS18 The program shall have a current schedule showing who is responsible for the children at all times;

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SWS19 Physical discipline by program staff is strictly prohibited.

SWS20 The program shall provide a variety of age-appropriate equipment, toys, and learning materials;

SWS21 Transportation shall be provided for any other services necessary to meet treatment goals.

SWS22 Program shall have policies and procedures that state staff shall not allow anyone except the legal guardian or a person authorized by the legal guardian to take a child away from the program. If an individual shows documentation of legal custody, staff shall record the person's identification before releasing the child.

SWS23 The program will provide room, board, and laundry facilities or services.

SWS24 Pregnant women, women with children, and children will be fed apart from other clients. If being fed in a common area they will receive their meals prior to or after other clients have vacated the area.

SWS25 The program may assess any amount for rent not to exceed the actual cost per day.

SWS26 The program staff are mandated reporters, and program shall have a procedure to use if a parent abuses or neglects a child, including reporting, intervention and documentation.

SWS27 The program must provide a safe and sanitary environment appropriate for children, to include at a minimum:

- a. Heating equipment shall be cool to touch safely;
- b. Heavy furniture and equipment shall be securely installed to prevent tipping or collapsing;
- c. Electrical outlets accessible to children shall have child-proof covers or safety devices;
- d. There shall be no cords or strings hanging within reach of a child;
- e. Cupboards, cabinets, closets, and refrigerators shall be secured to prevent trapping a child inside;
- f. Air conditioners, fans, and heating units shall be mounted out of children's reach or have safety guards;
- g. Grounds shall be kept free of standing water and sharp objects;
- h. Tap water shall be no hotter than 110 Fahrenheit;

- i. Items potentially dangerous for children (i.e. poison's bleach, etc.) shall be stored in a secure, locked environment;
- j. Areas that are more than two feet above ground level (such as stairs, porches, and platforms) shall have railings low enough for children to reach;
- k. Outdoor play areas shall be enclosed by a fence at least four feet high and shall not be viewable by the general public or anyone not associated with the SWS program;
- l. Tanks, ditches, sewer pipes, dangerous machinery, air condition units, heat pumps and other hazards on the grounds shall be fenced;
- n. m. Outdoor play equipment shall be in a safe location and securely anchored(unless portable by design);
- o. n . Buildings, furniture, and equipment shall not have openings or angles that could trap or injure a child or any part of the child's body; and
- p. o. Swing seats shall be durable, lightweight, and relatively pliable.

SWS28 Neither staff nor clients will use tobacco products within twenty-five feet of any program housing children.

CRIMINAL JUSTICE SYSTEM (CJS) - Programs requesting licensure to provide alcohol and drug treatment within the Criminal Justice System that may include Therapeutic Community (TC) or Drug Court shall in addition to the General Standards meet the requirements of the appropriate standards as it relates to their program found in the Criminal Justice System section. **Therapeutic communities shall follow the licensure requirements established in the Outpatient Behavioral Health Agency Licensure Manual in addition to CJS 11-17. The program shall develop, implement and have written policies and procedures with supporting documentation for all the following:**

- CJS1 Any person providing direct treatment services must receive at least four (4) hours of individual supervision or six (6) hours of group supervision monthly. Such supervision must be documented. Persons authorized to approve treatment plans, as specified in this manual, must perform this supervision.
- CJS2 Provides sufficient privacy to maintain confidentiality of the communication between counselor and client.
- CJS3 If the program uses space provided by another organization, there is a written agreement specifying the terms of such usage.
- CJS4 The program has at least one staff person present at all times during each shift who maintains a valid certification in First Aid (including naloxone training), CPR, or BLS and a nationally accredited evidence-based behavioral management program, such as NCPI.
- CJS5 The program shall not operate a new treatment site or make major programmatic changes at a present site without DPSQA approval.
- CJS6 Residential Treatment provides for a minimum of twenty (20) hours weekly (Sunday through Saturday) of structured treatment. (See Definition Section for an explanation of “structured treatment”).
- CJS7 A counselor’s caseload shall not exceed the thirty (30) to one (1) client/counselor ratio.
- CJS8 The initial treatment plan is completed within seven (7) days of admission.
- CJS9 The comprehensive treatment plan is developed and implemented no later than twenty-one (21) days from admission to residential services, thirty days (30) to outpatient services (including drug courts), and within forty-five (45) days from admission to therapeutic community (TC) programs.
- CJS10 Client treatment shall be documented at least weekly and shall minimally document:
- a. Treatment provided during the week;
 - b. The time frame that the note covers;

- c. The client's response to the treatment provided;
- d. Significant client events that occurred; and
- e. The name, signature and title of the staff person who wrote the note. TC programs will meet this requirement using a monthly (every 30 days), treatment plan review.

NOT FINAL

Additionally, TC units will adhere to the following standards:

- CJS11 Develop and implement a written mission and philosophy that addresses the beliefs, attitudes, and purpose of the Therapeutic Community (TC).
- CJS12 The TC program operates within a distinct space separate from the main prison population.
- CJS13 The TC shall provide a handbook or manual providing an explicit and comprehensive outline of the program, its mission, and its philosophy.
- CJS14 The handbook will be given to each participant upon entering the program and each staff member upon onset of employment.
- CJS15 The handbook shall provide a comprehensive section on the TC perspective on the substance abuse disorder.
- CJS16 The program will ensure that confrontation and consequence tools used by the TC shall not infringe upon the client's rights as defined and posted.
- CJS17 The staff member facilitating the confrontation group shall closely monitor and provide appropriate supervision

OPIOID TREATMENT (OP) - Programs seeking licensure as an Opioid Treatment Program (OTP) shall in addition to the General Standards meet the requirements of the standards listed in the Opioid Treatment section.

The Department of Human Services (DHS), Division of **Provider Services and Quality Assurance (DPSQA)** have developed these standards specifically for the administration of Opioid Treatment Programs (OTPs) in Arkansas. **The program shall make records available to DPSQA (or their designee), DAABHS, OMIG, MFCU upon request. In addition, access by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Drug Enforcement Agency (DEA) is also allowed for determination of compliance with CSAT, DEA as well as all governing federal regulations.**

The goal of opioid treatment is total rehabilitation of the client. While eventual withdrawal from the use of drugs, including methadone or buprenorphine, may be an appropriate treatment goal, however some clients may remain on opioid maintenance for relatively long periods of time. Periodic consideration of withdrawing from methadone/buprenorphine maintenance is appropriate only if it is in the individual client's interest. Such considerations are between the client and the treatment program.

The program shall be progressive in nature, addressing the client's individual need with methadone/buprenorphine as only one component of comprehensive treatment services.

The Program shall make records available to DPSQA upon request. In addition, access by the CSAT and the Drug Enforcement Administration (DEA) is also allowed for determination of compliance with CSAT and DEA rules.

APPLICANT SCREENING

- OP1 Applicant screening shall be extensive and thorough and shall form the basis for effective, long-term treatment planning. It shall include a staff assessment as to appropriateness of treatment that admission is voluntary, and the client understands the risks, benefits, and options.
- OP2 Prescription methadone is a highly addictive substance and entry into a Program is a critical decision for both the client and the Program. Before admitting an applicant to methadone treatment, the Program shall satisfy itself that the applicant fully understands the reasons for and ramifications of administrative detoxification and that the applicant voluntarily enters the Program with that knowledge.

ADMISSION CRITERIA

- OP3 The Program shall verify the applicant's name, address, date of birth and other critical identifying data.

- OP4 The Program shall document a one (1) year history of addiction and current physiological dependence. A one (1) year history of addiction means a period of continuous or episodic addiction for the one (1) year period immediately prior to application for admission to the Program. Documentation may consist of the applicant's past treatment history, with presence of clinical signs of addiction, such as, old, and fresh needle marks, constricted or dilated pupils, or an eroded or perforated nasal septum.
- OP5 For applicants who are under the age of eighteen (18) the Program shall document two (2) unsuccessful attempts at drug-free treatment, prior to being considered for admission to a Program. Note: No person under the age of eighteen (18) years of age shall be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.
- OP6 The Program shall give admission priority to pregnant women.
- OP7 The Medical Director may refuse treatment with a narcotic drug to a particular client if, in the reasonable clinical judgment of the Medical Director, the client would not benefit from such treatment. Prior to such a decision, appropriate staff may be consulted, as determined by the Medical Director.
- OP8 Upon admission the Program shall:
- a. Obtain the applicant's signature on a voluntary agreement admitting the applicant to the Program.
 - b. Verify the applicant's identification, including name, address, date of birth and other critical identifying data from a social security card, birth certificate, driver's license, etc. Copies of this identifying information shall include social security card and official photo identification and will become a part of the client's record.
 - c. Obtain a complete medical history from each client being admitted to treatment. The medical and laboratory examination of each client shall include:
 - (1) Investigation of the possibility of infectious disease and possible concurrent surgery problems;
 - (2) The complete blood count and differential;
 - (3) Serological tests for syphilis;
 - (4) Routine and microscopic urinalysis toxicology screening for drugs;
 - (5) Multiphase chemistry profile;

- (6) Intradermal Tuberculin Purified Protein Derivative (PPD) administered and interpreted.
- (7) A chest x-ray, Pap smear, biological test for pregnancy or screening for sickle cell disease if the examining medical personnel request these tests.

OP9 The Program shall not require a medical examination for a client transferring to a new Program who received a medical and laboratory examination within three (3) months prior to admission to the new Program. The Program physician may request a medical and laboratory examination for a transferring client. However, the new Program physician shall have, as part of the transfer summary, a medical summary and statement from the client's previous Program that indicates a significant medical problem. The transferred record shall include copies of the previous examination prior to admission.

OP10 Conduct and complete a counseling intake interview and develop a narrative psychosocial history within twenty-one (21) days of the client's admission date. This psychosocial narrative shall form the basis for preparing future treatment plans.

OP11 Develop a written statement, signed by the Medical Director, that the applicant is competent to sign the voluntary agreement admitting them to the Program.

OP12 Verify that the client is not currently enrolled in another opioid treatment program.

READMISSION CRITERIA

OP13 Readmission to a program depends on whether a client who is seeking readmission previously withdrew from methadone on a voluntary basis or as a result of an administrative decision due to the client's violation of Program policies.

OP14 A client, treated and later voluntarily detoxified from methadone maintenance treatment, may be readmitted to the Program without evidence to support findings of current physiological dependence, up to two (2) years after discharge, if the Program attended is able to document prior opioid maintenance treatment of six (6) months or more, and the admitting physician, in his or her reasonable clinical judgment, finds readmission to opioid maintenance treatment medically justified.

OP15 Clients seeking readmission to a Program after an administrative detoxification shall at a minimum wait thirty (30) days prior to applying for readmission. If a Program administratively detoxifies a client twice in a year then the client shall wait twelve (12) months to reapply for readmission.

EXCEPTIONS TO MINIMUM ADMISSION REQUIREMENTS

OP16 An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a Program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiological dependence on narcotics provided that prior to his or her institutionalization the client would have met the one (1) year admission criteria.

OP17 A program shall place a pregnant applicant on a maintenance regimen if the applicant has had a documented narcotic dependency in the past and may be in direct jeopardy of returning to narcotic dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiological dependence on narcotic drugs if a program physician certifies the pregnancy and, in his or her reasonable clinical judgment, justifies medical treatment.

SERVICES TO WOMEN

OP18 The Program shall test women of childbearing age for pregnancy at the time of admission unless medical personnel determine that the test is unnecessary.

OP19 In addition to federal laws and rules regarding pregnant clients, the Program shall implement written policies and procedures to ensure the accessibility of services to pregnant women. The Program shall:

- a. Give priority to pregnant women in its admission policy; and
- b. Arrange for medical care during pregnancy by appropriate referral, and verify that the client receives medical care as planned;

OP20 The Program shall inform pregnant clients of the Child Abuse Prevention and Treatment Act in accordance with state and federal laws.

OP21 The program will have specific policies and procedures developed to educate pregnant clients of the dangers and effects that alcohol and illicit drug use has on the fetus.

OP22 Conduct a special staffing with the entire treatment team to provide intensive case management for pregnant clients who are non-compliant with phase requirements. The Medical Director will develop specific protocols to ensure the safety of the fetus.

TREATMENT STRUCTURE

OP23 The Program shall provide the client a full range of treatment and rehabilitative services to include, but not limited to:

- a. Dosing;
- b. Case Management;
- c. Medical;
- d. Pre-natal (if necessary);
- e. Self-help;
- f. Diagnosis and Evaluation;
- g. Counseling Services; or
- h. Crisis Intervention.

OP24 The absence of the use of controlled substances, except as medically prescribed; social, emotional, behavioral and vocational status; and other individual client needs shall determine the frequency and extent of the services.

OP25 The assessment and treatment team shall consist of a Medical Director, medical staff and counselors who shall assess the client's needs and, with the client's input, develop a treatment plan.

OP26 As part of developing a treatment plan, the client shall have input in establishing or adjusting dosage levels.

OP27 The assessment and treatment team shall staff each case at least once each thirty (30) days during the first ninety (90) days of treatment and at least once each ninety (90) days thereafter.

OP28 The Medical Director shall sign off on the initial treatment plan when developed and the comprehensive treatment plan on an annual basis.

OP29 Services to each client shall include individual, group and family counseling at the following minimum levels:

- a. Phase I. Phase I consists of a minimum of a ninety (90) day period in which the client attends the Program for observation daily or at least six (6) days a week. During the first ninety (90) days of treatment, the take home supply is limited to a single dose each week. Phase I requires at least four (4) hours of counseling per week. The counseling sessions at a minimum shall consist of two (2) hours of group therapy sessions, one (1) hour of individual counseling, and one (1) hour of twelve step/self-help meeting per week. The assessment and treatment team and the client shall determine the client's assignment of group therapy attendance. The issues

to be discussed in group therapy sessions shall consist of at least a minimum but not limited to the following:

- (1) Family or Significant Others;
- (2) Living Skills;
- (3) Methadone Maintenance;
- (4) Peer Confrontation;
- (5) Positive Drug Screen;
- (6) Educational Training;
- (7) Vocational Training and/or Employment; and

NOT FINAL

- (8) Acquired Immunodeficiency Syndrome (AIDS) Education as related to Human Immunodeficiency Virus (HIV).

Prior to a client moving to Phase II, the client shall demonstrate a level of stability as evidenced by the following:

- (1) Absence of recent (past thirty (30) days) abuse of drugs (opioid or non-narcotic), including alcohol;
- (2) Clinic attendance as required in phase I;
- (3) Absence of serious behavioral problems at the clinic;
- (4) Absence of known criminal activity within the last thirty (30) days, e.g., drug dealing;
- (5) Stability of the client's home environment and social relationships;
- (6) Length of time in comprehensive maintenance treatment;
- (7) Assurance that take-home medication can be safely stored within the client's home; and
- (8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

In addition, the client shall provide assurance to the Program regarding safe transportation and storage of take-home medication.

- b. Phase II - Level 1. A client, admitted more than ninety (90) days and successfully completing Phase I, shall attend the Program no less than four (4) times weekly. The Program may issue no more than two (2) take home doses per week. A client must have continuous clean drug screens for the past thirty (30) days, while in Phase I, prior to advancement into Phase II Level 1. A client must spend a minimum of ninety (90) days in Phase II Level I. Prior to a client moving to Phase II Level 2, the client shall demonstrate a level of stability as evidences by the following:

- (1) Absence of recent [past sixty (60) days] abuse of drugs (opioid or non-narcotic), including alcohol;
- (2) Clinic attendance as required in Phase II, Level 1;
- (3) Absence of serious behavioral problems at the clinic;
- (4) Absence of known criminal activity within the last sixty (60) days, e.g., drug dealing;
- (5) Stability of the client's home environment and social relationships;
- (6) Length of time in comprehensive maintenance treatment;
- (7) Assurance that take-home medication can be safely stored within the client's home; and
- (8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential

risks of diversion.

- c. Phase II - Level 2. A client, admitted more than one hundred and eighty (180) days and successfully completing Phase II Level 1, shall attend the program no less than three (3) times per week. The Program may issue no more than three (3) take-home doses per week. A client must spend a minimum of ninety (90) days in Phase II Level 2. Prior to a client moving to Phase II Level 3, the client shall demonstrate a level of stability as evidenced by the following:

- (1) Absence of recent [past ninety (90) days] abuse of drugs (opioid or non-narcotic), including alcohol;
- (2) Clinic attendance as required in Phase II, Level 2
- (3) Absence of serious behavioral problems at the clinic;
- (4) Absence of known criminal activity within the last ninety (90) days, (e.g., drug dealing);
- (5) Stability of the client's home environment and social relationships;
- (6) Length of time in comprehensive maintenance treatment;
- (7) Assurance that take-home medication can be safely stored within the client's home; and
- (8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

- d. Phase II - Level 3. A client admitted more than two hundred and seventy (270) days and successfully completing Phase II Level 2 shall attend the program no less than one (1) time per week. The Program may issue no more than six (6) take-home doses at a time. A client must spend a minimum of ninety (90) days in Phase II Level 3.

During Phase II Level 1 a client shall attend at least two (2) hours of counseling (one of which shall be individual) and two (2) self-help group meetings per week. For the remainder of Phase II Levels 2 and 3 the client, primary counselor, medical director and other appropriate members of the treatment team shall determine a client's counseling and self-help activities provided that the minimum level of service delivery shall be one (1) hour of counseling per month and one (1) self-help group meeting per week.

- e. Phase III. A client admitted more than one (1) year and successfully completing Phase II shall attend the Program no less than one (1) time biweekly. (Not to exceed fifteen (15) calendar days). The Program may issue no more than fourteen (14) take home doses in fifteen (15) calendar days at a time. A client must have at least six (6) months of continuous clean screens, while in Phase II, prior to advancement into Phase III.

Phase III, the client, primary counselor, and medical director shall determine a client's counseling and self-help activities provided that the minimum level of service delivery shall be one (1) hour of counseling per month and two (2) self-help group meeting per month. The one (1) hour counseling may be either individual counseling or group therapy, as determined by staff and client.

- f. Phase IV. The Program may provide a twenty-eight (28) day supply of methadone if a client, admitted for two (2) years has successfully completed Phase III. A client must have at least twelve (12) months of continuous clean screens, while in Phase III, prior to advancement into Phase IV.

Phase IV requires at least one (1) hour counseling per month in addition to attendance at one (1) self-help group meetings per month as long as the client maintains a twenty-eight (28) day take-home medication status.

- g. Phase V. During the above four (4) phases a client, in consultation with the assessment and treatment team may elect to enter Phase V.
 - (1) This phase implements the methadone detoxification plan. The Program physician determines the take-home dosage schedule for the client. The primary counselor determines the number of counseling sessions provided during this phase based on the clinical judgment of the primary counselor with input from the client. At the onset of Phase V, the client may require an increased level of support services (i.e., increased levels of individual, group counseling, etc.). Prior to successful completion of Phase V the primary counselor and client shall develop a plan that shall integrate the client into a drug-free treatment regimen for ongoing support. The client's use of controlled substances except as medically prescribed, deterioration of social, emotional, vocational or behavioral status; and or other individual needs shall result in increased frequency and extent of treatment and rehabilitation services.
 - (2) The Program shall assess each client for referral, if appropriate, to Employment Security Division, vocational training and or enrollment in school. The Program shall conduct a follow-up at least every thirty (30) days.
 - (3) The assessment and treatment team and the client shall negotiate a methadone detoxification plan with potential target dates for implementation in Phase V. Such a plan may be short-term or long-term in nature based on the client's need and may include

intermittent periods of methadone/buprenorphine maintenance between detoxification attempts.

SPECIAL STAFFING

- OP30 The Program shall conduct a special staffing to determine an appropriate response whenever a client has two (2) or more drug screenings in a one (1) year period that are positive for illicit drugs other than methadone/buprenorphine.
- OP31 The Medical Director shall use test results as a guide to change treatment approaches and not as the sole criteria to force a client out of treatment.
- OP32 When using test results, the Medical Director shall distinguish presumptive laboratory results from definitive laboratory results.
- OP33 Clients in Phase II, Level III having a positive drug screen for illicit drugs and alcohol will be placed in Phase II, Level II to be completed in its entirety prior to moving back to Phase II, Level III.
- OP34 Clients in Phase III or IV having a positive drug screen for illicit drugs and alcohol will be placed in Phase II, Level III to be completed in its entirety prior to moving back to Phase III.
- OP35 Patients who are non-compliant with all requirements of their current phase level (i.e. positive toxicology screens and unexcused dosing and counseling absences) shall result in a decrease in phase level and take-home dose privileges. In addition, program staff must conduct a special staffing with the client present to determine corrective action protocol.

PROGRAM POLICIES

- OP36 The Program shall implement a written policy that states the Program shall not deny treatment to a person based on his or her actual or perceived sero status, HIV related condition or AIDS.
- OP37 Program staff shall receive yearly training on the subject of HIV and Hepatitis C infection and treatment of HIV and Hepatitis C infected clients.
- OP38 The Program shall have written policies for infection control, which are in compliance with the Center for Disease Control and Prevention Guidelines.
- OP39 The Program shall provide AIDS education to clients and shall provide or refer clients for HIV pre-test counseling and voluntary HIV testing. If the Program does test for AIDS, it shall be with the informed consent of the client. The Program shall assure the provision of pre and post-test counseling for the clients.

- OP40 The Program shall provide annual medical evaluations to clients as appropriate for dose level sero status and identified medical concerns.
- OP41 The Program shall provide or refer clients for tuberculosis and sexually transmitted disease (STD) testing upon admission and at least annually thereafter. However, Programs shall not require clients to receive HIV/AIDS testing.
- OP42 The Program shall develop written policies and procedures for continued treatment with methadone or buprenorphine in the event of an emergency or natural disaster.
- OP43 The Program shall have hours, which provide for early morning or late evening services to meet the needs of their client population.
- OP44 The Program shall implement written policies and procedures to ensure positive identification of the client before methadone or buprenorphine is administered.
- OP45 The Program shall develop written policies regarding the recording of client medication intake and a daily methadone/buprenorphine inventory. These policies shall comply with DEA, Arkansas State Pharmacy Board and Arkansas State Medical Board as appropriate.
- OP46 The Program shall develop and implement written policies and procedures to contact other opioid treatment programs within a two hundred (200) mile radius to prevent duplication of services to an individual. The policy shall be in accordance with Federal Confidentiality Regulations (42 CFR, Part 2).
- OP47 The Program shall monitor a client's progress and shall satisfy itself that the client is continuing to benefit from treatment.
- OP48 The Program shall not use incentives or rewards or unethical advertising practices to attract new clients. This shall not forbid the Program from rewarding clients that maintain exemplary compliance with program rules and their individualized treatment plans.
- OP49 The Program has the right to randomly schedule telephone requests to clients who have take home privileges requiring them to report to the treatment facility and to bring their remaining take-home medication with them. At least twice annually the Program shall randomly select at least five per cent (5%) of these clients who have take home privilege for this purpose.

- OP50 Programs shall be responsible for contacting the previous Programs of transferring clients regarding such issues as their stability in treatment and take home status, before initiating take home privileges for these clients.
- OP51 To prevent relapse, programs shall place transferring clients with take-home privileges on an increased drug screening surveillance schedule for the first thirty (30) days after admission.
- OP52 Client to counselor ratios shall not exceed 50:1
- OP53 Programs shall employ at least one full-time medical doctor, as licensed to practice medicine in the State of Arkansas, for every 300 clients.
- OP54 The medical director of an opioid treatment program will be American Board of Addiction Medicine (ABAM) certified; have documented references of working experience in an opioid treatment program, or have documented continuing education in addiction treatment or be approved for the Drug Addiction Treatment Act of 2000 (DATA 2000) waiver through SAMHSA.
- OP55 The Medical Director will be available to the program on a continual basis, seven (7) days per week, twenty-four (24) hours per day.
- OP56 Direct observation shall be used in collecting urine specimens. Observation shall be conducted professionally, ethically and in a manner, which respects clients privacy and does not damage the client-clinic relationship.
- OP57 Per 42 C.F.R Part 8.12, annually at least eight (8) random, periodic testing, including Breathalyzer tests for alcohol, shall be done to ascertain use of other substances, for clients with a history of abusing these substances.
- OP58 The program has policies and procedures that address the dangers associated with the use of benzodiazepines when taking methadone. This will include provisions for admission/discharge protocol for illicit use and obtaining a release of information with the prescribing physician's acknowledgement that the patient is also being prescribed methadone. The patient must sign and date and informed consent of the program's policy.
- OP59 When appropriate, family involvement shall be requested through a consent form to release information to family members.
- OP60 Each client whose daily dose is above 100 milligrams is required to be under observation while ingesting the drug at least six (6) days per week irrespective of the length of time in treatment, unless the Program has received prior approval from the State Opioid Treatment Authority (SOTA).

OP61 In addition to federal reporting requirements, the program will have specific policies and procedure to report lost or stolen doses, theft and diversion, and fatalities of overdose to the SOTA and DPSQA (incident reporting policy).

OP62 The program will have specific policies and procedures delineating staff access into the medication storage area(s).

EXCEPTIONAL TAKE HOME

OP63 Take home medication exceptions must be approved in writing, by the SOTA prior to dispensing. Exceptional take homes will not normally be granted to Phase I, Phase II, Phase III, and Phase IV clients. Reasons for exceptional requests, may include, but are not limited to the following:

- a. A client is found to have a physical disability which interferes with their ability to conform to the applicable mandatory schedule; the client may be permitted a temporary or reduced schedule, provided the client is also responsible in handling narcotic drugs.
- b. A client, because of exceptional circumstances such as illness, personal or family crisis, travel, or other hardship, is unable to conform to the applicable mandatory schedule, provided the client is also responsible in handling narcotic drugs. The rationale for the exception shall be based on the reasonable clinical judgment of the program's physician. The client's record shall document the rationale. The rationale is endorsed via the physician's signature.
- c. If the program is not in operation due to the observance of an official state holiday, clients may be permitted one extra take home dose and one fewer program visit per week on the day in which the holiday occurs. An official state holiday is the day on which state agencies are closed and routine state government business is not conducted.
- d. In the event that a winter storm watch is issued by the National Weather Service, a three (3) day take home dose may be dispensed. Additional days shall require SOTA approval. The SOTA retains the right to reduce or revoke the take home dosing.

OP64 The dosing area(s) used will be a separate area that provides sufficient privacy to maintain confidentiality of the client's identity and communication between staff and the client.

OP65 Any client receiving 100mg or larger methadone dose shall not be allowed exceptional take-home privileges unless approved via the SOTA.

OP66 All requests for methadone take-home medication exceptions must be submitted to the SOTA in writing or through SAMHSA/CSATEXTRANET.

Each request must document the following:

- a. The client number of the client for whom the request is made;
- b. The address, phone number and Social Security number of the client;
- c. Date of admission;
- d. Date of last request;
- e. Program number;
- f. The dates for the requested take-home;
- g. The rationale for the exceptions;
- h. The current dosing amount;
- i. Date of last positive drug screen;
- j. Current Phase; and
- k. Medical Director's signature.

Patient Exception Requests must be submitted online via SAMHSA's OTP Extranet Web site.

PROGRAM SECURITY

OP67 Programs are subject to DEA rules concerning the Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances (Chapter II Parts 1301 - 1307). Clients shall be physically separated from the narcotic storage and dispensing area.

OP68 The Program shall not allow clients to congregate or loiter on the grounds or around the building(s) wherein the Program operates.

OP69 Entrances that have windows will be tinted or have coverings, so the client's identity and confidentiality is protected from the view of the public.

CLIENT RECORDS

OP70 In addition to client record criteria OTP shall also contain:

- a. Documents and test results as generated by activities on admission;
- b. Client progress in treatment case notes;

- c. Results of case staffing;
- d. Results of drug screening tests;
- e. Such treatment plan reviews as required by Standard CTP2 herein; and
- f. Any other client related material deemed appropriate by the Program.

DRUG SCREENING

OP71 The Program shall complete an initial drug screening test or analysis for each client upon admission.

OP72 The Program shall conduct new client drug screening weekly for the first three (3) months in treatment. The Program may place a client who completes three (3) months of drug screening showing no indications of drug abuse on a monthly urine-testing schedule. **Annually, at least eight (8) drug screens must be completed on all clients.**

OP73 Programs shall implement procedures, including the random collection of samples, to effectively minimize the possibility of falsification of the sample.

OP74 The Program shall use drug screening as a clinical tool for the purposes of diagnosis and the development of treatment plans. After admission, the results of a single screening report shall not determine significant treatment decisions.

OP75 Clients on a monthly schedule for whom screening reports indicate positive results for drugs other than methadone shall return to a weekly schedule for a period of time clinically indicated by the physician.

OP76 The Program shall analyze each sample for opiates; methadone; amphetamines; crack/cocaine; benzodiazepines; marijuana and other drugs as may be indicated by clients use patterns.

OP77 Laboratories that perform the testing required under this rule shall be in compliance with applicable Federal proficiency testing and licensing standards and applicable state standards.

DOSAGE REPORTING REQUIREMENTS

OP78 The Medical Director may order methadone dosages in excess of 100 milligrams but less than 120 milligrams only where medically indicated. The Medical Director shall fully document the reasons for the dosage level and report such orders to the SOTA.

OP79 The Medical Director shall obtain prior written approval from the SOTA for methadone dosage orders in excess of 120 milligrams.

TAKE-HOME MEDICATION

OP80 The requirement of time in treatment is a minimum reference point after which a client may be eligible for take-home medication privileges. The time reference does not mean that a client in treatment for a particular time has a specific right to take-home medication. Since the use of take-home privileges creates a danger of not only diversion, but also accidental poisoning, the Medical Director must make every attempt to ensure that take-home medication is given only to clients who will benefit from it and who have demonstrated responsibility in handling methadone.

Thus, regardless of time in treatment, a Medical Director may, in his or her reasonable judgment, deny or rescind the take-home medication privileges of a client. Concurrently, the client shall provide assurance to the Program that take-home medication can be safely transported and stored by the client for the client's use only. Warning labels identifying the dangers associated with the ingestion of methadone shall be placed on every take home dose.

24-HOUR EMERGENCY SERVICES

OP81 Clients shall have access to the Program in case of an off-hour emergency. The Program shall maintain a 24-hour Emergency Hot-Line with individuals designated as on-call to handle client emergencies.

TRANSFERRING OR VISITING CLIENTS

OP82 When a client transfers from one Program to another, the transferring Program shall send copies of the transferring client's records to the licensed receiving Program prior to admission. Transferring clients shall enter Phase I for a minimum of two (2) weeks. With successful completion of Phase I, they enter the appropriate treatment phase.

OP83 Individuals visiting the State of Arkansas, who are part of a methadone treatment, program, shall have their home program provide information to a licensed Program prior to the individual's arrival in the state.

OP84 The Arkansas program shall provide qualified visiting clients up to twenty-eight (28) days of methadone medication. However, take-home privileges shall not be greater than the privileges accorded by the home program, and in no case for longer than six (6) days.

DISCHARGE PROCEDURES

OP85 In order to remain in the Program and to successfully move through treatment, clients shall be in compliance with Program rules or risk administrative detoxification from methadone. For the purpose of these standards, an infraction means threats of violence or actual bodily harm to staff or another client, disruptive behavior, community incidents (loitering, diversion of methadone, sale or purchase of drugs), continued unexcused absences from counseling and other serious rule violations. Clients may also be discharged for failure to benefit from the Program. When a Program determines to discharge a client, the Program shall provide a written statement containing:

- a. The reason(s) for discharge;
- b. Written notice of his or her right to request review of the decision by the Program Director or his or her designee; and
- c. A copy of the appeal procedures.

COMMUNITY LIAISON AND CONCERNS

OP86 A Program shall instruct clients not to cause unnecessary disruption to the community by loitering in the vicinity of the Program, or engaging in disorderly conduct or harassment.

The Program may discharge clients who cause such disruption to the community pursuant to the Standards.

OP87 Each Program shall provide the SOTA with a specific plan to avoid disrupting the community and the actions it shall take to assure responsiveness to community needs. The plan will include forming a committee of representative members of the community. Such committee shall meet at least once annually.

OP88 Further actions include assigning a staff member to act as community liaison, to establish an open dialog between the community and the program administration. Educational material shall be made available to the immediate community regarding the treatment of opioid addiction.

STAFF TRAINING

OP89 In an effort to maintain quality care, the program shall develop a training plan for personnel that foster consistency of care in accordance with rapidly evolving knowledge in the opioid treatment field.

OP90 The program shall develop a method of rapidly disseminating information about pharmacological issues and other advances in the field.

RECORD KEEPING AND REPORTING REQUIREMENTS

OP91 The program shall keep records and make such reports required by the DEA 1304.01 - 1304.38 of Chapter II - Drug Enforcement Administration, Department of Justice, part 1304 Records and Reports of Registrants.

OP92 The program shall adhere to record keeping and reporting requirements of the CSAT, HHS, 291.505 (d) (13). These records shall include but not be limited to (i) Client Care, (ii) Drug Dispensing, (iii) Client's Record.

OP93 The program shall provide other reports as required by the SOTA with records as required by DEA and CSAT rules.

OP94 The program shall provide other reports as required by the SOTA.

CLIENT APPEAL RIGHTS

OP95 Decisions regarding a client's treatment by staff are subject to appeal. The program shall develop appeal procedures that allow clients to directly appeal to the SOTA.

OP96 The SOTA shall approve the procedures. In addition, procedures shall include a provision that a central file of client appeals be maintained at the program site for review by the SOTA staff.

OP97 The program shall post a list of client's rights in a conspicuous place for the public.

PROGRAM APPEAL RIGHTS

OP98 An entity may appeal the disapproval of an application or Program closure by the SOTA. Refer to Section 6.00 of Alcohol and Drug Abuse Prevention's Rules of Practice and Procedure for the Appeal Process for Adverse Action.

PROGRAM CLOSURE

OP99 Failure of the program to adhere to CSAT/DEA rules or Standards of the SA may result in revocation of program approval and/or licensure.

OP100 The SA shall report Programs recommended for closure to the CSAT/DEA for revocation of the right to receive shipments of narcotic drugs in accordance with 21 CFR, 291.505(h).

NOT FINAL

DEFINITIONS

Relative to Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs

Addiction Severity Index (ASI) - A semi-structured assessment instrument designed to be used with clients presenting for substance abuse treatment. It covers seven (7) important areas of a client's life: medical, employment/support, drug and alcohol use, legal, family/social, opinions about alcohol and drug use, and psychological. The instrument documents lifetime difficulties in these seven (7) areas and focuses on difficulties in the thirty (30) days prior to assessment.

Administrative Detoxification - The gradual, medically controlled withdrawal of methadone.

Admission - The point in an alcohol or drug abuser's relationship with the program at which the intake process has been completed and the individual is entitled to receive services.

Aftercare - The component of the treatment program which assures the provision of continued contact with the client following the termination of services from a primary care modality, designed to support and to increase the gains made to date in the treatment process. Aftercare plan development should start prior to discharge, but is not implemented until discharge.

Alcohol or Drug Abuser/Addict - An abuser is a person who voluntarily uses alcohol or other drugs in such a way that their social or economic functioning is disrupted. An addict is a person who is physically and/or psychologically dependent on alcohol or other drugs and has little or no control over the amounts consumed, leading to substantial health endangerment, or social functioning disruption and economic functioning disruption.

Applicant - Any individual who has applied for admission to a treatment program, but is not yet admitted to the program.

Applicant Screening - The act of determining eligibility for treatment.

Assessment - The process of collecting sufficient data to enable evaluation of an individual's strengths, weaknesses, problems, and needs so that a treatment plan can be developed.

Chief Executive Officer - The individual appointed by the governing board to set in behalf of the overall daily management of the organization.

Client - An individual who has an alcohol or other drug abuse problem, for whom intake procedures have been completed, who is admitted to the program, and remains active in the treatment provided by the program, and has not been discharged.

Counselor - An individual who, by virtue of education, training or experience, provides treatment, which includes advice, opinion, or instruction to an individual or in a group setting to allow opportunity for a person to explore their problems related directly or indirectly to alcohol and/or other drug abuse or dependence:.

Definitive Laboratory Results - Confirmatory tests conducted by a National Institute of Drug Abuse (NIDA) certified laboratory.

Detoxification - The withdrawal of a person from a physiologically addicting substance.

Detoxification Treatment for Opioid Dependence - The dispensing of a narcotic drug in decreasing doses to an individual to alleviate adverse physiological and psychological effects of withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state within such period.

Direct Care - Any individual who provides chemical dependency education or counseling of treatment related activities.

Documentation - Provision of written, dated, and authenticated evidence (signed by person's name and title) to substantiate compliance with standards (e.g., minutes of meetings, memoranda, schedules, notices, announcement).

Emergency Care - A network of services that provides all persons having acute problems related to alcohol and other drug use and abuse readily available diagnosis and care, as well as appropriate referral for continuing care after emergency treatment.

Family - Individuals as defined by law, or significant others that claim relationship to the client.

Fiscal Management System - Procedures that provide management control of the financial aspects of program operations. Such procedures include cost accounting, program budgeting, materials purchasing, and client billing standards.

GOVCONNECT - GovConnect is the management information system for the collection and reporting of client related data prescribed by the State.

Governing Board - That person or persons with the ultimate authority and responsibility for the overall operation of the program.

Intake - The process of collecting and assessing information to determine the appropriateness of admitting an individual in an alcohol and drug abuse treatment program.

Licensure - The process by which the Alcohol and Drug Abuse Prevention determines if a person, partnership, association, or corporation may operate an alcohol and drug abuse treatment program.

Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs - The standards developed by the Office of Alcohol and Drug Abuse Prevention, which licensed treatment programs shall comply with.

May - Term in the interpretation of a standard to reflect an acceptable method that is recognized, but not necessarily preferred.

Medical Director - A physician licensed to practice medicine in the State of Arkansas who assumes responsibility for the administration of medical services performed by the Program, ensuring that the Program is in compliance with federal, state and local laws and regulations. In an Opioid Treatment Program the Medical Director assumes the responsibility regarding the medical treatment of narcotic addiction with a narcotic drug.

Methadone Hydrochloride - An opioid (a synthetic opiate) that is primarily used for the treatment of narcotic addiction in detoxification or maintenance programs.

Narcotic Dependent - A narcotic dependent is an individual who physiologically needs opiate or a synthetic opiate to prevent the onset of signs of withdrawal.

NCPI - Crisis Prevention Institute's training in Non-violent Crisis Prevention and Intervention.

Observation Detoxification - Includes monitoring on a 24-hours per day basis of a client who is undergoing mild withdrawal in a residential/live in setting. Monitoring will consist of taking the client's vital signs. Vital signs will be taken by a staff member trained and certified by DPSQA, a Medical Doctor, Registered Nurse, Licensed Psychiatric Technical Nurse or Licensed Practical Nurse. The facility shall establish approved emergency medical procedures. These services shall be available should the client's condition deteriorate and emergency procedures be required.

Opioid Maintenance - The dispensing of methadone for more than 180 days in the treatment of an individual for dependence on opiates.

Opioid Treatment Program - An entity that:

- (1) Administers or dispenses an approved narcotic drug to a narcotic addict for maintenance or detoxification treatment;
- (2) Provides a comprehensive range of medical and rehabilitative services;
- (3) Is approved by the SOTA and the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT);
- (4) Is registered with the Drug Enforcement Administration (DEA) to use a narcotic drug for the treatment of narcotic addiction; and
- (5) Is open at least six (6) days a week.

Outpatient Program - A non live-in program offering treatment or rehabilitation services to alcohol or drug abusers on a scheduled or non-scheduled basis.

Outpatient Service - Family - Counseling provided in an outpatient environment to a substance abuse client and family members or significant other.

Outpatient Service - Group - Counseling provided in an outpatient environment to more than one substance abuse client.

Outpatient Service - Individual - Includes care provided to a substance abuse client in an outpatient environment.

Outreach Public Education and Information - The dissemination of relevant information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community and stimulating social action to increase the services provided for people with problems associated with the use of alcohol and/or other drugs. It also includes the process of reaching into a community systematically for the purpose of identifying persons in need of services, informing individuals and their families as to the availability of services, locating additional services, and enhancing the entry into the service delivery system.

Partial Day Treatment - Care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting. This service shall include at a minimum intake, individual and group therapy, psychosocial education, case management and a minimum of one hot meal per day. Partial Day Treatment shall be a minimum of

four (4) hours per day for five (5) days per week. In addition to the minimum services, treatment may include drug testing, medical care other than detoxification and other appropriate services.

Presumptive Laboratory Results - Screening test results that have not been confirmed by a National Institute of Drug Abuse (NIDA) certified laboratory.

Program - An individual, partnership, corporation, association, government subdivision or public or private organization that provides treatment services.

Program Component - A category into which a specific group of interrelated services can be classified (e.g., outpatient care).

Program Sponsor - A person (or representative of an organization) who is responsible for the operation of a Program and who assumes responsibility for its employees, including practitioners, agents or other persons providing services at the Program and is knowledgeable of substance abuse treatment issues.

Progress Note - That portion of the client's case which describes the progress of the client and his (her) current status in meeting the goals set in the treatment plan, as well as describing the efforts of staff members to help the client achieve those stated goals. Progress notes also include documentation of those events and activities related to the client's treatment.

Referral Agreement - A written document defining a relationship between the program and an outside resource for the provision of client services not available within the alcohol and/or other drug abuse treatment program.

Regional Alcohol And Drug Detoxification Services (RADD Services) - A process providing the client with up to three days detoxification services and aftercare plan.

Regional Detoxification Specialist - A person trained and certified by Alcohol and Drug Abuse Prevention. Training will provide competency, at a minimum, in the following areas:

1. Current RADD Program Policies and Procedures;
2. Taking of vital signs (temperature, pulse, respiration and blood pressure);
3. Evaluation of presenting symptoms and compiling an accurate substance abuse history;
4. Current certification in cardiopulmonary resuscitation (CPR);
5. Current certification in a first aid course;
6. Current Non-Violent Crisis Intervention certification (CPI) in defusing hostile situations; and,
7. Knowledge of alternate social, rehabilitation and emergency referral resources.

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

Residential Program - A twenty-four (24) hour, seven (7) days per week, non-medical, live-in facility offering treatment and rehabilitation services to facilitate the alcohol and/or other drug abuser's ability to live and work in the community. Includes care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting with supportive living arrangements. This service shall include at a minimum, intake, individual and group therapy, case management and room and board. In addition to the minimum services, residential service may include drug testing, medical care other than detoxification, and other appropriate services.

Services - Services are program components rendered to clients which shall include, but are not limited to: (1) Medical evaluations; (2) Counseling; and (3) Rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement) which shall support the client in becoming a productive member of society.

Shall - Term used to indicate a mandatory statement, the only acceptable method under the present standards.

Significant Other - An individual who has an intimate relationship with another, but who is not related by heredity or law.

Specialized Women's Services (SWS) - At facilities designated as SWS a unit of service will be one day for a family. A family is considered one mother and up to two children below the age of seven (7). Services at a minimum include case management, alcohol and other drug treatment, child care, transportation, medical treatment, housing, education/job skills training, parenting skills, aftercare, family education and support and house rules.

Staff - Any individual who provides services to the program on a regular basis as a paid employee.

Standards - Specifications representing the minimal characteristics of an alcohol and/or other drug abuse treatment program, which are acceptable for the licensing of a program.

State Authority (SA) – The Director, or designee, of the Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention, or its successor.

State Opioid Treatment Authority (SOTA) - The Director, or designee, of the Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention, or its successor.

Structured Treatment - An activity facilitated by a staff member, an appropriate volunteer, or a representative from an outside agency (client meditation and study groups are not structured treatment).

Substance Abuse Treatment - A process whereby services are provided to an individual with the intent of the cessation of harmful or addictive use of alcohol and/or other drugs. Treatment must include, but should not be limited to, counseling. Treatment promotes the ultimate goal of the individual reaching their fullest physical, mental, social, vocational and economic capabilities possible.

Take-Home Medication - Take-Home medications refer to those doses of methadone consumed by the client under conditions of no direct observation by a medical provider.

Treatment Plan - A written plan developed after assessment, which specifies the goals, activities and services appropriate to meet the objective needs of the client.

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

Treatment Staff - The group of personnel of the alcohol and/or other drug abuse treatment program, which is directly involved in client care or treatment.

Update - A dated and signed review of a report, plan or program with or without revision.

Volunteer - Any person who of their own free will provides goods or service without any financial gain. Volunteers may not supplant paid staff.

Working Agreement - A written contract, letter of document, or other document that defines the relationship.

(Addendum 1)
**ARKANSAS DEPARTMENT OF HUMAN
SERVICES
DIVISION OF BEHAVIORAL HEALTH
SERVICES ALCOHOL AND DRUG ABUSE
PREVENTION
4313 West Markham, Third Floor
Administration Little Rock,
Arkansas 72205
(501) 686-9866 – FAX (501) 686-9396**

APPLICATION FOR LICENSURE

First time applicants shall submit a \$75.00 application fee

☐ **NEW APPLICANT**

☐ **RENEWAL**

☐ **CHANGE IN STATUS** (check ALL that apply):

☐ New Site

☐ New Address

☐ New Owner

☐ Adding a new level of service
☐ Increase in Bed Capacity
or adolescent)

☐ Change in Client Population (adult

NAME OF FACILITY TO BE LICENSED (dba if used):

Legal Name of Facility

Mailing Address (Headquarters)

Physical Address (Headquarters)

City

State

Zip Code

Telephone

County

()

Facility Contact Person for Licensure (Name and Title)

Telephone

FAX Number

()

SERVICES NEEDING LICENSURE

- | | | | |
|--------------------------------------|--|--|-------------------------------------|
| <input type="checkbox"/> Residential | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Partial Day | <input type="checkbox"/> Drug Court |
| <input type="checkbox"/> SWS | <input type="checkbox"/> Adolescent Services | <input type="checkbox"/> Therapeutic Community | |
| <input type="checkbox"/> Opioid | <input type="checkbox"/> Other (Specify) | <input type="checkbox"/> SATP | |

FACILITY CLASSIFICATION

- | | |
|---|---|
| <input type="checkbox"/> Medical Facility | <input type="checkbox"/> Independent Facility |
| <input type="checkbox"/> Community Mental Health Facility | |
| <input type="checkbox"/> Correctional Facility | |

LEGAL STATUS

- | |
|-------------------------------------|
| <input type="checkbox"/> NonProfit |
| <input type="checkbox"/> For Profit |
| <input type="checkbox"/> Public |

ACCREDITATION

- | |
|--------------------------------|
| <input type="checkbox"/> JCAHO |
| <input type="checkbox"/> CARF |
| <input type="checkbox"/> COA |

Projected Date to Open for New Facilities and Programs:

/ /

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION ON THIS APPLICATION IS TRUE AND CORRECT.

Typed Name of Chief Executive Officer

Signature of Chief Executive Officer

Date

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
COMPREHENSIVE SUBSTANCE ABUSE TREATMENT SERVICES (CSATS) VENDOR
PERFORMANCE BASED CONTRACTING**

Pursuant to Ark. Code Ann. 19-11-1010 et. seq., the selected Comprehensive Substance Abuse Treatment Service (CSATS) Vendor shall comply with performance-based standards. Following are the performances-based standards that will be a part of the contract and with which each CSATS Vendor must comply for acceptable performance to occur under the contract.

- I. The CSATS Vendor must comply with all statutes, regulations, codes, ordinances, and licensure or certification requirements applicable to the CSATS Vendor or the CSATS Vendors' agents and employees and to the subject matter of the contract. Failure to comply shall be deemed unacceptable performance.
- II. Except as otherwise required by law, the CSATS Vendor agrees to hold the contracting Division/Office harmless and to indemnify the contracting Division/Office for any additional costs of alternatively accomplishing the goals of the contract, as well as any liability, including liability for costs or fees, which the contracting Division/Office may sustain as a result of the CSATS Vendor's performance or lack of performance.
- III. During the term of the contract, the Division/Office will complete sufficient performance evaluation(s) to determine if the CSATS Vendor's performance is acceptable.
- IV. The State shall have the right to modify, add, or delete Performance Standards throughout the term of the contract, should the State determine it is in its best interest to do so. Any changes or additions to performance standards will be made in good faith following acceptable industry standards and may include the input of the vendor so as to establish standards that are reasonably achievable.
- V. In the standards below, a failure to furnish documentation of the provision of services is, itself, a breach of this standard.
- VI. The contract program deliverables and performance indicators to be performed by each CSATS Vendor are:

Service Criteria	Acceptable Performance ¹	Damages for Insufficient Performances ²
<p>1. GENERAL COMPLIANCE</p> <p>The CSAT Vendor must maintain compliance with all regulatory agencies applicable to these services.</p> <p>The CSATS Vendor must maintain compliance with the most current versions of the Division of Aging Adult and Behavioral Health Services (DAABHS) Alcohol and Drug Abuse Rules of Practice & Procedure and the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs.</p> <p>The CSATS Vendor must be nationally accredited by the Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA). Accreditation must include all appropriate substance abuse treatment service areas provided by the CSAT Vendor and include all sites providing substance abuse treatment services.</p> <p>The CSAT Vendor must ensure DAABHS and the Division of Provider Services and Quality Assurance (DPSQA) staff are informed prior to any changes in management Staff, contact information, site moves, additional sites, or changes in ownership within five (5) business days. New sites must be inspected and licensed by DAABHS before services are provided.</p> <p>The CSAT Vendor must provide DAABHS with evidence of its current national accreditation status. The Vendor must send DAABHS copies of all correspondence related to national accreditation within five (5) business days of being sent or received. Upon completion of any survey by a national accrediting body, the CSAT Vendor must forward final reports to DAABHS immediately upon receipt.</p> <p>The CSAT Vendor must forward copies of any correspondence (e.g. letter, facsimile, email, or other) regarding ongoing communication to and from the accrediting organization to DAABHS within five (5) business days of the date the correspondence was sent or received. This shall include national accreditation reporting requirements, including without limitation: Annual Conformation to Quality Reports, Maintenance of Accreditation, or Intra-Cycle Monitoring Profiles (if applicable based on accreditation type).</p> <p>The CSAT Vendor must report any adverse actions taken by national accrediting bodies, changes in accreditation status, or adverse actions taken by any other agency deemed to have regulatory</p>	<p>This service criteria must be provided and documented for State review and for the duration of the contract</p> <p>Vendor must always maintain one hundred percent (100%) compliance with this service criteria throughout the term of the contract.</p>	<p>1st incident (i.e. DAABHS and/or DPSQA finds a single instance where records and reporting services were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS and DPSQA within twenty (20) business days of the request.</p> <p>2nd incident: The CSAT Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DAABHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

¹ The service levels articulated below are not the exclusive obligations of the Vendor. Please see the RFQ for a full list of duties and requirements.

² The damages set forth herein are not intended to limit the remedies otherwise available to the State in law or in equity.

<p>oversight to DAABHS within seventy-two (72) hours of receipt of findings. A copy of CSAT Vendor's corrective action plans and/or evidence of CSAT Vendor's corrective action must be sent to DPSQA within five (5) business days of approval by the accrediting body or any other regulatory agency.</p> <p>The CSAT Vendor must always maintain enrollment as a service provider in the Arkansas Medicaid Program throughout the contracted term.</p>		
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>2. Records and Reporting Services</p> <p>In a manner and timeframe prescribed DAABHS, the CSATS Vendor must provide regular and special reports or plans. The CSATS Vendor must ensure all reporting information is submitted to DAABHS within designated time frames.</p> <p>The CSATS Vendor must ensure client information for the previous month is entered into ADMIS no later than the close of business on the fifth working day of the following month. This includes services to clients, Admission reports, Environmental Change Reports, and Discharge Reports.</p> <p>The CSATS Vendor must submit the Wait List and Capacity Management reports as directed by DAABHS.</p> <p>The CSATS Vendor must submit an Annual Program Report by June 15th of the preceding contract year. DAABHS will send out the mandatory format to providers no later than April 30th of each year.</p> <p>The CSATS Vendor must submit an annual independent financial and compliance audit that conforms to the "Guidelines for Financial and Compliance Audits of Programs Funded by the Arkansas Department of Human Services." The copies of all audit reports conducted under these guidelines must be submitted to the Department of Human Services as follows:</p> <ul style="list-style-type: none"> ○ If a Government Auditing Standards Audit is performed, the Audit Report must be submitted within one-hundred twenty (120) days following the Fiscal Year of a Provider. ○ If a Uniform Guidance Audit is performed, the Audit Report must be submitted within nine (9) months following the Fiscal year End of a Provider. <p>Submission is to be made directly to the following:</p> <p style="text-align: center;">Director of Audits, Office of Payment Integrity and Audit (OPIA)- Audit Section Department of Human Services P.O. Box 1437, Slot 270 Little Rock, Arkansas 72203-1437</p>	<p>This Program Deliverable must be provided and documented for State review. The contract must be provided one hundred (100%) of the time they are required, as determined by DAABHS.</p>	<p>1st incident (i.e. DAABHS finds a single instance where records and reporting services were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request.</p> <p>Should a corrective action plan be submitted, the CSATS Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: DHS will withhold payment for all services through this contract if reports are not submitted within required timelines. This will include year-end close out. Non-compliance or repeated non-compliance with any deadlines may result in subsequent year funding cuts.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

<p>Or email a copy to: ContactDHSAudit@arkansas.gov (preferred). An additional copy of the audit must be submitted electronically by e-mail as a Word Document, attachment to DAABHS designated staff member.</p> <p>The CSAT Vendor must ensure compliance with the DAABHS Incident Reporting Policy, including time frames for submission.</p> <p>The CSAT Vendor must ensure compliance with any other reporting information requested by DAABHS within the timeframe established for that reporting purpose.</p> <p>The CSAT Vendor will participate in trainings and meetings as required by DAABHS.</p>		
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>3. Program Staffing</p> <p>The CSAT Vendor must be responsible for ensuring all services (client-related or non-client related) are provided by appropriate qualified or credentialed persons.</p> <p>Staff providing treatment-related services must have current licenses or certifications with supporting documentation located in their personnel file.</p> <p>The CSAT Vendor must ensure the minimum number of staff providing treatment-related services, or support staff if utilized, have current certification in CPI, CPR, and First Aid. For SWS programs the CPR certification must include infant and child CPR.</p> <p>For detoxification programs, staff monitoring clients must be a currently certified RDS, or a RADD Qualified Staff (physician, RN, or LPN).</p> <p>Evidence of criminal background checks on all staff with direct contact with clients, or with access to client records, must be in personnel files. Maltreatment background checks must also be completed and in personnel files for any staff with direct contact with children, adolescents, or adults. Criminal background checks are to be completed upon hire, and at least every five (5) years thereafter. Maltreatment background checks must be completed at least every two (2) years.</p>	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverable were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter</p>

<p>There must be evidence of annual performance evaluations on all staff that have been employed for a year, including contracted staff.</p> <p>For any staff requiring supervision (e.g. Counselors-in-Training (CITS) based on their certification or licensure must have evidence of on-going supervision.</p> <p>All staff, interns, or volunteers must be qualified for their positions or responsibilities based on job-descriptions and must also undergo appropriate background checks relevant to the population served.</p>		<p>penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>4. Physical Plant Requirements</p> <p>The CSAT Vendor must be responsible for ensuring all services are provided in safe, secure, and health environment.</p> <p>The CSAT Vendor must maintain compliance with all physical plant requirements as specified in the most current version of the Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. Compliance must include areas relevant to any and all services provided.</p> <p>The CSAT Vendor must ensure that all service site utilities (gas, electricity, water, plumbing, etc.) are maintained in proper working condition. The CSAT Vendor will notify DAABHS within twenty-four (24) hours of any issues with facility utilities.</p> <p>Physical facility repairs must be completed by appropriately qualified persons or technicians.</p> <p>The CSAT Vendor must ensure that all utilities are properly repaired within seventy-two (72) hours of a determination that a deficiency exists (except when repair is responsibility of utility company).</p>	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>5. Standards of Care</p> <p>The CSAT Vendor must provide services using professionally recognized standards of care that include:</p> <p>A. The CSAT Vendor is responsible for ensuring clients funded by DAABHS meets eligibility guidelines. The CSAT Vendor will receive payment from DAABHS for necessary services provided to individuals whose income is at or below 150% of the Federal Poverty Level as issued in the Federal Register by the Department of Health and Human Services (HHS). The poverty guidelines are also available online at https://aspe.hhs.gov/2019-poverty-guidelines. Income must be evaluated over the course of the last twelve (12) months.</p> <p>B. The CSAT Vendor must ensure Evidenced-based Practices are utilized. The materials used must be relevant to the population served and the modality of treatment.</p> <ul style="list-style-type: none"> Evidence-based materials must be selected from the following Substance Abuse and Mental Health Services Administration (SAMHSA) link: https://www.samhsa.gov/ebp-resource-center. The CSAT Vendor must ensure that staff providing services have documented training in the identified Evidenced-based curriculum. Newly hired staff will have ninety (90) days to complete training in the Evidenced-based curriculum. Evidence of training must be placed in the personnel file. The clinical documentation in client files must indicate that the Evidence-based materials are being implemented appropriately. Policies and procedures must be in place regarding the training, continuing education required of staff, as well as the required use of Evidence-Based Programs. <p>C. The CSAT Vendor must ensure family/support network involvement in the treatment process.</p> <ul style="list-style-type: none"> There must be documented attempts to assure meaningful family/support network involvement. If involvement is contraindicated, then there must be documentation as to why. 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

<ul style="list-style-type: none"> • Adolescents involved in substance abuse treatment must have at least one (1) counseling session per month that involves a parent or legal guardian. • Clients in Specialized Women's Services who have children enrolled in treatment with the client must have documented contact/interactions as outlined in the SWS section of the most current version of the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. The CSAT Vendor must also make every effort to involve children of the client living elsewhere and these efforts must be documented. <p>D. The CSAT Vendor must ensure that treatment services are strengths-based, trauma-informed, holistic, culturally relevant, educational, individualized, and recovery-oriented.</p> <ul style="list-style-type: none"> • Clients' strengths must be identified during the screening/intake/assessment process. Identification should continue throughout the course of treatment and until the time of discharge. Clinical documentation must reflect that strengths are utilized when appropriate and are considered a key part of the treatment process. • Treatment must include documented educational/informational activities relevant to enhancing the quality of life, prevention, resiliency, and recovery. • There must be clear evidence that clients are involved in the development of treatment goals and objectives, revisions of goals and objectives, and in the development of an aftercare plan. • All documentation must be individualized and client specific. • Aftercare and discharge planning must be individualized and include identification of appropriate referrals, specific and relevant community resources, and include individualized and specific plans on how to maintain or exceed progress achieved during the course of treatment. 		
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>6. Technology Capabilities</p> <p>The CSAT Vendor must ensure technology capabilities as required by DAABHS.</p>	<p>All the program deliverable must be met and documented for State Review and for the</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these</p>

<p>A. The CSAT Vendor must maintain a fully functioning Electronic Health Records system.</p> <ul style="list-style-type: none"> The CSAT Vendor must ensure that all required clinical documentation, consents, notifications, receipts, etc., are available upon request. Technology must ensure adequate security, confidentiality, back-up, and disaster recovery preparedness. <p>B. The CSAT Vendor must maintain a twenty-four (24) hour emergency phone number, operable seven (7) days a week for each individual catchment area to assist with emergency situations and access to services. The phone number must be provided to clients, visible at entries, and provided on answering machines. Policies and procedures must be in place outlining the training and management of this process.</p>	<p>duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>7. Program Full Array of Services---Sub Contractors</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor may choose to engage subcontractors to assist in providing the full array of services. If the CSAT Vendor is unable to provide the full array of services independently, then they must engage subcontractor(s) to</p>	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due</p>

<p>ensure the full array of services is available. However, the CSAT Vendor must provide at least 51% of the full array of services.</p> <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p> <ul style="list-style-type: none"> • DAABHS must have written notification of all subcontractors and the specific services they are providing. DAABHS must be notified within forty-eight (48) hours of the subcontract being implemented. If subcontracts are terminated for any reason(s), DAABHS needs to be notified within forty-eight (48) hours with a written explanation as to how the full array of services will be maintained. • If the CSAT Vendor completes the assessment and initial or comprehensive treatment plan for the client and then refers the client to a subcontractor for the direct services, the CSAT Vendor must share the assessment and other relevant client information with the applicable subcontractor within twenty-four (24) hours. This is to ensure that appropriate treatment services can be initiated in a timely manner. • All DAABHS funded services provided by the CSAT Vendor and their subcontractor(s) must be entered into the Alcohol and Drug Management Information System (ADMIS) by the CSAT Vendor by the fifth (5th) working day of the following month. • All subcontractors are subject to the same requirements as the Primary CSAT Vendor regarding the contract requirements, national accreditation status, compliance with the most current version of the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs, the most current version of the DAABHS Rules of Practice. • The CSAT Vendor must develop and implement a monitoring process for all subcontractors at least quarterly. 	<p>(100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
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Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>8. Program Full Array of Services—Residential Treatment Services</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must ensure access to residential treatment for individuals in their designated catchment area.</p> <ul style="list-style-type: none"> Residential Treatment Services must include documented evidence of a pre-admission screening and an intake/assessment, which at a minimum includes financial eligibility, evidence-based screening tools for substance abuse and co-occurring problems. American Society of Addiction Medicine (ASAM)-based determination of treatment modality, an initial treatment plan, and a comprehensive treatment plan, Individuals in residential treatment must be provided services listed below: <ul style="list-style-type: none"> Individual counseling Group counseling Support network involvement/Family Counseling Psychoeducation Care Coordination Discharge/Aftercare Planning It may also include periodic drug testing. Residential Treatment Services must include twenty-eight (28) hours of structured treatment weekly provided over the course of at least six (6) days a week. Residential Treatment includes room and board. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>9. Program Full Array of Services-Residential Treatment Adolescents</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must ensure access to residential treatment for adolescents in their designated catchment area.</p> <ul style="list-style-type: none"> Residential Treatment Services must include documented evidence of a pre-admission screening and an intake/assessment, which at a minimum includes financial eligibility, evidence-based screening tools for substance abuse and co-occurring problems, ASAM-based determination of treatment modality, an initial treatment plan, and a comprehensive treatment plan. Individuals in residential treatment must be provided services listed below. <ul style="list-style-type: none"> Individual counseling Group Counseling Support network involvement/Family Counseling Psychoeducation Care Coordination Discharge/Aftercare Planning It may also include periodic drug testing. Residential Treatment Services must include twenty-eight (28) hours of structured treatment weekly provided over the course of at least six (6) days a week. Residential Treatment includes room and board. Treatment Plans for adolescents must address adolescent specific needs and issues. There must be a separate, identifiable organized unit providing substance abuse treatment services that represents a significant part of the continuum of therapeutic modalities comprising comprehensive substance abuse services to adolescents. Residential and day treatment programs must have policies and procedures that govern access to client education as required by the Arkansas Department of Education. Staff employed with adolescent programs will have training specific to the clients served, such as: impact of substance abuse on children; identifying domestic violence; abuse, neglect; empowering the client and families to restore family functioning; development and age appropriate behaviors; parenting skills; self-esteem; peer pressure and bullying. 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

<p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>		
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>10. Program Full Array of Services—Specialized Women's Services</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must ensure access to Specialized Women's Services for families in their designated catchment area.</p> <ul style="list-style-type: none"> Specialized Women's Services (SWS) Programs must include documentation evidence of a pre-admission screening and an intake/assessment, which at a minimum includes financial eligibility, evidence-based screening tools for substance abuse and co-occurring problems, ASAM-based determination of treatment modality, an initial treatment plan, and a comprehensive treatment plan. Individuals in SWS treatment programs must be provided services listed below. <ul style="list-style-type: none"> Individual Counseling Group Counseling Support network involvement/Family Counseling Substance abuse treatment services Psychosocial education Care Coordination Discharge/Aftercare Planning SWS services must also include documentation of childcare, transportation, a full range of medical treatment, housing, education/job skills training, parenting and child development training, family reunification, family education and support, and house rules. The program will provide room, board and laundry facilities. It may also include periodic drug testing. Treatment services must include thirty (30) hours of structured treatment weekly. 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

<ul style="list-style-type: none"> • Employed women must attend at least fifteen (15) hours of therapeutic services. • A family is defined by one mother and up to two children under the age of seven (7). Children in treatment with their mother must receive age appropriate therapy and medical treatment as needed. • The physical environment, educational and program elements, and staff qualifications must meet or exceed licensure standards as identified in the most current revision of the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. • If placement is not readily available for an individual to be determined to need SWS services, DAABHS is to be notified. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>		
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>11. Program Full Array of Services-Outpatient Substance Abuse Treatment</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must ensure access to a continuum of Outpatient Substance Abuse Treatment to individuals in their designated catchment area.</p> <ul style="list-style-type: none"> • A pre-admission screening and intake/assessment must be performed for all individuals participating in all outpatient treatment services. At a minimum, this includes a financial eligibility determination, evidence-based screening tools for substance abuse and co-occurring problems, ASAM-based determination of treatment modality, initial treatment plan, and a comprehensive treatment plan. • Individuals in Outpatient treatment programs must be provided services listed below: <ul style="list-style-type: none"> ○ Individual Counseling 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled</p>

<ul style="list-style-type: none"> ○ Family /Support Network Counseling ○ Group Counseling ○ Care Coordination ○ Psychosocial Education ○ Discharge/Aftercare Planning ● Partial Day Program Outpatient Services must be a minimum of four (4) hours per day for five (5) days per week and must include at least one (1) hot meal a day. ○ Individuals in Partial Day Treatment Programs must provide the services listed below, as determined to be medically necessary: <ul style="list-style-type: none"> i. Individual Counseling ii. Group Counseling iii. Care Coordination iv. Psychosocial Education v. Discharge/Aftercare Planning ○ It may include periodic drug testing ○ It may include Support Network Involvement/Family Counseling. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>12. Program Full Array of Services—Local Judges/Courts</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must work with local judges and courts to provide outpatient substance abuse treatment to adolescents involved in juvenile drug courts to ensure continuity, access, and quality of services for participants.</p> <ul style="list-style-type: none"> ● The CSAT Vendor will be an active member of the juvenile drug court team for a specific judicial district. ● The CSAT Vendor will attend all scheduled drug court team meetings. ● The CSAT Vendor will attend relevant drug court hearings. ● CSAT Vendor will engage in collaborative treatment planning with the drug court team to ensure 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount</p>

<p>interdisciplinary and coordinated treatment of involved adolescents.</p> <ul style="list-style-type: none"> • The CSATS Vendor will provide updates to the court and the drug court team regarding the progress of the adolescent's treatment plan. • The CSAT Vendor will adhere to the rules and guidelines of the juvenile drug court for which they are partnering with. • The CSAT Vendor will maintain continuous and consistent communication with the drug court team and drug court judge to ensure compliance with the drug court rules, guidelines and orders. • The CSAT Vendor as a member of the drug court team, will develop and follow individualized and comprehensive treatment plans for adolescents in the drug court program. • The CSAT Vendor will provide Care Coordination services to participants according to the needs identified in their comprehensive needs assessments and documented in the treatment plan. • The CSATS Vendor will provide frequent and periodic drug screenings in accordance with orders of the court. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>13. Program Full Array of Services—Observational Detoxification</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must ensure access to Observational Detoxification to individuals in their designated catchment area.</p> <ul style="list-style-type: none"> • Observational Detoxification Services must include documented evidence of pre-admission screening, intake/assessment, which at a minimum includes financial eligibility, evidence-based screening tools for substance abuse and co-occurring problems, ASAM- 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p>

<p>based determination of treatment modality, a withdrawal risk assessment, and a stabilization plan.</p> <ul style="list-style-type: none"> Documentation of vitals and food/fluid intake as indicated in the most current version of the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs, progress notes, and discharge/aftercare planning are required. The discharge/aftercare planning must outline, at a minimum, referral for ongoing counseling, treatment, and/or recovery-oriented support services. RADD services must be provided by qualified staff as outlined in the most current version of DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. RADD programs must comply with physical plant requirements specific to RADD areas as outlined in the most current version of the DAABHS Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to imposes stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
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Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>14. Program Full Array of Services—Interim Services</p> <p>The CSAT Vendor must provide the full array of services.</p> <p>The CSAT Vendor must provide and document the provision of Interim Services to individuals placed on a waiting list for entrance to a substance abuse treatment program in their designated catchment area.</p> <ul style="list-style-type: none"> At a minimum, 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 ensure transmission doesn't occur, and referral for HIV or TB services if necessary. 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request. Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p>

<ul style="list-style-type: none"> 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 to services. All requirements for Interim Services identified in the most current version of the DAABHS Rules of Practice and Procedure must be met. This includes specific criteria outlined for any identified priority population. <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>15. Program Full Array of Services—Care Coordination</p> <p>The CSAT Vendor must ensure access to Care Coordination to individuals in their designated catchment area.</p> <p>Care Coordination services are services that will assist the client and family in gaining access to needed medical, social, educational, and other services. Care Coordination will be provided using a wrap-around model and will include the following activities:</p> <ul style="list-style-type: none"> Input into the treatment planning process. Coordination of the treatment planning team. Referral to services and resources identified in the treatment plan. 	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request.</p> <p>Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p>

<ul style="list-style-type: none"> Facilitating linkages between levels of care. Monitoring and follow up activities that are necessary to ensure the goals identified in the treatment plan are met or revised as needed and assisting with transitioning between levels of care and/or integrating back into the community. <p>(Based on funding availability, contract utilization will be regularly reviewed, and contract amounts may increase or decrease based on the review).</p> <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>	<p>determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>
Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>16. Priority Population</p> <p>The CSAT Vendor must comply with service provision for priority populations and comply with required timeframes as identified by SAMHSA and in the most current version of the DAABHS Rules of Practice and Procedures.</p> <p>The CSAT Vendor will establish policies and procedures to prioritize the following populations in the order listed below:</p> <ol style="list-style-type: none"> Pregnant Intravenous drug users must receive services within forty-eight (48) hours. Pregnant Women must receive services within forty-eight (48) hours. Intravenous drug users must receive services within fourteen (14) days. <p>Priority populations placed on waiting lists must be offered Interim Services within timeframes established in the most current version of the DAABHS 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 ensure transmission doesn't occur, and referred for HIV or TB services if necessary. For pregnant women, Interim Services must also include counseling on the effects of alcohol and drug use on the</p>	<p>All the program deliverable must be met and documented for State Review and for the duration of the contract. The services must be provided one hundred (100%) of the time they are required, as determined by the Division of Aging Adult and Behavioral Health Services (DAABHS).</p> <p>This program deliverable shall be evaluated on an ad hoc or periodic basis as determined by DAABHS. DAABHS reserves the right to audit any time period for vendor compliance with these deliverables.</p>	<p>1st incident (i.e. DAABHS finds a single instance where Program Deliverables were not rendered in accordance with these standards): An acceptable Corrective Action Plan will be due to DAABHS within twenty (20) business days of the request.</p> <p>Should a corrective action plan be submitted, the CSAT Vendor shall ensure that all corrective actions presented in the plan are fully implemented within the specific timeframes.</p> <p>2nd incident: The Vendor shall be assessed a penalty in the amount of five percent (5%) deducted from the total monthly scheduled payment to the Vendor by the State for services in the month of the occurrence of the 2nd incident.</p> <p>3rd incident: DHS reserves the right to impose stricter penalties that may include additional financial penalties and/or up to the termination of the contract.</p>

<p>fetus. A referral for prenatal care must be made within twenty-four (24) hours of the request for admission to services.</p> <p>Interim Services must be made available to all persons on the waiting list to enter a substance abuse treatment program.</p> <p>The CSAT Vendor must contact individual receiving Interim Services at least every fourteen (14) days and document efforts to keep the client engaged in seeking treatment services.</p> <p>DAABHS must be notified immediately if a priority population client cannot be admitted to the CSAT Vendor's program within the required timeframes. DAABHS will assist with locating a clinically appropriate placement.</p> <p>Detailed documentation for Interim Services offerings and administration must be maintained by the CSAT Vendor.</p> <p>The CSAT Vendor must assure access to Residential Treatment Services when indicated as the necessary level of care by ASAM.</p> <ol style="list-style-type: none"> 1. Individuals in need of Residential Care must be admitted or referred to an available bed within fourteen (14) days of determination of need. 2. Individuals identified as a priority population as identified by SAMHSA and in the most current version of the DAABHS Rules of Practice and Procedure. <p>The CSAT Vendor must ensure access to substance abuse treatment services throughout the entirety of the contract period.</p> <p>The CSAT Vendor must ensure access to all services under this Contract for any person who must, but statute and/or court order, register himself or herself as a sex offender under the Ark Code §§ 12-12-905 and 12-12-906, if the individual's assessed community notification level is not higher than a Level 2, and the individual would otherwise be eligible for those services."</p>		
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Service Criteria	Acceptable Performance	Damages for Insufficient Performances
<p>17. Billing the Appropriate Payor---Fee for Service</p> <p>As explained in the RFQ, in most instances this Contract's funds are only accessible if another payor (such as Medicaid, Medicare, or private insurance) is not otherwise available. Each Vendor is required to bill these other available payors instead of billing the State for services rendered on a fee-for-service basis.</p> <p>Additionally, Vendor shall demonstrate ongoing staff development and recruitment processes to ensure good stewardship of state and federal funds.</p>	<p>The Vendor must bill available payors instead of billing the State on a fee-for-services basis. The Vendor must comply with this requirement one hundred percent (100%) of the time.</p>	<p>In each instance that the State finds that it was billed, on a fee-for-service basis, for the rendering of services that would have been billable to another payor, the State shall assess a damage equal to one hundred fifty percent (150%) of the amount billed to the State that should have been billed to a different payor.</p>
<p>18. Billing the Appropriate Payor—Accessing Block Grant Funds</p> <p>As explained in the RFQ, in most instances this Contract's funds are only accessible if another payor (such as Medicaid or private insurance) is not otherwise available.</p> <p>Also as detailed in the RFQ, Vendors are required to maintain records of when block grant funds were accessed to fund the provision of services.</p> <p>Thus, in each instance that a Vendor accesses block grant funds for the provision of Contract services (and documents it accordingly), the Vendor must first assure that other payors were not otherwise available.</p>	<p>The Vendor must only access block grant funds when other payors were not available. The Vendor must comply with this requirement one hundred percent (100%) of the time.</p>	<p>In each instance where the State finds that block grant funds were accessed when other payors should have been accessed the State shall assess damages in the amount of one hundred fifty percent (150%) of the amount improperly accessed from the block grant.</p> <p>Only services appropriately rendered from the block grant funds will be considered in the calculation of future block grant amounts.</p>

Failure to meet the minimum Performance Standards are specified may result in the assessment of damages.

In the event a Performance Standards is not met, the vendor will have the opportunity to defend or respond to, or cure to the satisfaction of the State, the insufficiency. The State may waive damages if it determines there were extenuating factors beyond the control of the vendor that hindered the performance of services of it is in the best interest of the State. In these instances, the State shall have final determination of the performance acceptability.

Environmental Factors and Plan

11. 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 2022-FFY 2023?

☐ Yes ☐ No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma¹ is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services. It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma² paper.

¹ 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.

² Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guides 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 M/SUD providers? ☒ Yes ☐ No
3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? ☐ Yes ☒ No
4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ☒ Yes ☐ No
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☒ Yes ☐ No
6. Does the state use an evidence-based intervention to treat trauma? ☒ Yes ☐ No
7. Does the state have any activities related to this section that you would like to highlight.

The State does not directly provide training at this time. However it is definitely supported with state and federal dollars. The Division of Aging, Adult, and Behavioral Health Services (DAABHS) allocated \$500,000.00 of American Rescue Plan Act funding directly to support free, trauma-specific trainings. Our largest teaching hospital, the University of Arkansas for Medical Sciences (UAMS), has a Center for Excellence through the Psychiatric Research Institute branch known as ARBEST (Arkansas Building Effective Services for Trauma). ARBEST offers a significant amount of free training to professionals and laypersons specific to

trauma. The DAABHS Division of Aging, Adult, and Behavioral Health Services has partnered with ARBEST to promote and fund Cognitive Processing Therapy, Components for Enhancing Clinician Experience and Reducing Trauma, Trauma-Focused Cognitive Behavioral Therapy, and Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behaviors. ARBEST is working to develop some specific training for laypersons/adults in any setting who interact with children and teens who have experienced trauma. All of these trainings are free and many are being offered 2-3 times while we still have American Rescue Plan Act funding available.

ARBEST offers additional trainings with alternative funding sources such as Parent-Child Interactional Therapy, Child-Parent Psychotherapy, and DC:0-5. ARBEST also offers free periodic, short webinars (one hour) on topics such as commercial sexual exploitation, Multidisciplinary Team Approach to Child Advocacy and the Role of the Mental Health Provider, and maternal substance abuse and infant/child outcomes. Shortly after recent and devastating tornados ripped through our state ARBEST quickly responded to develop school-focused materials to help support children who have undergone climate-related stressors/trauma.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.¹ Almost two thirds of people in prison and jail meet criteria for a substance use disorder.² As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.³ States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

¹Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

²Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

³Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☒ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☒ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☒ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☒ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☒ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☒ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☒ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☒ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☒ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☒ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☒ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☒ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☒ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☒ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☒ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? ☐ Yes ☒ No
If so, please describe.

3. 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 M/SUD and other essential domains such as employment, education, and finances? ☒ Yes ☐ No

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

None at this time.

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

Not at this time.

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Question 3. While the State does have this inter-agency coordinating committee, it is not housed DHS, but rather within the criminal justice system.

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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 the use of medications for substance use disorders? ☒ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ☒ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds?
 - a) ☒ Methadone
 - b) ☒ Buprenorphine, Buprenorphine/naloxone
 - c) ☐ Disulfiram
 - d) ☐ Acamprosate
 - e) ☒ Naltrexone (oral, IM)
 - f) ☐ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

Arkansas supports use of medications for opioid use disorder and added this service to Medicaid in 2019 with expanded appointments, expanded lab services, expanded radiology services, and a program to ensure monthly visits and counseling x 1 year and quarterly visits and counseling thereafter.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes "[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)" as well as an [Advisory: Peer Support Services in Crisis Care](#) and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "[National Guidelines for Child and Youth Behavioral Health Crisis Care](#)" which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

For many years our Community Mental Health Centers (CMHC) were the only behavioral health providers in Arkansas. They were our sole safety net for individuals with SMI/SED needs. In more recent years, our Medicaid provider list expanded significantly and per policy, all Medicaid providers are mandated to ensure crisis services were available for their clients. With the latter expansion, our CMHCs were responsible for their clients, but also for indigent care (defined as those without insurance coverage) for persons without health insurance coverage. In 2014, Arkansas became an expansion state and many Arkansans obtained health care coverage expansion policies, further narrowing the scope of care for our CMHCs. All Medicaid providers are required to provide access to crisis

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

- a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
- b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.
- c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA

guidelines.

d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Someone to respond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe place to go or to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Briefly explain your stages of implementation selections here.

Persons in all areas/counties of the state have access to 988. Some of our CMHCs have access to warm lines answered by Peer or paraprofessionals. During the pandemic, we allowed for crisis screenings/crisis interventions to be provided by telemedicine. CMHCs have a response time of no more than 15 minutes to directly connect with the individual in crisis. For individuals needing to be evaluated in-person, there is a two-hour time limit to make direct, face-to-face contact. As previously stated, our CMHCs cover all 75 counties across the state. All Behavioral Health Agencies (Medicaid providers) are mandated to have 24/7 emergency response plans. There are three flaws with program sustainment. Some counties are still very rural in certain areas. Though broadband access is better

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Arkansas will be relying heavily on the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit as we develop our state-wide crisis system. Also as previously mentioned, we have contracted with a consulting firm to assist with evaluating our current behavioral health system as a whole, and to provide some guidance to updating our system.

Arkansas plans to use Centers for Medicaid and Medicare Services (CMS) Home and Community Based Services American Rescue Plan (ARP) funding to develop a statewide mobile crisis response system proposal. A request has been made for state ARP funding to

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Funding is being used to partially support our Crisis Stabilization Units at this time. However, the 5% set aside utilization may be revised as we develop our new system.

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

None at this time.

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

None at this time.



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NOT FINAL

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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) Use 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

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.

Recovery and recovery support services for adults with SMI in our state is still relatively new. In 2021 Arkansas began initiatives to incorporate training for mental health, substance use disorder, and co-occurring disorders into our Arkansas Model Peer Curriculum. Adjustments have been made, and are evaluated on an on-going basis, to our Peer Program (applications, curriculum, training) to ensure inclusivity for mental health issues. At the state level we are working to incorporate recovery- based language and requirements in our documents, contracts, websites, and procedures.

The Division of Youth Services is currently our only youth Peer Support program and they focus on justice-involved youth. Peer services include groups and individual contacts while in the DYS program, but also focuses on resources for aftercare needs.

Our two pilot Mobile Crisis projects are required to employ peers. Though they have had some overall struggles with staffing, they each been able to maintain at least one Peer Specialist on their team for the last six months. As Arkansas works to build a state-wide Crisis System, we believe our Peer workforce is going to be a critical asset to this endeavor.

One of our main Therapeutic Community providers with 11 locations across the state has embraced employment of Peers in recovery from mental health issues. We have Peers employed in 4 medical hospitals with plans to expand. Our Community Mental Health Center providers are required to have Peers on staff, but they have reported difficulty finding Peers. The State provides list of certified Peers upon request to any agency looking to hire a Peer.

The state is currently in the process of developing and implementing Assertive Community Treatment teams. These teams will be required to have a minimum of one Peer Specialist.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Arkansas Substance Use Disorder Treatment providers have a long history of employing Peer Specialists. Several of our Medication -Assisted Treatment programs are in the process of employing Peers right now.

Arkansas has a total of four Recovery Community Organizations which provide free Peer services to community members in need. A new Recovery Housing initiative has begun this year working with the McShin Foundation. Our goal is to have 10 recovery houses become nationally certified through the National Alliance for Recovery Residence program (NARR).

We are in the process of providing funding to eighteen different counties with Specialty Courts to hire twenty-one Peer Specialists to work in their programs.

We have a great partnership with the Arkansas Department of Corrections with our Inside/Out program. We graduated two classes of currently incarcerated persons who have completed Core training. Immediately upon release they become eligible to test for a Peer-In-Training certification making them eligible to start working as Peer under supervision. Additional classes will be scheduled for fall of 2023. At this time, our program is limited to men, but we want to expand to include at least one women's facility in the next two years.

Our Peers Advocating for Collaborative Treatment (PACT) program is a combination of jail-based and treatment provider-based programs with goal for individuals to become employed, find housing, be reunited with families, and in general become productive members of society.

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

We are proud of our three-tiered certification program which we feel encourages professional growth and the development of a career ladder for this workforce.

We believe one area needing focus in this dire time of workforce issues is to educate on how Peers can be effectively used as a member of a team.

We are very excited that the Block Grant applications now require information on recovery-based services. This is speeding up our efforts to start gathering quality data on Peer and recovery-based services.

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

None at this time.

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Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

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

1. Does the state's Olmstead plan include:

Housing services provided	<input type="radio"/> Yes <input type="radio"/> No
Home and community-based services	<input type="radio"/> Yes <input type="radio"/> No
Peer support services	<input type="radio"/> Yes <input type="radio"/> No
Employment services.	<input type="radio"/> Yes <input type="radio"/> No
2. Does the state have a plan to transition individuals from hospital to community settings? ☐ Yes ☐ No
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?

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.¹ 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 24.² For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.³

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 21.⁴

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.⁵

According to data from the 2017 Report to Congress⁶ 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 M/SUD 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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

¹Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

²Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

³Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁴The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁵Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶ http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
 - a) The recovery of children and youth with SED? ☒ Yes ☐ No
 - b) The resilience of children and youth with SED? ☒ Yes ☐ No
 - c) The recovery of children and youth with SUD? ☒ Yes ☐ No
 - d) The resilience of children and youth with SUD? ☒ Yes ☐ No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - a) Child welfare? ☒ Yes ☐ No
 - b) Health care? ☒ Yes ☐ No
 - c) Juvenile justice? ☒ Yes ☐ No
 - d) Education? ☒ Yes ☐ No
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? ☒ Yes ☐ No
 - b) Costs? ☒ Yes ☐ No
 - c) Outcomes for children and youth services? ☒ Yes ☐ No
4. Does the state provide training in evidence-based:
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
 - b) Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No
5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult M/SUD system? ☒ Yes ☐ No
 - b) for youth in foster care? ☒ Yes ☐ No
 - c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ☒ Yes ☐ No
 - d) Does the state have an established FEP program? ☒ Yes ☐ No
 - Does the state have an established CHRP program? ☐ Yes ☒ No
 - e) Is the state providing trauma informed care? ☒ Yes ☐ No
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.)

DAABHS ensures behavioral health services are available to children and youth throughout the state. Currently outpatient services receive Medicaid funds under the Outpatient Behavioral Health Services for the under 21 population, or under the PASSE system, which includes treatment services for mental health or substance use disorders. There are over 300 sites certified behavioral health

agencies across the state and well over 500 Independently Licensed Clinicians (also Medicaid providers) who can provide outpatient treatment services for mental health or substance use disorders. One of the most critical pieces of our system transformation involves the requirement of all PASSE beneficiaries to receive Care Coordination. Care Coordination includes development of the person-centered service plan (PCSP). The PCSP assures continuity of care across all services and all service providers. At a minimum, the PCSP includes health education and coaching, coordination between healthcare providers for diagnostics, ambulatory care, and hospital services, assistance with social determinants of health, promotion of activities focused on the health of a client and their community, and community-based medication management. The PASSE Care Coordinator is responsible for assisting the member with moving between service settings and must ensure care takes place in the least restrictive setting.

Juvenile Drug Court services are available in 10 judicial districts (Benton, Johnson, Pope, Independence, Cleburne, White, Faulkner, Craighead, Cross, St. Francis, Garland, Saline, Jefferson, Columbia, Ashley, and Phillips counties).

The Division of Youth Services (DYS) has undergone a two-year overhaul to ensure that youth in their custody have access to appropriate mental health and substance use disorder screenings, assessments, evidence-based mental health and substance use disorder treatment services, and robust aftercare planning. Youth in DYS custody also have access to Peer services. Additionally, DAABHS pays for care coordination in the PASSE system and youth outside of the DYS system with SED and involvement in the juvenile justice system have service coordination that intersects with law enforcement and probation.

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

Not at this time.

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

None at this time

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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:

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.

The Arkansas Department of Health (ADH) Substance Misuse & Injury Prevention section implements several evidence-based programs to address the need for suicide prevention and intervention in the state. A significant amount of information can be found on-line at <https://www.healthy.arkansas.gov/programs-services/topics/suicide-prevention> or by calling 501-683-0707. Below are some of their current programs or links to other programs supporting suicide prevention efforts:

 - Arkansas Lifeline Call Center is a part of the national 988 Suicide & Crisis Lifeline. This line has a special feature for those who are veterans. Arkansas currently has three call centers who support incoming calls on 988.
 - The ADH Suicide Prevention Program promotes or implements the following trainings:
 - a) Youth Suicide Prevention 101
 - b) Question, Persuade, Refer (QPR)
 - c) Safe TALK
 - d) Applied Suicide Intervention Skills Training (ASIST)
 - Suicide Prevention Helpful Web Sites
https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Helpful_Sites.pdf
 - SAMHSA <https://www.samhsa.gov/find-help/national-helpline>, which includes links to helpful resources
 - Special program and resources for veterans experiencing suicidal thoughts and behaviors, including treatment options and self-help tools <https://www.maketheconnection.net/conditions/suicide>
 - The Trevor Project <https://www.thetrevorproject.org/>
 - NAMI sponsored activities and events:
 - a) During Suicide Prevention Awareness Month a NAMIWalk event for fundraising takes place
 - b) host in-person and virtual support groups
 - c) NAMI on Campus program which support peer-run clubs in high schools and on college campuses
 - d) NAMI Basic is a multi-session virtual course available for parents, caregivers, or other family who provide care for persons 22 or younger who are experiencing mental health symptoms
 - e) NAMI Homefront is a multi-session educational program for families, caregivers, and friends of military service members/veterans with a mental health condition
 - f) NAMI supports a peer-led Family Support Group
 - g) NAMI Connections Recovery Support Group is a peer-led group for adults experiencing mental health symptoms
 - A listing of resources for Suicide Prevention – After a Suicide Toolkit:
[https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Programs_Promoted_by_ADH_2019_\(002\).pdf](https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Programs_Promoted_by_ADH_2019_(002).pdf)
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

If yes, please describe how barriers are eliminated.

Part of our plan to implement more effective Crisis Services includes working toward rapid connection with a Peer as a part of the discharge plan after an individual has experienced an acute hospital admission. We are working to build our Peer workforce and have plans to place Peers in emergency departments in key areas of the state. Another statewide requirement is that outpatient agencies must get an appointment scheduled for person discharging from acute care facilities within seven calendar days, and an appointment with a prescriber must be made within thirty calendar days.
5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ☒ Yes ☐ No

If so, please describe the population of focus?

We are in the early stages of developing and implementing a state-side crisis system which will provide mobile crisis services in all 75 counties. As mentioned above, we continue to address our plan to implement more effective Crisis Services includes working toward rapid connection with a Peer as a part of the discharge plan after an individual has experienced an acute hospital admission.

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

None at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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?
NA
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 continues to rely on and communicate with our behavioral health stakeholders. One large project soon to be underway is an overall evaluation of our behavioral health system, which will also have a specific focus on the best use of our Community Mental Health Centers going forward. Meetings have been scheduled with stakeholders to have an open discussion about needs and gaps which remain in our communities. Our focus is certainly on enhancing home and community-based services for adults and children, and taking more of a targeted approach to educating consumers, stakeholders, and providers of service about

Recovery-oriented approaches, Peer services, and diversion from the Arkansas State Hospital.

Close working relationships and open lines of communication with our four Provider-led Arkansas Shared Savings Entity (PASSE) groups are critical to the success of our programs. Key staff with each PASSE are involved in many aspects of decision-making and evaluation of needs and gaps and overall implementation for all new programs.

Our Division of Aging, Adult, and Behavioral Health Services/Office of Substance Abuse and Mental Health has always maintained an excellent relationship with our sister Department of Human Services (DHS) Divisions, including the Division of Medical Services (Medicaid), the Division of Children and Family Services, the Division of Youth Services, and the Division of Developmental Disability Services. During the navigation of the public health emergency, our communication with another DHS Division, the Division of County Operations, gained momentum regarding making determinations about program eligibility for thousands of Arkansans.

Our updates to the Medicaid expansion program will target improved outcomes for maternal and infant health, stabilizing and strengthening rural communities, and a third category, the Success Life 360 Home population. The latter group includes veterans aged 19-30, persons formerly in foster care and now aged 19-27, those formerly in the custody of DYS and now aged 19-24, and persons aged 19-24 who were formerly incarcerated. Each of these groups will receive support and intensive services to help address health-related social needs, including finding their individual path to long-term economic independence through work and education. The improved Qualified Health Plans will facilitate closer relationships with DHS and rural and critical access hospitals, but also assist with DHS being able to hold the insurance carriers more accountable for outcomes and financial controls.

Arkansas has a School-Based Mental Health program with services being provided in local schools with Medicaid reimbursement. Additionally, schools can make referrals to certified and enrolled Medicaid providers with the school site being an allowable place of service. Therefore, most students receive services through the Medicaid program. The schools enter into agreements through Memorandum of Understandings with provider agencies, which fulfill the needed services regardless of payor source that have been identified by schools under IDEA.

DAABHS/OSAMH has entered into a partnership with the Arkansas Specialty Courts and will soon have Justice-Involved trained Peers in 19 courtrooms across the state. We hope that this endeavor will allow for opportunities to provide education to the judicial system on the many benefits of having Peers participate in the Specialty courtrooms.

DAABHS/OSAMH actively participates in multiple interdisciplinary teams across other DHS divisions to staff complex cases involving children, youth, and adults.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, 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 an Advisory/Planning Council (PC). 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 PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).¹

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 M/SUD 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.

¹<https://www.samhsa.gov/grants/block-grants/resources> [samhsa.gov]

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

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.)

The Arkansas Behavioral Health Planning and Advisory Council's (ABHPAC) Block Grant subcommittee began meeting in March 22, 2023 to review documents. The Division of Aging, Adult, and Behavioral Health Services (DAABHS)/Office of Substance Abuse and Mental Health (OSAMH) provided ABHPAC Block Grant subcommittee members (12) with training and education about the Block Grant process, along with access to review the combined block grant application from previous years and drafts of the state's response to this application. DAABHS/OSAMH staff were present at every meeting upon request of this subcommittee to be available for questions, provide explanations, and to share about some of the new goals our agency is in the process of developing. Meetings were also held on April 8 & 22, May 13 & 27, June 10 & 24. The final meeting is scheduled for July 25.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

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 monthly. 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 DAABHS/OSAMH chairs the Treatment and Prevention Subcommittee.

The AADACC meetings are open to the public and a representative from ABHPAC may attend. ABHPAC's ability to attend meetings has been infrequent for the last two years due to meeting conflicts and limited in-person meetings.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ☒ Yes ☐ No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☒ Yes ☐ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council is comprised of consumers, family members, providers, and representatives of state and private agencies. Over the course of the public health emergency, our membership and overall activities declined. In the past 6-8 months we have worked to regroup and revitalize our Council. Council members organized a fall conference with guest speakers covering topics such as Peer Support, Equality in the LGBTQ community, Rural Area Deficits, Situational Awareness, A Holistic Approach to Care, and Ending Mental Health Care Disparities. Our Block Grant subcommittee began our review process with completing a SWOT analysis.

Recruitment of members to properly represent various groups indicated by legislation was also a focus. The Council has also renewed efforts to partner with the National Alliance on Mental Illness for a few projects and is scheduled to be a vendor at the upcoming Behavioral Health Institute Conference in early August of 2023.

The council is federally mandated through PL 102-321 to review the state plans for the block grant and provide recommendations to the State on gaps in services, and to serve as an advocate for adults with SMI, children with SED and others who might be experiencing mental health needs.

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

DAABHS leadership and ABHPAC are interested any technical assistance regarding leadership strategies for this group.

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Footnotes:

NOT FINAL

Paula Stone, Director of the Office of Substance Abuse and Mental Health
Arkansas Division of Aging, Adult & Behavioral Health Services
P.O. Box 1437, slot W-241
Little Rock, AR 72203-1437

July 24, 2023

Dear Director Stone,

The AR Behavioral Health Planning and Advisory Council (ABHPAC), as mandated by SAMHSA & PL 102-321, has reviewed the FFY 2021 – FFY 2023 Block Grant document to prepare comments, concerns, and questions for the FFY 2024 – 2025 Block Grant.

We have a block grant committee of 12, comprised of ABHPAC members and outside consultants, attending meetings; with a core group of 5 members who attended all 7 meetings.

The group was excited to review Dr. Anita Everett's letter, dated June 1, 2023, addressed to State Planners & Planning Council Members. The list of 10 TA Needs is in-line with our discussions and on-going activities. The six best practices listed are also either on-going, or part of future plans. Pulling from Dr. Everett's letter below are what we've accomplished or what we are working on.

ABHPAC meets bi-monthly, but COVID pandemic caused these meetings to transition to virtual. We are now in the process of moving back to in-person meetings, with virtual access for those who need accommodation. Transitioning from COVID and virtual meetings will hopefully improve meaningful and active participation. The virtual meetings were well attended, and we are hopeful that these attendance rates will continue as we transition back to in-person meetings.

In years past, ABHPAC had six youth (members of Youth MOVE) that were very active. But, since System of Care (SOC) is no longer in Arkansas, Youth MOVE is not active any

longer and our youth dwindled down and then COVID pandemic happened. We are excited to announce we have two new youth members.

Historically, the Division of Aging Adult and Behavioral Health Services has provided the Council with all data requested. During the 2023 block grant review, the ABHPAC Liaison, DAABHS staff member, attended ALL block grant committee meetings, which were held for four hours for six Saturday's. Bridget Atkins, ABHPAC Liaison, has made sure all data needs were met and has been an indispensable asset in answering many questions at our meetings and finding answers for us for the questions she couldn't answer. Since the Block Grant Committee met on Saturdays, we have really appreciated her dedication to our process.

The Block Grant Committee held six meetings to review data, develop a Strength, Weakness, Opportunities and Threats (SWOT), and develop comments.

The block grant review process was previously interrupted due to COVID but seems to be moving forward very well this year.

Substance Use services have oversight by the Arkansas Drug Abuse Coordinating Council as mandated by state law. ABHPAC, who is federally mandated, is diligently working to include and involve individuals receiving services from the substance use system and substance use providers. The block grant committee included two individuals certified in providing Peer Recovery Services who are also supervisors of peers. Additionally, their lived experience is in Substance Use Disorder (SUD), and one member is certified in the substance use prevention area.

While the Block Grant Committee was occurring, other activities were put on hold. Those activities, including the next council retreat, will be held in the future. We hope that our state agency representatives and substance use members are active participants. We recently

developed a SWOT, and at the next retreat our intention is to turn it into ABHPAC's strategic plan.

The Council has had excellent communication with the DAABHS Liaison and DAABHS Block Grant contact, Rachael Veregge. However, communication with DAABHS leadership has been limited, and enhanced communication is desired. DAABHS is more than willing to help in providing documents that we need and has made sure we have what we need in a timely manner, as we ask for it.

Recruiting and retaining an active and diverse council is a constant struggle, but we are actively planning to help improve this process. Some of the strategies we are going to use include updating the brochure and by-laws. Delegating responsibilities and duties as outlined in the Public Law 102 –321, assets will be assessed and individuals with specific skills will be recruited to increase council capacity and diversity.

Advocacy is something that seems to have fallen away over the years, but the desire to be more active at the state and legislative level is present; this is a priority for the Council.

ABHPAC's yearly budget is \$42,000. We provide mileage reimbursements to those attending in-person meetings and training at the yearly retreat during the past year. ABHPAC has also provided several members the opportunity to attend out of state conferences.

We do not use any college data. The data about the Block Grant has always come from DAABHS and none of that is university-based. Moving forward, ABHPAC has three members that are employees of the Arkansas Center for Health Improvement, with University of Arkansas for Medical Sciences. The possibility of utilizing data collected by this entity will be explored.

The concerns of the Council are as follows:

- Partnerships with universities could improve the First Episode of Psychosis (FEP) awareness and services throughout the state. Early identification and structured treatment of FEP has strong support through research. Federal Mental Health Block Grant reviewers have noted significant deficiencies in Arkansas FEP services over the past few years. ABHPAC requests enhanced focus on FEP identification, outreach services, and accountability of fund expenditures.
- The Arkansas Olmstead plan was first written in 2003, and revised in 2008, but no additional data was added. There are thirty action steps, including one to maintain the Governor's Integrated Taskforce (GIST). ABHPAC believes this should be updated, and action steps completed.
- The Arkansas System of Care (SOC) for Children has shifted to the Provider-led Arkansas Shared Savings Entity (PASSE) system. Family Support Partners, Peer Recovery Specialist, and Youth Peers are now Medicaid billable services, which is a huge success for the state of Arkansas. There is still a lack of mental health providers willing to employ them, and those billable codes are not being used as often. The substance use providers have Peer Recovery Support Specialists (PRSS) and Peer Supervisors working with clients but are unable to bill Medicaid for services unless they chose to be Medicaid providers. Currently, they do not have youth peers (ages 18-24). Education about the substance use recovery career ladder and certification process should be provided to the mental health providers. Medicaid does cover outpatient and detox therapy services for SUD issues. This is for anyone with Medicaid, not just for those in a PASSE. These include individual treatment, group treatment, family treatment, multi-

family group, psychoeducation, and detox services. Many private/Medicaid expansion policies also cover SUD services, some even include residential SUD treatment.

- There is a serious issue with adequate staff for providers which could be improved upon with competitive pay. For instance, there was a bid for four mobile crisis units, but only two mental health providers applied. Due to the lack of competitive pay, they were unable to fill the positions.
- Although the System of Care grant is no longer implemented in our state, are the PASSE familiar with Wraparound, and have they been trained to provide this service to our children?
- ABHPAC believes having access to mental health data would improve our ability to evaluate the Arkansas service system.

ABHPAC looks forward to reviewing the annual report, and the data contained within.

Thank you to DAABHS for their continued support in the block grant review process. ABHPAC is proud of the relationship we have with DAABHS, and we are committed to working alongside them as we strive to improve the system services delivered to Arkansans.

Sincerely,

Angela Lassiter

ABHPAC Chair

Kellie VanCuren

ABHPAC Vice Chair

Joyce Soularie

ABHPAC Previous Chair



Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.
 State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Bridget Atkins	State Employees		P.O. Box 1437 Slot W241 Little Rock AR, 72203 PH: 501-686-9515	bridget.atkins@dhs.arkansas.gov
Alexanderia Barnes	Parents of children with SED		2409 Woodland Ave Springdale AR, 72762 PH: 479-530-9196	alexanderia96@gmail.com
Marty Bender	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1420 Azalea Drive Clarksville AR, 72830 PH: 479-977-2034	mbender6922@yahoo.com
Steven Blackwood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 23805 Little Rock AR, 72221 PH: 501-920-8110	arkansasplanning@gmail.com
Patricia Brannin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7 Lawrence Drive Little Rock AR, 72205 PH: 501-589-5633	Pat_Huckeby@yahoo.com
Keya Brooks	State Employees		3915 West 8th Street Little Rock AR, 72204 PH: 501-340-5608	kbrooks@pulaskicounty.net
Lester Cupp	Persons in recovery from or providing treatment for or advocating for SUD services		617 South Elm Street Beebe AR, 72012 PH: 479-719-5207	LICupp@uams.edu
Rodney Farley	State Employees		P.O. Box 1437 Slot S -380 Little Rock AR, 72203 PH: 501-682-1461	rodney.farley@dhs.arkansas.gov
Sheena Garrard	State Employees		P.O. Box 1437 Little Rock AR, 72203 PH: 870-352-7006	Sheena.Garrard2@dhs.arkansas.gov
Carla Harper	Parents of children with SED		7215 Azalea Drive Little Rock AR, 72209 PH: 501-563-9281	carla.harper31@yahoo.com

Stephanie Marie Harper	Providers		P.O. Box 187 Star City AR, 71667 PH: 870-370-1099	s.harper@deltacounseling.org
Frank Hellmer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		13200 Chenal Parkway Little Rock AR, 72211 PH: 501-831-9199	phrankdatank@gmail.com
Megan Larissa Holden	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1602 Juniper Circle Springdale AR, 72764 PH: 479-305-3537	holdenmeagan712@gmail.com
Gaye Jones-Washington	State Employees		1115 Ferguson Drive Benton AR, 72015 PH: 501-944-0188	gaye.jones-washington@arkansas.gov
Buster Lackey	Others (Advocates who are not State employees or providers)		4412 Dawson Drive Little Rock AR, 72216 PH: 501-626-5199	buster.lackey@namiarkansas.org
Angela Lassiter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		200 West K Avenue North Little Rock AR, 72116 PH: 501-428-2218	angie.lassiter@ymail.com
Christopher Lieux	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7800 Williamsburg Road Fort Smith AR, 72903 PH: 479-420-0528	clieux@hotmail.com
Margaret Linker	State Employees		1302 Pike Avenue North Little Rock AR, 72114 PH: 501-683-2282	margaret.linker@arkansas.gov
Stephanie Martin	Providers		56 Laval Circle Little Rock AR, 72223 PH: 501-680-5330	stephmartin1@yahoo.com
Scott Mashburn	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		935 North Highland Avenue Fayetteville AR, 72701 PH: 479-601-6014	s.mashburn@scbglobal.net
Beth Mathys	State Employees		613 West Sevier Street Benton AR, 72015 PH: 501-682-5727	beth.mathys@ade.arkansas.gov
Rosemarie Moyster	Parents of children with SED		10712 Mt Pleasant Cutoff Cabot AR, 72023 PH: 501-414-9231	rosemariemoyster@yahoo.com
Monty Payne	Persons in recovery from or providing treatment for or advocating for SUD services		901 South Maple Little Rock AR, 72201 PH: 501-744-1131	monte@wolfstreet.org
Dena Perry	State Employees		P.O. Box 1437 Little Rock AR, 72203 PH: 501-320-6006	dena.perry@dhs.arkansas.gov
Stephanie Pifer	Individuals in Recovery (to include adults with SMI who are receiving, or		224 East Denning Altus AR, 72821	stephpifer@yahoo.com

	have received, mental health services)		PH: 479-213-3241	
Abram Izaiah Portillo	Youth/adolescent representative (or member from an organization serving young people)		P.O. Box 650 Springdale AR, 72765 PH: 479-318-5850	portilloiziah1@gmail.com
Michelle Siemiller	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		417 Sorrell Street Harrison AR, 72601 PH: 870-754-0339	michellesiemiller@gmail.com
Joyce Soularie	Family Members of Individuals in Recovery (to include family members of adults with SMI)		40 Collines Road Jacksonville AR, 72076 PH: 501-773-0040	jlsoularie2017@outlook.com
Rebecca Sparks	Providers		8901 S. 30th Street Fort Smith AR, 72908 PH: 479-719-4505	bbass1772@gmail.com
Andrew Mitchell Stout	Youth/adolescent representative (or member from an organization serving young people)		1901 West Shady Grove Road Springdale AR, 72764 PH: 479-408-3175	andrewstout2014@gmail.com
Sonja Thomas	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3915 West 8th Street Little Rock AR, 72204 PH: 501-240-6551	sonjaythomas@aol.com
Kellie VanCuren	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 650 Springdale AR, 72765 PH: 479-530-9254	kellievancuren@gmail.com
Daronda Elaine Williams	Family Members of Individuals in Recovery (to include family members of adults with SMI)		425 East Walnut Street Prescott AR, 71857 PH: 870-299-3325	ewrecyc@outlook.com
Janette Williams-Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		140 Staton Road Cabot AR, 72023 PH: 501-920-6958	janette.williamssmith@yahoo.com
Patti Lyn Yager	Parents of children with SED		45 Compass Point Sherwood AR, 72120 PH: 501-516-3578	patti@wolfstreet.org

*Council members should be listed only once by type of membership and Agency/organization represented.

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Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	5	
Parents of children with SED	4	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	1	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	20	64.52%
State Employees	8	
Providers	3	
Vacancies	0	
Total State Employees & Providers	11	35.48%
Individuals/Family Members from Diverse Racial and Ethnic Populations	20	
Individuals/Family Members from LGBTQI+ Populations	2	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	2	
Total Membership (Should count all members of the council)	31	

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22. 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? ☐ Yes ☒ No

b) Posting of the plan on the web for public comment? ☒ Yes ☐ No

If yes, provide URL:

<https://humanservices.arkansas.gov/divisions-shared-services/aging-adult-behavioral-health-services/reports-publications/>

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

No

c) Other (e.g. public service announcements, print media) ☐ Yes ☒ No

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

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23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>.

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf> ,

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf> ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
 - Include proposed protocols, timeline for implementation, and overall budget
 - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

End Notes

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

² Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵ ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

NOT FINAL

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

NOT FINAL