ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Behavioral Health Services

305 South Palm · Little Rock, AR 72205
501-686-9164 · Fax: 501-686-9182 · TDD: 501-686-9176

TO: Interested Parties

FROM: Rachael Veregge, Grants Administrator Coordinator

DATE: July 30, 2019

RE: Public Comment Period

Attached is the Federal Fiscal Year 2020-2021 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 July 30, 2019-August 28, 2019.

Copies of the application can be found on our website:
https://humanservices.arkansas.gov/about-dhs/daabhs/publications-documents

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

Arkansas

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/29/2019 3.14.23 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 2020

End Year 2021

State SAPT DUNS Number

Number 119841336

Expiration Date

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

Agency Name Arkansas Department of Human Services

Organizational Unit Division of 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 Kirk

Last Name Lane

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

Mailing Address Post Office Box 1437, Slot W-241

City Little Rock

Zip Code 72203-1437

Telephone 501-683-0380

Fax 501-686-9182

Email Address kirk.lane@dhs.arkansas.gov

State CMHS DUNS Number

Number 119841336

Expiration Date

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 Helath Services

Mailing Address	Post Office 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	Rachael
Last Name	Veregge
Telephone	501-320-6431
Fax	501-686-9182
Email Address	rachael.veregge@dhs.arkansas.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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 nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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 of 1984.
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
   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 Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
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
   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 Designee[1]: Jay Hill

Title: Division Director

Date Signed: July 1, 2019

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
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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;
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   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
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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.)
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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.
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 Certifications summarized above.

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

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

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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Jay Hill

Signature of CEO or Designee[1]: Jay Hill

Title: Division Director

Date Signed: July 1, 2019
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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: 04/19/2019 Expires: 04/30/2022

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, 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. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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 (DAABH) 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). DAABH is 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 through eight (8) contracts with substance abuse treatment providers and sub-contracts with thirteen (13) prevention providers covering the state. The DAABH fulfills its responsibility for the provision of public mental health services by operating a 222-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). Each 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 (now Division Aging, Adult and Behavioral Health Services or DAABHS). In addition, Act 433 of 1971 authorized the Division to distribute funds appropriated by the Legislature to CMHCs or clinics within the State. In the 1970s a primary role of CMHCs was to help clients transition from the Arkansas State Hospital (ASH) to the community. At that time, services were primarily clinic based.

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, crises 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.

As Medicaid coverage has changed over the years, including the addition of the private option (Arkansas Works program), and as the population with no payor source for mental health services has changed, the behavioral health service array has also changed. Until recently, behavioral health services in Arkansas were provided by thirteen (13) CMHCs and over fifty (50) certified Medicaid mental and behavioral health providers serving Arkansas Medicaid members. In 2017 special language was removed from statues identifying specific agencies by name as state funded behavioral health providers. In 2019 the CMHC providers were procured by a competitive bid process. Since that time, DHS has continued to undergo a behavioral health transformation, which includes the implementation of the Provider-led Arkansas Shared Savings Entity (PASSE) model. 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. The evolution of the continuum of care does not diminish the work of the CMHC providers which are the focus of the mental health block grant funds. Further, the CMHC 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 without a payor source for acute care hospitalization when these services are medically necessary. Further, the CMHC providers will utilize mobile crisis screenings as assessments when individuals present in crises 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, public information campaign to educate the local community with information about available services, hours or 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) 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 population 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 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, the Department of Human Services (DHS) has 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 is 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 Provider Led Arkansas Shared Savings Entity (PASSE), the bulk of services for children and adults with SED/SMI who have Medicaid are now managed by these organization. Those without Medicaid are served through state contracts. 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.

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 189 treatment providers, with eight (8) of those funded by DAABHS to provide substance use disorder prevention, treatment, and recovery services throughout the State. All contracted substance abuse providers in Arkansas are nationally accredited. As required by the licensure standards and is 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 setting 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 Panning. The children in care with their mothers are assessed and receive comprehensive physical and mental health services as determined by the assessment.

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

There are ten (10) juvenile drug courts (JDC) across the state. Drug courts refer clients to local substance abuse providers to provide outpatient services and drug screens. Funded providers work with the JDC to provide substance abuse treatment, which includes outpatient and residential services.

The Arkansas Prevention System currently consists of thirteen (13) Regional Prevention Providers (RPP). The system serves as a statewide infrastructure for providing resource support necessary to promote capacity development at the local level. The RPP represents 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 M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

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

The US Census Bureau reports that as of July 1, 2018 the population of Arkansas is estimated to be 3,013,825. Arkansas is predominately a rural state with 39 of 75 counties have less than 20,000 residents. Children, those 17 years of age and younger, comprise 29.9% of the state's population while the those 65 and older, comprise 16.6% of the population. The male to female ratio is fairly even in Arkansas with females having a slightly higher ratio at 50.9%. The most predominant race and ethnic origins in the state are individuals who are white and non-Hispanic or Latino (72.5%). The largest minority group are individuals who are African American (15.7%). Arkansans aged 25 and older who were high school graduate or higher represented 85.6% of the population and 22.0% had received a bachelor's degree or higher. The median household income was $42,336 from 2012-2016. This is the second lowest in the nation. Twelve Arkansas counties had a median household greater than $42,336. The percentage of Arkansans living below the poverty level in 2016 was 18.8%, compared to 15.1% for the United States. Arkansas ranks 48 in the United State in overall health. 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 2014, four of the top five causes of death in Arkansas and seven of the top ten were related to chronic diseases, poor mental health and substance abuse. All the top five causes of death can be exacerbated by alcohol, tobacco, and other substances.

The 2018 Arkansas State of Well-being, a report on substance abuse in Arkansas prepared by the Arkansas Foundation for Medical Care (AFMC) for the Arkansas Department of Human Services, Division of Aging, Adult and Behavioral Health Services provides a demographic breakdown of population, education, economy and health within the state. This report also highlights the past successes and areas of focus for the future.

<u>Substance Use Successes in Arkansas:</u>

- Alcohol
    - Fewer high school students are drinking, including binge drinking
    - More youth perceive drinking 1-2 alcoholic beverages day as a great risk
    - Fewer Arkansas adults drink compared with the national average
    - Fewer women are drinking during pregnancy
- Tobacco
    - Fewer students are smoking; smoking has been decreasing at each grade level; a decline of 15.6%
    - Fewer adults are smoking, from 24.7% in 2014 to 23.6% in 2016.
    - Fewer women are using tobacco during pregnancy. The rates of live births to women who used tobacco during pregnancy decreased from 14.9%.
- Marijuana
    - Fewer high school students are using marijuana. A steady decrease over the last six years. Fewer high school students are using marijuana heavily. From 5.1% in 2011 to 3.5% in 2016.
    - Fewer adults currently use marijuana (7.3%) compared to the national average (8.5%).
- Opioids
    - Non-medical use of pain relivers among adolescents 12-17 has slowly been declining over the last 5 years.
    - Lifetime and current use of heroin among youth has remained stable at rates of less than 1%
    - Since 2012, the drug poisoning death rate in Arkansas has remained slightly lower than the national rate.
    - Arkansas collected a record setting 14 tons of old or expired prescription drugs at the National Drug Table Back even in October 2017.

- Stimulants and Other Drugs
    - Lifetime usage of cocaine among adolescents is lower than the national average.
    - Fewer students are using inhalants
    - Fewer students are using prescriptions drugs

Substance Use Areas for Focus in Arkansas:

- Alcohol
    - Since 2006 there has been on drastic change or decrease in the percentage of adults who drank heavily.
    - There was a slight increase in the percentage of adults who reported binge drinking.
    - Continued emphasis on education of the effects of alcohol during pregnancy to support awareness of fetal alcohol spectrum disorders (FASD) and preventable outcomes.
- Tobacco
    - A larger portion of Arkansas youth report current tobacco use than nationally.
    - More Arkansans suffer from cardiovascular and lung disease than the national average.
    - More Arkansas women smoke during pregnancy than the national average.
- Marijuana
    - Out of ten high school seniors, three had tried marijuana, two currently use marijuana and 1 heavily uses marijuana
    - Between 2013-2105, the percentage of adults who use marijuana increased from 6.8% in 2013-2014 to 7.3% in 2014-2015.
    - More than half (53.6%) of drug related arrests were attributed to marijuana or hashish.
    - Continuing education on the effects of marijuana during pregnancy can help support preventable outcomes like development deficits in children.
- Opioids
    - Non-medical use of prescription pain relivers among adolescents 12-17 in Arkansas is higher than the national average.
    - More high school seniors in Arkansas use heroin when compared to the national average.
    - Compared to the US, Arkansas has a higher annual rate of opioid pain reliver prescriptions dispensed by pharmacies.
    - Since 2000, there has been more than a tenfold rise in the numbers of neonatal abstinence syndrome (NAS) cases in Arkansas. NAS is a condition where newborns experience withdrawal symptoms after exposure in the womb.
- Stimulants and Other Drugs
    - More Arkansas students are current inhalant users than the national average
    - No significant change has been observed in the use of methamphetamine since 2011 among high school students in Arkansas
    - More young adults (those 18-25) are using illicit drugs than those aged 26 and older.

Substance Abuse Treatment Successes in Arkansas

- A large percentage of those registering for the Tobacco Quitline heard about the program through mass media. Since 2013, a 48.3% increase in respondents who indicated they heard about the Tobacco Quitline through commercials on TV.
- In 2016, a lower percentage (4.7%) of Arkansans needed but did not receive alcohol treatment compared to the US (5.8%).

Substance Abuse Treatment Areas for Focus in Arkansas

- Since 2013, there has been a decrease in the number of respondents who indicated that a health professional advised them to quit tobacco.
- Young adults (18-25 years of age), represent the age group that had the highest estimated percentage of needing but not receiving treatment for illicit drug and alcohol abuse.
- More public awareness is needed on limiting minor's access to tobacco
- Increase participation in the AR Take Back events
- Increase public education on drugged driving
- Prevent Adverse Childhood Experiences (ACEs) and build resilience
- Targeting activities to at-risk youth and adults will strengthen prevention programs throughout the state.

The Arkansas State Epidemiological Outcome Workgroup (AR-SEOW) has fulfilled its purpose of providing a comprehensive picture of substance abuse challenges in Arkansas. As a Managing, analytic, and advisory agent of AR-SEOW, the Arkansas Foundation for Medical Care (AFMC) has identified data sources and has collected and integrated data on substance abuse. In turn, analytic staff have developed an information infrastructure that facilitates the exchange of knowledge, advances policy making collaboration into continuous assessment, planning and monitoring of substance abuse prevention practices. The information infrastructure is based on a web portal, www.preventionworksar.com that houses tables, figures, interactive maps, an annual statewide and county epidemiological profile. Several reports are housed in this web portal, including the Statewide Epidemiological Profile of Substance Use, the Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas, as well as the Arkansas Prevention Needs Assessment Survey.

AFMC also prepares the Risk Factor's 2018: Adolescent Drug and Alcohol Abuse in Arkansas Report for DAABHS. This report creates both a statewide and individual county profile across several domains from 2013 through 2017. Some data are reported by fiscal year, some are reported by calendar year, and others are reported on a specific census date or five-year estimates. All rates are per 1,000 unless otherwise indicated. The Risk Factors report is designed to be a tool for Arkansas' 13 prevention providers and other prevention leaders to increase the effectiveness of regional, county and community efforts to prevent the abuse of alcohol, tobacco and other drugs. Before applying the information presented in this report at the county level, it is important to have knowledge about local conditions, risks and resources as well as local prevention services already in place. Risk factors exist in different environments (i.e. community, family, school and peer/individual) and are grouped into domains accordingly.

Key Findings of the AR-SEOW 2019 Annual Report

Substance Use

- Arkansas has a higher rate of youth and adults using tobacco products compared with the national rate
- Twelfth-graders in Arkansas are more likely to have tried electronic vapor products in 2017 compared with other grades within the state and nationally
- Eighth-, 10th- and 12th-graders in Arkansas are more likely to use cigarettes and smokeless tobacco than those across the United States
- The rate of Arkansas mothers who smoke has remained stable over the past few years and is higher than the national rate
- In youth, the rate of current alcohol use and the rate of binge drinking has been declining since 2014
- All students surveyed in Arkansas are more likely than students across the nation to have had "10 or more drinks"

- Since 2014, there has been an increase in the number of adults who currently use or binge drink alcohol
- Rates of current marijuana use declined slightly over the last four years
- Since 2008–2009, the number of adults who use marijuana has increased both nationally and statewide
- Fewer Arkansas adults have used marijuana in the past year compared with the national average
- Compared with the national rate, more Arkansas students have misused prescription drugs in 2017
- Rates of prescription drug use among students have remained steady since 2014
- Arkansas had the third highest number of prescriptions written for opioids in 2015; however, a lower rate of opioid related overdose deaths is noted
- Rates of current and lifetime drug abuse among Arkansas youth remained steady over the last four years
- The rate of cocaine use is higher among Arkansans ages 18–25 years but lower than the national average for the same age range
- Use of methamphetamine is higher among Arkansas adults as compared with the national rate

Consequences

- The use of tobacco in pregnant women decreased between 2014 and 2017
- The use of alcohol in pregnant women remained steady between 2012 and 2015
- The number of babies born in Arkansas with neonatal abstinence syndrome has increased nearly 3 ½ times between 2008 and 2015, with the largest increase occurring after 2010
- The rates of people in Arkansas being told that they have heart disease, COPD or have had a stroke have remained steady since 2014
- The death rate of lung cancer is decreasing in Arkansas
- The death rate of alcoholic liver disease is increasing in Arkansas
- Slightly more than one-fifth of students reporting that they made mostly D's or F's also reported using any drugs
- Suicide rates in Arkansas have been increasing over the last several years of reporting
- The rates of high school students in Arkansas attempting suicide or being injured in a suicide attempt is increasing and remains higher than the national average

Contributing Factors

- Compared with the United States, Arkansas students are less likely to perceive a "great risk" for smoking or drinking one or two drinks every day
- The perception of risk for smoking is steady for eighth-, 10th- and 12th-graders in Arkansas
- The percentage of adults perceiving risk in smoking, drinking and using marijuana has decreased over the last few measurement periods, particularly regarding marijuana use
- Youth's perception of the risk of trying marijuana has declined over the past few years
- Rates of Arkansas youth feeling sad or hopeless remained steady from 2009 to 2015 but increased in 2016
- More Arkansas adults are depressed than the national average
- Both nationally and statewide, 12- to 17-year-old individuals had the highest rate of major depressive episodes in 2017, followed by those in the age range of 18–25
- Most high school students who are religious do not participate in substance misuse
- Since 2013, students reported a decrease in the rate of parents who have favorable attitudes towards drug use
- The rate of students with peers who have attitudes favorable to drug use has declined over the last four years
- Bullying in Arkansas is occurring at higher rates compared with U.S. rates
- The percentage of students reporting either being bullied at school or electronically in 2017 is higher than in 2011

- The prevalence of transitions and mobility has declined since 2016
- The rate of homeless students decreased slightly from 2013 to 2015 but increased between 2015 and 2017
- Tobacco sales to minors in Arkansas increased between 2013 and 2014 but has since declined
- The unemployment rate and the percentage of population below the poverty level in Arkansas remain higher compared with the U.S. rates

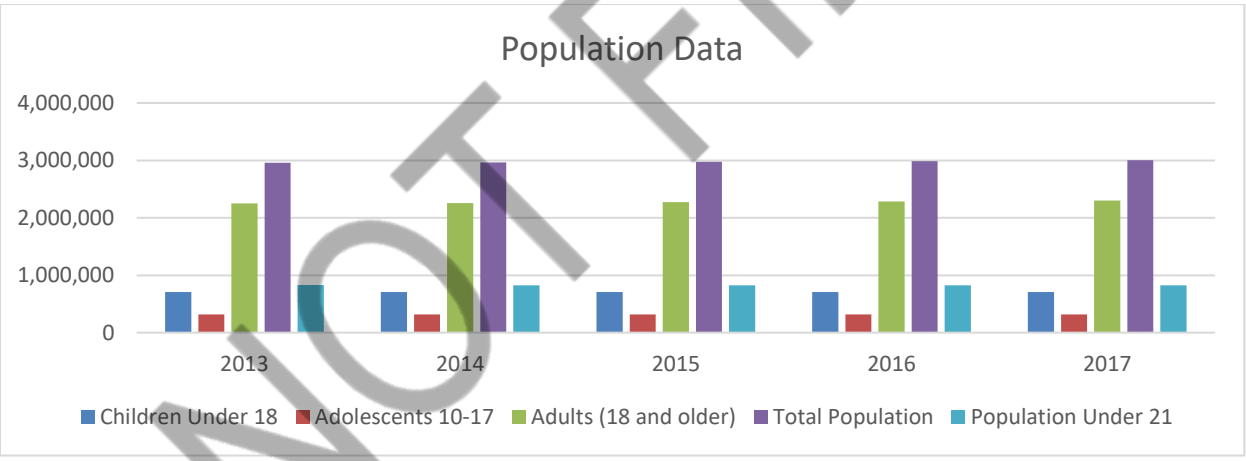
Treatment Admissions for Substance Abuse

- The rate of juveniles, pregnant women and adults in alcohol or drug treatment increased slightly between 2013 and 2017
- Arkansas has a lower percent of people needing but not receiving treatment compared with the U.S. rate

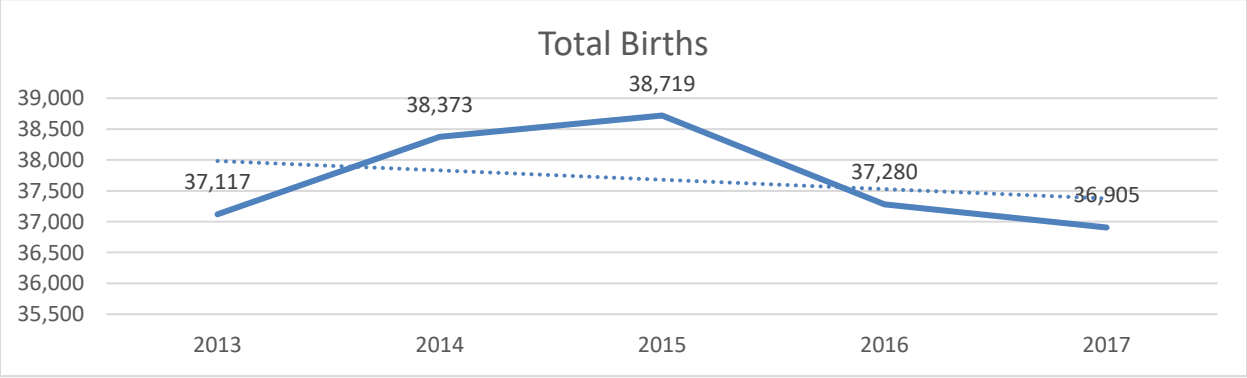
The Risk Factor's 2018: Adolescent Drug and Alcohol Abuse in Arkansas Report

The most recent Risk Factors report provides reliable behavioral health data and information for community and government leaders in Arkansas from 2013-2017. The organization and content of the Risk Factors report identifies common risk factors of socioeconomic determinants for behavioral health in Arkansas. Data from this report is used as a tool for targeting where and how to use resources for behavioral health services in Arkansas. The following tables highlight some of the socioeconomic factors presented in this report.

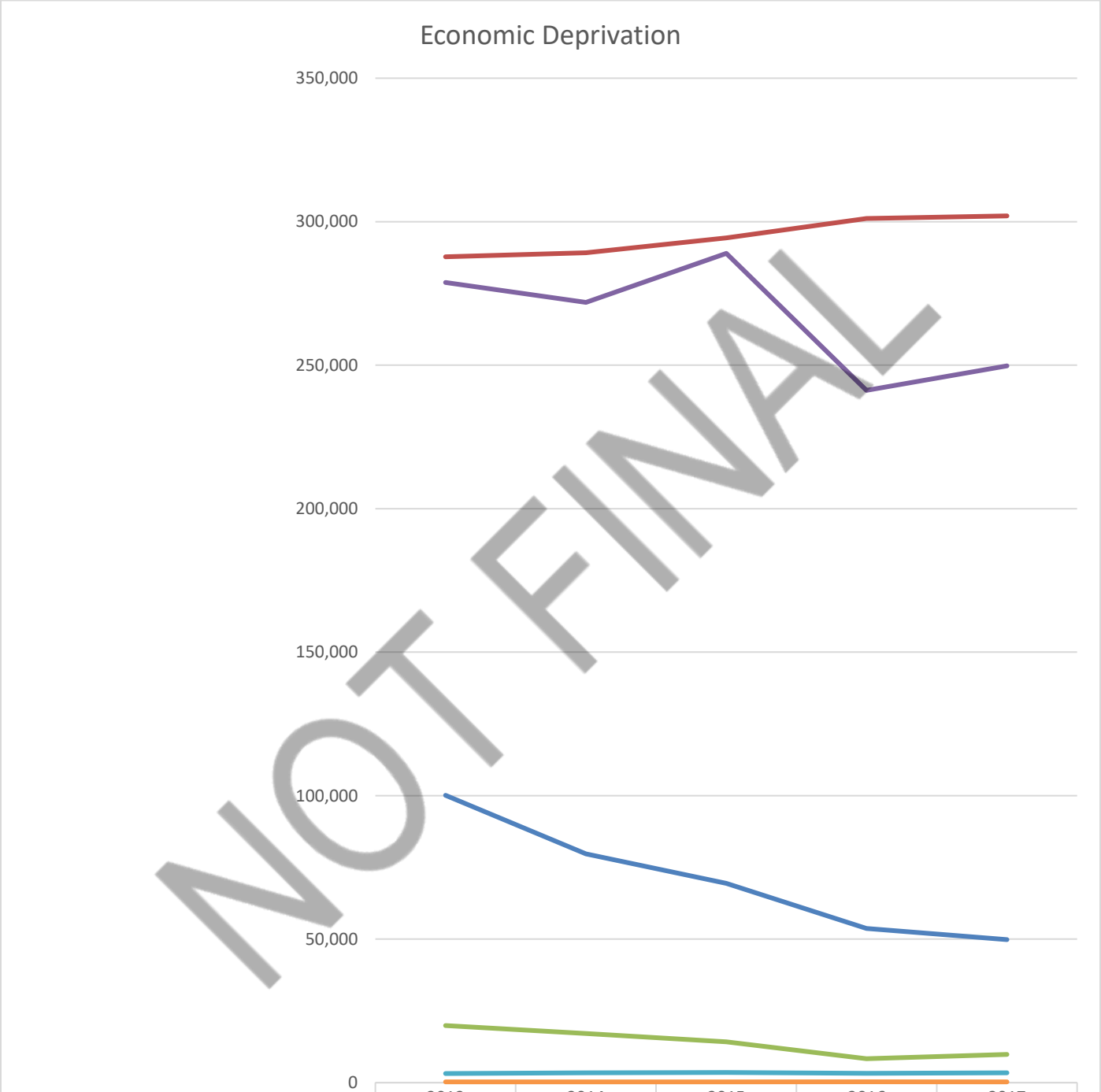
This population data table compares the breakdown by age group from 2013-2017.



In Arkansas, the trendline shows a decrease in the number of births since the boom in 2014-2015.

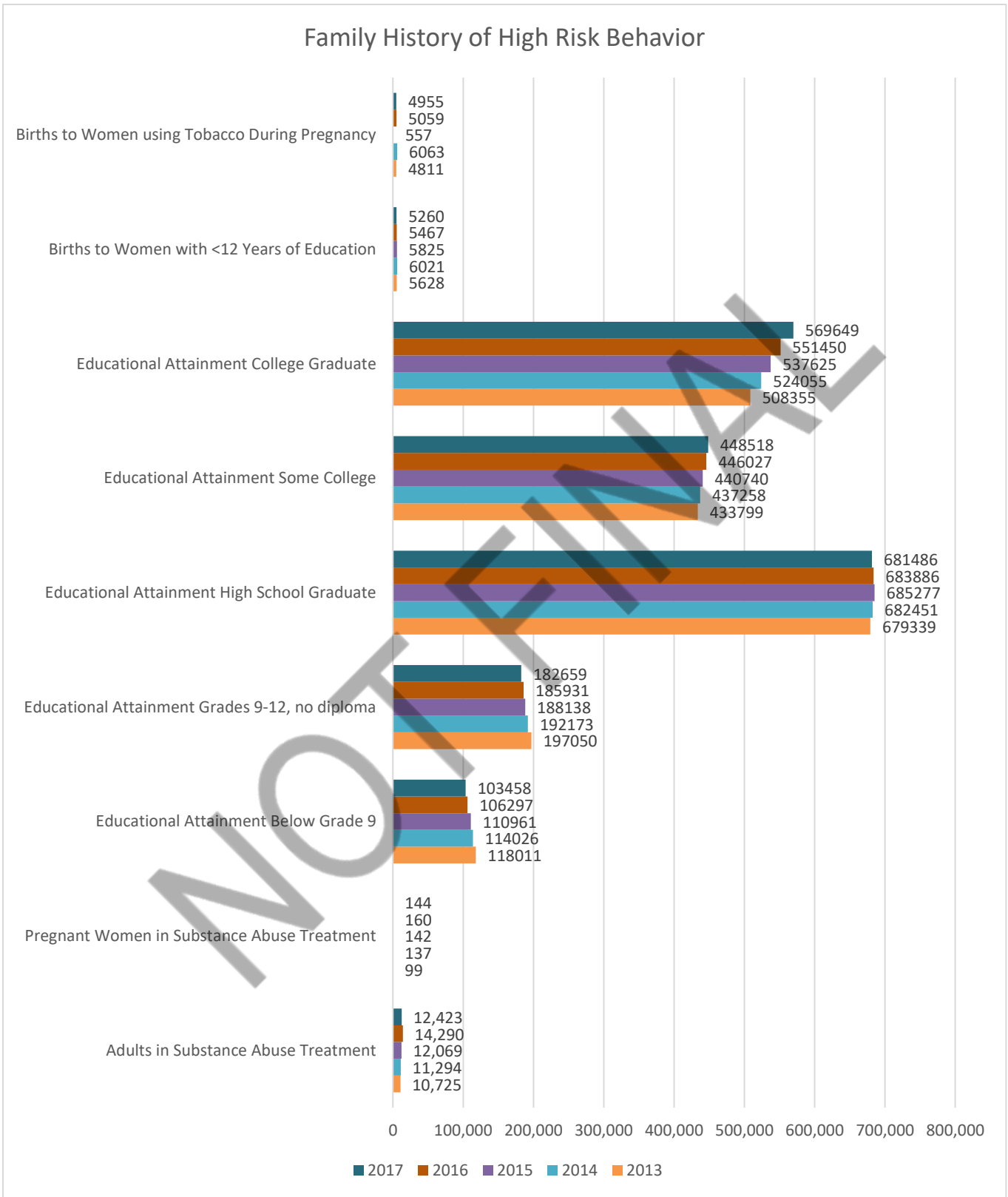


This chart identifies some of the economic factors that increase the risk of adolescent drug and alcohol abuse in Arkansas from 2013-2017.

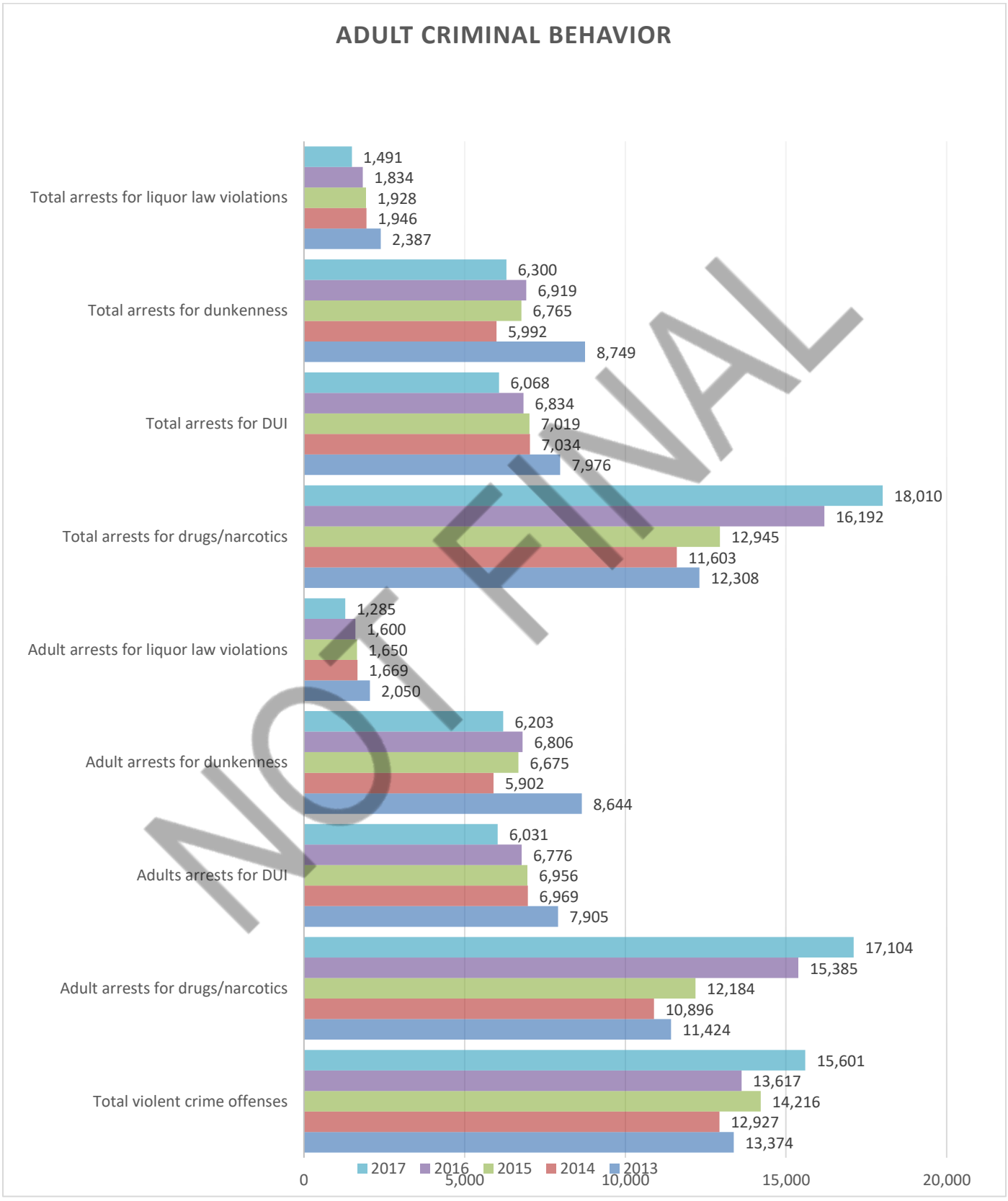


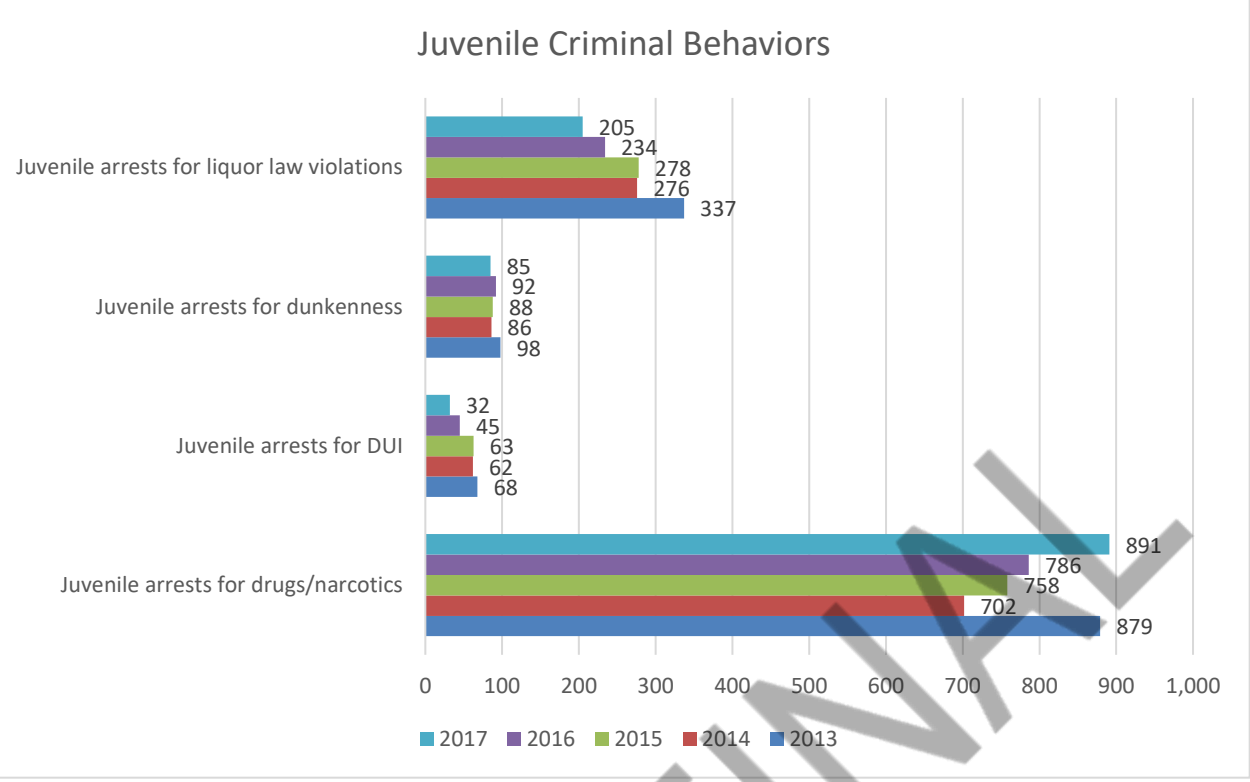
	2013	2014	2015	2016	2017
Unemployment	100,123	79,730	69,486	53,698	49,835
Children Eligible for Rree or Reduced Price Lunches	287,775	289,215	294,339	301,073	302,013
Children Receiving TEA	19,891	17,144	14,238	8,342	9,878
Children Receiving Food Stamps	278,781	271,847	288,963	241,227	249,724
Low Birth Weights	3,179	3,420	3,541	3,216	3,392
Infant Mortality	271	278	280	301	277

This chart outlines the indicators of high-risk behaviors that can be attributed to family history from 2013-2017.



The following two tables document various crime statistics in Arkansas related to alcohol and drugs from 2013-2017 in both adults and in juveniles.





While many gaps have services are now being addressed through the behavioral health transformation, DAABHS has identified the following unmet service needs and/or gaps in the behavioral health system:

- Transitional services for youth entering adulthood
- Focus on special populations such as LGBTQ, aging and the military
- Statewide crisis services
- Access to services in rural areas
- Behavioral health services within the criminal justice system for adults
- Incorporating multiple data systems that do not interface with one another and cross multiple Divisions within DHS.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

etc.).

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

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness

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

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

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

   With the behavioral health Medicaid transformation, effective July 1, 2017, the state Medicaid Management Information System collects claims data on all mental health and substance use treatment services provided to behavioral health beneficiaries. This system is housed within the Division of Medical Services (DMS), the State Medicaid Agency.

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

   - The Alcohol Drug Management Information System (ADMIS) is a web enabled database system maintained by the Department of Human Services (DHS) Office of Systems Technology and operated by staff of DBHS. The system is utilized to collect client level data from admission to discharge using the National Outcome Measures (NOMS) and payment by fee-for-service, and budget based participants. The ADMIS data is used to report to SAMHSA's substance abuse treatment admission data set called Treatment Episode Data Set (TEDS).
   - The DAABHS Service Process Quality Management Data Mart (SPQM) collects client level data and provides reports based on various aspects (consumer satisfaction survey reporting, acute care reporting, for example) of the Community Mental Health Centers (CMHCs) and the Arkansas State Hospital (ASH). The primary purposes of the SPQM Data Mart is to 1) assist with required Federal Reporting to include Client Level Data to support National Outcomes Measures; 2) assist with Required State Level Reporting to support reports to the state legislature; and 3) produce Individual Provider Level Reporting to support quality initiatives and benchmarking across the CMHCs. The SPQM data mart captures mental health service data across the State's 17 service provider entities, which include 15 certified Community Mental Health Centers (CMHCs), certified 2 private, nonprofit specialty Community Mental Health Clinics, 1 Affiliate, and the Arkansas State Hospital. Raw transaction data is transformed to produce specialty reporting cubes as available for ad hoc reporting. The data mart features advanced security protocols to include next generation

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

- The Arkansas Department of Human Services (DHS) data warehouse is a centralized data repository consisting of disparate contributing source systems from both within and external to DHS. The data warehouse provides access to cross divisional and agency information for analysis and decision support. DHS data warehouse provides both historical and current views of contributing data. Business processes are denoted for grouping similar actions across DHS in an effort for data cleansing, consistency, and presentation. Security for access to the contained data governed by the contributing source data owner. DBHS is one of the contributors of data to the system and uses the capabilities of the data warehouse to complete state level data and policy analysis.

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

- The Web Infrastructure for Treatment Services (WITS) is a data repository that helps maintain plans, goals, objectives and activities related to substance abuse prevention and early intervention services. The system has a report system that is capable of tracking NOMS and block grant related data.
- The Arkansas Prevention Needs Assessment Student Survey (APNA) is an annual survey of grades 6, 8, 10 and 12 school students in Arkansas. The majority of school districts participate in this needs assessment survey. The needs assessment survey instrument consists of more than 120 questions measuring current students' use of alcohol, tobacco, and other drugs, anti-social behaviors and the prevalence of 22 risk and 4 protective factors. Results are reported in an aggregate form at various levels including state, county, school districts and schools. This survey has been conducted since 2002. In 2016, 184 out of 238 public school districts completed the APNA Survey.
- The Mental Health Statistics Improvement Project (MHSIP) is an adult and child/adolescent consumer satisfaction survey conducted on a sample of more than 3,000 adult and child/adolescents receiving services from the 13 Community Mental Health Centers. The survey covers the following domains: overall satisfaction, access to services, treatment outcomes, consumer participation in treatment planning, quality and appropriateness of services, cultural sensitivity of staff, social connectedness, and improved functioning. In 2016, the rate of return was 25% for Child Mental Health Surveys and 28% for Adult Mental Health Surveys.

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

DAABHS has multiple data collection systems (see question #1) which are all stand-alone systems. The primary system that collects data on Substance Abuse treatment is the Alcohol

Drug Management Information System (ADMIS). The primary system that collects data on Mental Health services is Service Process Quality Management Data Mart (SPQM). A separate state Medicaid administrative and billing data collects claims related data for substance abuse and/or mental health services. While these systems do not share data, data elements may be cross referenced and analyzed to inform policy decisions.

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

   DAABHS's primary Substance Use Disorder treatment data system (ADMIS) and Mental Health services data system (SPQM) collect and report data at the client level (e.g. number of clients served).

   In the SPQM system, Individual Client Identifiers originally sourced as SSN's are eliminated from the CLD data reporting data mart and replaced with new numbers derived from a separate key system. Source identifiers in transactions are randomly assigned new serials within the key system and those serials are reported for CLD.

   In the ADMIS system, the Client ID is used as the main identifier and users refrain from using the SSN as the identifier. The ADMIS system also uses Least Privilege to limit authorizations. Providers cannot view any client information or treatment for clients receiving services from other providers.

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

   n/a

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

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Substance Abuse Prevention

Priority Type: SAP

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

Goal of the priority area:

Support implementation of prevention programs and strategies that increase the perception of risk associated with the use of alcohol, tobacco, marijuana and prescription drugs by youth in Arkansas.

Objective:

The overall goal 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 road map on enhancing prevention infrastructure at local and state levels.

Strategies to attain the objective:

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 risks using evidence based substance abuse prevention curriculum, peer leadership programs, and parenting/family management classes.
3. Provide prevention training to physical education (PE), counselors and health teachers who are primarily responsible for substance abuse prevention in classrooms.
4. Partner with community coalitions, policy makers, and other stakeholders to change community norms towards alcohol usage.
5. Partner with law enforcement and local policy makers to enforce social host law to reduce hosting underage drinking parties in their communities
6. 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.
7. Partner with Criminal Justice Institute to provide training on Naloxone to all first responders, school resource officers, and other community stakeholders.
8. Continue efforts to promote drug take back days and medicine drop boxes to reduce access to prescription drugs.
9. Encourage enforcement of prescription drug monitoring programs to reduce the over prescribing of medication and doctor shopping.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Lower the reported 30 day alcohol usage rate among middle and high school students

Baseline Measurement: SFY 2017 = 11%

First-year target/outcome measurement: SFY 2019 = 10%

Second-year target/outcome measurement: SFY 2021 = 9%

Data Source:

Arkansas Prevention Needs Assessment (APNA) Survey

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

The most recent questionnaire was then modified in 2002 to create the APNA survey. Modifications, including the addition of specific questions about substance use, tobacco availability, and tobacco use, allowed the APNA survey to more accurately reflect the Arkansas substance use and problem behavior climate. Throughout the years, trending substances have been added to the questionnaire (e.g.,over-the-counter drugs, e-cigarettes, bath salts, prescription drugs, etc). However, the measurement of risk and protective factors, along with the prevalence of alcohol, tobacco, and other drug use and antisocial behaviors, has always maintained core elements to allow for year-to-year comparisons.

Data issues/caveats that affect outcome measures::

Print surveys returned are first checked to eliminate blank, damaged or unusable forms or, forms reporting students being in grades 7, 9, or 11. Staff scan the forms and prepare the data for analysis. For online surveys, data is collected on load-balanced virtual servers and combined with data from paper surveys before analysis. To ensure anonymity and as part of the dataset development, the scoring system automatically suppresses the calculation of results when any subgroup of data contains responses from fewer than 10 students. Data from these small subgroups are, however, aggregated into reports for larger geographic areas (i.e., district, regional, and state reports).

Beyond the preliminary checks for valid surveys, several other checks are built into the data screening process to minimize the inclusion of students who were not truthful in their responses. Invalid individual student surveys were identified using five specific criteria: 1) the student indicated that he or she was "Not Honest at All" in completing the survey; 2) the student reported an impossibly high frequency of multiple drug use; 3) the student indicated that he or she had used the non-existent drug Pegaramide; 4) there was a large age differential between grade level and the student's age as reported by the student; and 5) the student report contained logical inconsistencies between past 30-day use and lifetime use rates.

Indicator #: 2

Indicator: Increase the reported perception of risk for marijuana use among Arkansas youth

Baseline Measurement: SFY 2017 = 41%

First-year target/outcome measurement: SFY 2019 = 43%

Second-year target/outcome measurement: SFY 20201 = 45%

Data Source:

Arkansas Prevention Needs Assessment (APNA) Survey

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

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Data issues/caveats that affect outcome measures::

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student indicated that he or she was "Not Honest at All" in completing the survey; 2) the student reported an impossibly high frequency of multiple drug use; 3) the student indicated that he or she had used the non-existent drug Pegaramide; 4) there was a large age differential between grade level and the student's age as reported by the student; and 5) the student report contained logical inconsistencies between past 30-day use and lifetime use rates.

Indicator #: 3

Indicator: Lower the reported 30 day rate for misuse of prescription drugs

Baseline Measurement: SFY 2017 = 3%

First-year target/outcome measurement: SFY 2019 = 2.9%

Second-year target/outcome measurement: SFY 2021 = 2.75

Data Source:

Arkansas Prevention Needs Assessment (APNA) survey.

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

The most recent questionnaire was then modified in 2002 to create the APNA survey. Modifications, including the addition of specific questions about substance use, tobacco availability, and tobacco use, allowed the APNA survey to more accurately reflect the Arkansas substance use and problem behavior climate. Throughout the years, trending substances have been added to the questionnaire (e.g., over-the-counter drugs, e-cigarettes, bath salts, prescription drugs, etc). However, the measurement of risk and protective factors, along with the prevalence of alcohol, tobacco, and other drug use and antisocial behaviors, has always maintained core elements to allow for year-to-year comparisons

Data issues/caveats that affect outcome measures::

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Indicator #: 4

Indicator: Lower the reported 30 day cigarette usage among middle and high school students

Baseline Measurement: SFY 2017 = 5.4%

First-year target/outcome measurement: SFY2019 = 5%

Second-year target/outcome measurement: SFY 2021 = 4.6%

Data Source:

Arkansas Prevention Needs Assessment (APNA) Survey

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

The most recent questionnaire was then modified in 2002 to create the APNA survey. Modifications, including the addition of specific questions about substance use, tobacco availability, and tobacco use, allowed the APNA survey to more accurately reflect the Arkansas substance use and problem behavior climate. Throughout the years, trending substances have been added to the questionnaire (e.g., over-the-counter drugs, e-cigarettes, bath salts, prescription drugs, etc). However, the measurement of risk and protective factors, along with the prevalence of alcohol, tobacco, and other drug use and antisocial behaviors, has always maintained core elements to allow for year-to-year comparisons

Data issues/caveats that affect outcome measures::

Print surveys returned are first checked to eliminate blank, damaged or unusable forms or, forms reporting students being in grades 7, 9, or 11. Staff scan the forms and prepare the data for analysis. For online surveys, data is collected on load-balanced virtual servers and combined with data from paper surveys before analysis. To ensure anonymity and as part of the dataset development, the scoring system automatically suppresses the calculation of results when any subgroup of data contains responses from fewer than 10 students. Data from these small subgroups are, however, aggregated into reports for larger geographic areas (i.e., district, regional, and state reports).

Beyond the preliminary checks for valid surveys, several other checks are built into the data screening process to minimize the inclusion of students who were not truthful in their responses. Invalid individual student surveys were identified using five specific criteria: 1) the student indicated that he or she was “Not Honest at All” in completing the survey; 2) the student reported an impossibly high frequency of multiple drug use; 3) the student indicated that he or she had used the non-existent drug Pegaramide; 4) there was a large age differential between grade level and the student’s age as reported by the student; and 5) the student report contained logical inconsistencies between past 30-day use and lifetime use rates.

Indicator #: 5

Indicator: Lower the lifetime e-cigarette usage rate among middle and high school students

Baseline Measurement: SFY 2017 = 16.5%

First-year target/outcome measurement: SFY 2019 = 15.9%

Second-year target/outcome measurement: SFY 2021 = 14.9%

Data Source:

Arkansas Prevention Needs Assessment (APNA) survey

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

The most recent questionnaire was then modified in 2002 to create the APNA survey. Modifications, including the addition of specific questions about substance use, tobacco availability, and tobacco use, allowed the APNA survey to more accurately reflect the Arkansas substance use and problem behavior climate. Throughout the years, trending substances have been added to the questionnaire (e.g., over-the-counter drugs, e-cigarettes, bath salts, prescription drugs, etc). However, the measurement of risk and protective factors, along with the prevalence of alcohol, tobacco, and other drug use and antisocial behaviors, has always maintained core elements to allow for year-to-year comparisons

Data issues/caveats that affect outcome measures::

Print surveys returned are first checked to eliminate blank, damaged or unusable forms or, forms reporting students being in grades 7, 9, or 11. Staff scan the forms and prepare the data for analysis. For online surveys, data is collected on load-balanced virtual servers and combined with data from paper surveys before analysis. To ensure anonymity and as part of the dataset development, the scoring system automatically suppresses the calculation of results when any subgroup of data contains responses from fewer than 10 students. Data from these small subgroups are, however, aggregated into reports for larger geographic areas (i.e., district, regional, and state reports).

Beyond the preliminary checks for valid surveys, several other checks are built into the data screening process to minimize the inclusion of students who were not truthful in their responses. Invalid individual student surveys were identified using five specific criteria: 1) the student indicated that he or she was "Not Honest at All" in completing the survey; 2) the student reported an impossibly high frequency of multiple drug use; 3) the student indicated that he or she had used the non-existent drug Pegaramide; 4) there was a large age differential between grade level and the student's age as reported by the student; and 5) the student report contained logical inconsistencies between past 30-day use and lifetime use rates.

Indicator #: 6

Indicator: Lower the reported 30 day smokeless tobacco usage rate among middle and high school students

Baseline Measurement: SFY 2017 = 4.1%

First-year target/outcome measurement: SFY 2019 = 3.9%

Second-year target/outcome measurement: SFY 2021 = 3.6%

Data Source:

Arkansas Prevention Needs Assessment (APNA) survey

Description of Data:

The APNA survey instrument has a rich history of collecting valid data from Arkansas students. Through the years, the instrument has evolved to respond to current trends in drug use, to allow for comparisons with national data, and to collect data on risk and protective factor indicators that assist substance use prevention and other programming designed for student well-being.

The original survey was developed in 1992 by the Center for Substance Abuse Prevention through the Social Development Research Group at the University of Washington. This instrument was modified with results of cognitive pre-testing and other statistical analyses to maximize the validity of the collected survey data. An administration protocol was developed and tested to ensure that the anonymity of the data collection process was communicated to the students resulting in improved honesty in the data set.

The most recent questionnaire was then modified in 2002 to create the APNA survey. Modifications, including the addition of specific questions about substance use, tobacco availability, and tobacco use, allowed the APNA survey to more accurately reflect the Arkansas substance use and problem behavior climate. Throughout the years, trending substances have been added to the questionnaire (e.g., over-the-counter drugs, e-cigarettes, bath salts, prescription drugs, etc). However, the measurement of risk and protective factors, along with the prevalence of alcohol, tobacco, and other drug use and antisocial behaviors, has always maintained core elements to allow for year-to-year comparisons.

Data issues/caveats that affect outcome measures::

Print surveys returned are first checked to eliminate blank, damaged or unusable forms or, forms reporting students being in grades 7, 9, or 11. Staff scan the forms and prepare the data for analysis. For online surveys, data is collected on load-balanced virtual servers and combined with data from paper surveys before analysis. To ensure anonymity and as part of the dataset development, the scoring system automatically suppresses the calculation of results when any subgroup of data contains responses from fewer than 10 students. Data from these small subgroups are, however, aggregated into reports for larger geographic areas (i.e., district, regional, and state reports).

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Priority #: 2

Priority Area: Substance Use Disorder (SUD) Treatment Workforce Development

Priority Type: SAP

Population(s): PWWDC, PWID

Goal of the priority area:

Increase state capacity to provide SUD treatment in Arkansas.

Objective:

Provide high quality SUD treatment based on evidence based practices.

Strategies to attain the objective:

1. Support certification programs for counselors-in-training.
2. Support cross-over training of Licensed Mental Health Professionals.
3. Build quality through support of evidence based practice training for substance abuse treatment professionals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of individuals who have received certification as an Alcohol and Drug Counselor

Baseline Measurement: 62

First-year target/outcome measurement: 3% increase from baseline

Second-year target/outcome measurement: 5% increase from baseline

Data Source:

Arkansas Substance Abuse Certification Board records

Description of Data:

Baseline is total of individuals who passed the SUD treatment Alcohol and Drug Counselor certification exam in CY 2018.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: Increase the number of individuals who have received certification as an Advanced Alcohol and Drug Counselor

Baseline Measurement: 17

First-year target/outcome measurement: 3% increase from baseline

Second-year target/outcome measurement: 5% increase from baseline

Data Source:

Arkansas Substance Abuse Certification Board

Description of Data:

Baseline is total of individuals who passed the SUD treatment Advanced Alcohol and Drug Counselor certification exam in CY 2018.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Increase the number of individuals who have received certification as a Clinical Supervisor

Baseline Measurement: 18

First-year target/outcome measurement: 3% increase from baseline

Second-year target/outcome measurement: 5% increase from baseline

Data Source:

Arkansas Substance Abuse Certification Board

Description of Data:

Baseline is total of individuals who passed the SUD treatment Clinical Supervisor certification exam in CY 2018.

Data issues/caveats that affect outcome measures::

None

Priority #: 3

Priority Area: Access to Substance Use Disorder Treatment services

Priority Type: SAT

Population(s): PWWDC, PP, Other (Rural)

Goal of the priority area:

Maintain or expand access to SUD treatment programs in Arkansas

Objective:

Ensure statewide access to SUD treatment, especially in rural areas of the state.

Strategies to attain the objective:

1. Continue to support an array of licensed SUD treatment programs offered statewide including detoxification, residential, outpatient services, partial day treatment, adolescent services, therapeutic community, drug court, and specialized women's services.
2. Contract with select regional providers to support services to indigent clients across all regions of the state.
3. Support initiatives of state public behavioral health system including Medicaid funding for SUD outpatient treatment and community-based programming.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of clients admitted to SUD treatment progams offered through state licensed providers.

Baseline Measurement: SFY 2018 = 15,917

First-year target/outcome measurement: 1.5% increase from baseline

Second-year target/outcome measurement: 3% increase from baseline

Data Source:

ADMIS - Alcohol/Drug Management Information System, Treatment Information Report provided by program admit date.

Description of Data:

Count of treatment episodes based on admissions during SFY 2018. This count includes services provided by all state licensed providers across all funding types.

Data issues/caveats that affect outcome measures::

This is a count of treatment episodes across all treatment programs. If the same client attended more than one treatment program during the reporting period, the client is duplicated in the count.

Priority #: 4

Priority Area: Access to Mental Health Treatment Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand access to quality mental health services for all citizens of Arkansas

Objective:

Increase the state's capacity to provide high quality mental health treatment services.

Strategies to attain the objective:

1. Support case management services to under insured and uninsured clients served by Community Mental Health Centers (CMHCs).
2. Connect under insured and uninsured clients to available payor sources and decrease the number of mental block grant funds as the payor of last resort.
3. Increase the number of certified mental health providers operating statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of under insured Community Mental Health Centers (CMHC) clients who receive case management services

Baseline Measurement: 16.1% = 8808/50,323 for 07/01/18-06/30/19

First-year target/outcome measurement: 1.5% increase from baseline

Second-year target/outcome measurement: 3% increase from baseline

Data Source:

Monthly Client Services Report

Description of Data:

The Monthly Client Services Report is sourced from the CMHCs electronic health record systems and provides self-reported unique client counts of uninsured and under insured clients who received services from the CMHCs.

Data issues/caveats that affect outcome measures::

Percent = number of under insured individuals who received case management servies through CMHCs / numbers of under insured individuals who received any service through the CMHC.

Indicator #: 2

Indicator: Increase the percent of uninsured Community Mental Health Centers (CMHCs) clients who receive case management services.

Baseline Measurement: 5.2% = 995/19,092 for 07/01/18-06/30/19

First-year target/outcome measurement: 1.5% increase from baseline

Second-year target/outcome measurement: 3% increase from baseline

Data Source:

Monthly Client Services Reports

Description of Data:

The Monthly Client Services Report is sourced from the CMHC electronic health record systems and provides self-reported unique client counts of uninsured and under insured clients who received services from the CMHCs.

Data issues/caveats that affect outcome measures::

Number of uninsured individuals who received case management services through the CMHCs / Number of uninsured individuals who any service through the CMHCs.

Indicator #: 3

Indicator: Connect under insured clients to available payor sources and decrease number of under insured individuals using block grant funds as payor of last resort

Baseline Measurement: 50,323 for 7/1/2018 to 6/30/2019 (SFY 2019)

First-year target/outcome measurement: 1.5% decrease from baseline

Second-year target/outcome measurement: 3% decrease from baseline

Data Source:

Monthly Client Services Report

Description of Data:

The Monthly Client Services Report is sourced from the CMHC electronic health record systems and provides self-reported unique client counts of uninsured and under insured clients who received services from the CMHCs.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 4

Indicator: Connect uninsured clients to available payor sources and decrease the number of uninsured using block grant funds as payor of last resort

Baseline Measurement: 19,092 for 07/01/18-06/30/19

First-year target/outcome measurement: 1.5% decrease from baseline

Second-year target/outcome measurement: 3% decrease from baseline

Data Source:

Monthly Client Services Reports

Description of Data:

The Monthly Client Services Report is sourced from the CMHC electronic health record systems and provides self-reported unique client counts of uninsured and under insured clients who received services from the CMHCs.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 5

Indicator: Increase the number of Behavioral Health Agencies per 1000 residents statewide.

Baseline Measurement: 311 as of May 2019

First-year target/outcome measurement: 3% increase from baseline

Second-year target/outcome measurement: 4.5% increase from baseline

Data Source:

Division of Provider Services and Quality Assurance's (DPSQA) License and Certification Unit

Description of Data:

Records of certified provider by DSQA are comprised of those providers who been licensed and/or certified, as required by the regulations.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 6

Indicator: Increase the number of Independently Licensed Practitioners per 1000 residents statewide

Baseline Measurement: 207 as of May 2019

First-year target/outcome measurement: 3% increase from baseline

Second-year target/outcome measurement: 4.55 increase from baseline

Data Source:

Division of Provider Services & Quality Assurance's (DPSQA) License & Certification Unit

Description of Data:

Records form the DPSQA of currently licensed and/or certified providers as required by regulation

Data issues/caveats that affect outcome measures::

None.

Priority #: 5

Priority Area: Beneficiary Support

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To assist and educate beneficiaries in navigating the various social and behavioral health systems to access services.

Objective:

To improve access to resource information.

Strategies to attain the objective:

1. Increase public awareness of behavioral health services.
2. Provide education, outreach, and increase state interaction with beneficiaries.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual number of completed beneficiary support calls.

Baseline Measurement: 0

First-year target/outcome measurement: Establish baseline

Second-year target/outcome measurement: 3% increase from baseline

Data Source:

Arkansas Foundation for Medical Care (AFMC) outreach reports

Description of Data:

AFMC call tracking report

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Increase the number of community education campaigns provided by Community Mental Health Centers (CMHC's) related to First Episode of Psychosis. (FEP).
Baseline Measurement:	0% of CMHCs performing community education outreach focused on First Episode of Psychosis at least twice a month.
First-year target/outcome measurement:	Increase to 50% of CMHCs engaging in performing community education outreach focused on First Episode of Psychosis at least twice a month.
Second-year target/outcome measurement:	Increase to 100% of CMHCs engaging in performing community education outreach focused on First Episode of Psychosis at least twice a month.

Data Source:

CMHC Monthly Report on FEP

Description of Data:

Contract management of the CMHCs who receive funding under the mental health block grant requires providers to report on activities and services provided during the previous month.

Data issues/caveats that affect outcome measures::

20% of CMHC's reported performing 1 FEP focused educational outreach in the first quarter of SFY 2018; however, 0% reported at least 2 FEP focused educational outreach activities per month.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$18,299,165		$0	$0	$2,980,072	$0	$17,212,176
a. Pregnant Women and Women with Dependent Children**	$2,338,724		$0	$0	$0	$0	$0
b. All Other	$15,960,441		$0	$0	$2,980,072	$0	$17,212,176
2. Primary Prevention	$7,424,288		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$1,352,287		$0	$0	$0	$0	$0
10. Total	**$27,075,740**	**$0**	**$0**	**$0**	**$2,980,072**	**$0**	**$17,212,176**

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$1,197,174	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$4,093,076	$2,257,123	$39,094,091	$0	$1,120,153
7. Other 24 Hour Care		$0	$27,446,143	$0	$15,105,024	$0	$2,323,407
8. Ambulatory/Community Non-24 Hour Care		$10,415,416	$0	$0	$18,794,720	$0	$0
9. Administration (Excluding Program and Provider Level)***		$359,152	$0	$0	$0	$0	$0
10. Total	**$0**	**$11,971,742**	**$31,539,219**	**$2,257,123**	**$72,993,835**	**$0**	**$3,443,560**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	101	191
2. Women with Dependent Children	2868	1869
3. Individuals with a co-occurring M/SUD	2721	4334
4. Persons who inject drugs	574	2974
5. Persons experiencing homelessness	1579	1203

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

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$9,134,582
2 . Primary Substance Abuse Prevention	$3,712,144
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	$676,144
6. Total	**$13,522,870**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$315,161
	Selective	$157,581
	Indicated	$52,527
	Unspecified	
	Total	**$525,269**
2. Education	Universal	$466,895
	Selective	$179,575
	Indicated	$71,830
	Unspecified	
	Total	**$718,300**
3. Alternatives	Universal	$82,632
	Selective	$23,609
	Indicated	$11,805
	Unspecified	
	Total	**$118,046**
4. Problem Identification and Referral	Universal	$13,364
	Selective	$17,818
	Indicated	$13,364
	Unspecified	
	Total	**$44,546**
	Universal	$612,467

5. Community-Based Process	Selective	$174,990
	Indicated	$87,495
	Unspecified	
	Total	**$874,952**
6. Environmental	Universal	$600,922
	Selective	$300,461
	Indicated	$100,154
	Unspecified	
	Total	**$1,001,537**
7. Section 1926 Tobacco	Universal	$43,432
	Selective	
	Indicated	
	Unspecified	
	Total	**$43,432**
8. Other	Universal	$386,063
	Selective	
	Indicated	
	Unspecified	
	Total	**$386,063**
Total Prevention Expenditures		**$3,712,145**
Total SABG Award*		**$13,522,870**
Planned Primary Prevention Percentage		**27.45 %**

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

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Footnotes:

Information Dissemination = 14.15%
Education = 19.35%
Alternatives = 3.18%
Problem Identification & Referral = 1.20%
Community Based Practices = 23.57%

Environmental = 26.98%
Tobacco (Synar) = 117%
Other = 10.40%

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$1,221,295
Universal Indirect	$1,239,114
Selective	$1,025,294
Indicated	$226,812
Column Total	**$3,712,515**
Total SABG Award*	**$13,522,870**
Planned Primary Prevention Percentage	**27.45 %**

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

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Universal Direct = 33%
Universal Indirect = 33%
Selective = 28%
Indicated = 6%

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

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

Footnotes:

Planning Tables

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

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems		$145,000	
2. Infrastructure Support			
3. Partnerships, community outreach, and needs assessment		$323,000	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement		$2,950,602	
6. Research and Evaluation		$37,121	
7. Training and Education		$256,421	
8. Total	**$0**	**$3,712,144**	**$0**

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

Planning Tables

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

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

Activity	FFY 2020 Block Grant
1. Information Systems	
2. Infrastructure Support	
3. Partnerships, community outreach, and needs assessment	$98,150
4. Planning Council Activities (MHBG required, SABG optional)	$42,000
5. Quality Assurance and Improvement	
6. Research and Evaluation	
7. Training and Education	
8. Total	**$140,150**

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

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

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

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

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

Arkansas' behavioral health system and the Medicaid system began a huge overhaul on July 1, 2017. Part of the transformation includes Medicaid paying for outpatient substance use disorder treatment for all Medicaid recipients, and the addition of new services, such as Supportive Housing and Supportive Employment. Existing Medicaid providers are now able to provide mental health treatment services and substance use disorder treatment services. Substance use disorder providers have been encouraged to become Medicaid providers. A Primary Care Physician's (PCP) office is an allowable place of service in the Outpatient Behavioral Health system, as are Federally Qualified Health Centers, Rural Health Clinics, and Public Health Clinics.

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

2. Arkansas implemented changes to the Medicaid system through expansion of substance use disorder treatment services for all Medicaid recipients as well as a Provider Led Managed Care model. Here, the total cost of care for each Medicaid recipient, who has been determined to be SED or SMI by an Independent Assessment (which evaluates functional status and/or deficits), and has current behavioral health needs will be managed through a care coordination model for management and coordination of treatment of all medically needed services. Each PASSE receives a per-member per-month (PMPM) global rate for all enrolled members. The PMPM rate is established based on the Independent Assessment outcome, which is periodically updated.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

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

Both the Division of Medical Services and the Division of Aging Adult & Behavioral Health Services

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii)	heart disease	○ Yes	◉ No
iii)	hypertension	○ Yes	◉ No
iv)	high cholesterol	○ Yes	◉ No
v)	diabetes	○ Yes	◉ No
c)	Recovery supports	◉ Yes	○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ◉ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

None at this time.

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

The Provider-Led Arkansas Shared Savings Entity (PASSE) is our new model of organized care that addresses the needs of Medicaid recipients who have complex behavioral health and/or intellectual & developmental disabilities service needs. Under this unique organized care model, providers of specialty and medical services will enter into new partnerships with experienced organizations that perform the administrative functions of managed care. PASSE implementation began with members receiving Care Coordination services from the PASSE as of February 1, 2018. The PASSEs took full risk for all assigned members on March 1, 2019. In addition, Arkansas has improved access to adult inpatient psychiatric services, including those with a co-occurring substance use disorder through the PASSEs ability to utilize free standing psychiatric units.

Please indicate areas of technical assistance needed related to this section

None at this time.

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2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], 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/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. 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, LGBTQ 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. 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.

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

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] 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?

None at this time.

Please indicate areas of technical assistance needed related to this section

None at this time.

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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:

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center 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 Evidence-Based Practices Resource Center 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 for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the 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 promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] 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)**[55] 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. 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, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] 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

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

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

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

[53] http://psychiatryonline.org/

[54] http://store.samhsa.gov

[55] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

3. 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.

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. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

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

Arkansas has implemented components of the Coordinated Specialty Care model with the Community Mental Health Centers (CMHC) across the state. Individuals that experience an early serious mental illness are able to receive the following components including evidenced-based individual & family therapy, psychoeducation, and low-dose medications. CMHCs typically use the Cognitive Behavioral Therapy for Psychosis (CBT-P) model or the Individual Resiliency Training (IRT) model.

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

For those individuals qualifying for PASSE enrollment, the PASSE Care Coordination service ensures comprehensive care, including medical care, in the least restrictive setting. The State contracts for all behavioral health services require the use of evidence-based treatment models and individualized treatment services which are medically necessary.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery (●) Yes ( ) No

supports for those with ESMI?

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (•) Yes ( ) No

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

Providers are allowed to choose an appropriate treatment model for ESMI individuals, as long as the model is evidenced-based. Arkansas providers are using Cognitive Behavioral Therapy for Psychosis and Individual Resiliency Training models.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

The state will continue to promote the use of Coordinated Specialty Care Model within CMHCs. Supportive Employment and Supportive Housing are new services for our state. Providers will be required to continue to improve the capacity of the CSC team to address and monitor suicidal behavior, improvement of symptoms, and individual functioning. Additionally, CMHC contracts that went into effect on July 1, 2019 have increased requirements and monitoring for community outreach efforts.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state collects data on a monthly basis. We expect that with increased community outreach and education that the number of individuals receiving services for ESMI will increase over the next two years.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia, Bipolar Disorder, Schizo-affective Disorder, Psychosis NOS, and Schizoid Personality Disorder

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

None at this time.

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP 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.

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.

NA

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, the Behavioral Health Agencies, also Medicaid providers, have historically been required to be nationally accredited through CARF, TJC, or COA. These accrediting entities require a plan of care. Additionally, those persons with PASSE membership attribution are required to a have a Person-Centered Service Plan (PCSP) created by the PASSE Care Coordinator collaboratively with the beneficiary and their identified supports. The Coordinator is required to engage all service providers, the PASSE member, and any caregivers or natural supports in the development of the PCSP. One state contract specifically related to ensuring behavioral health services for persons without insurance, or without a payor source for a medically necessary behavioral health services, require a plan of care, whereas persons receiving fee-for-service Medicaid funded counseling level services only requires a primary care physician referral for behavioral health services.

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

Persons with PASSE membership are required to a have a Person-Centered Service Plan (PCSP) created by the PASSE Care Coordinator collaboratively with the beneficiary and their identified supports. The Coordinator is required to engage all service providers, the PASSE member, and any caregivers or natural supports in the development of the PCSP. An important note is that beneficiaries now participate in the development of the PCSP and this plan is completely independent of the service providers. One state contract specifically related to ensuring behavioral health services for persons without insurance, or without a payor source for a medically necessary behavioral health services, require a plan of care, whereas persons receiving fee-for-service Medicaid funded counseling level services only requires a primary care physician referral for behavioral health services.

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

None at this time.

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6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for 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 SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with 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 SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of 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 items:

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

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with 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?

Please indicate areas of technical assistance needed related to this section

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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**[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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process*** 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.

Please respond to the following items

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) 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)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

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

- [ ] Archival indicators (Please list)

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

Arkansas Prevention Needs Assessment (APNA)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

To help define needs and assess priorities.

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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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.

Capacity Building

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

If yes, please describe

Arkansas Prevention Certification Board

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

If yes, please describe mechanism used

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

If yes, please describe mechanism used

Substance Abuse Skills Training

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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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.

Planning

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

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

see attachment

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

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **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 SABG primary prevention funds? (●) Yes ( ) No

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

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

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.

Narratve Question

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Implementation

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

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

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

- **a)** Information Dissemination:

  Clearinghouse, material, media
- **b)** Education:

  Education for youth and families
- **c)** Alternatives:

  Youth leadership activities
- **d)** Problem Identification and Referral:

  Referral for those with SUD
- **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 SABG dollars are used only to fund primary ○ Yes ◉ No

prevention services not funded through other means?

If yes, please describe

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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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 disorder prevention that was developed within the last five years? ○ Yes ◉ No

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

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☑ Other (please list:)

  monitoring compliance of performance deliverables with contracted providers.
- **g)** ☐ Not applicable/no prevention evaluation plan

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

ARKANSAS STRATEGIC PREVENTION PLAN

SFY 2019-2023

Strategic Five Year Plan

ARKANSAS DEPARTMENT OF HUMAN SERVICES

UA LITTLE ROCK

MidSOUTH CENTER FOR PREVENTION AND TRAINING

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

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

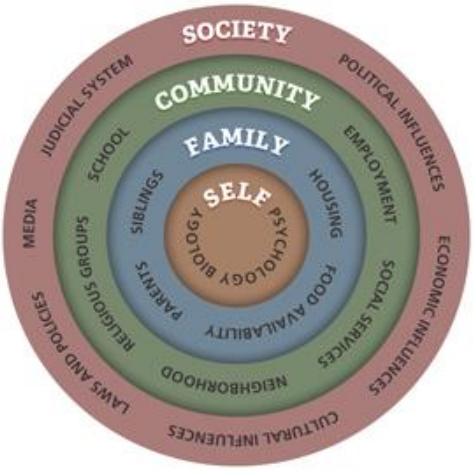
Prevention is the promotion of constructive lifestyles and norms that discourage alcohol, tobacco and other drug (ATOD) abuse. It is a proactive process designed to empower individuals and communities to meet the challenges of life events and transitions throughout the lifespan by creating and reinforcing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

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.

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.

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

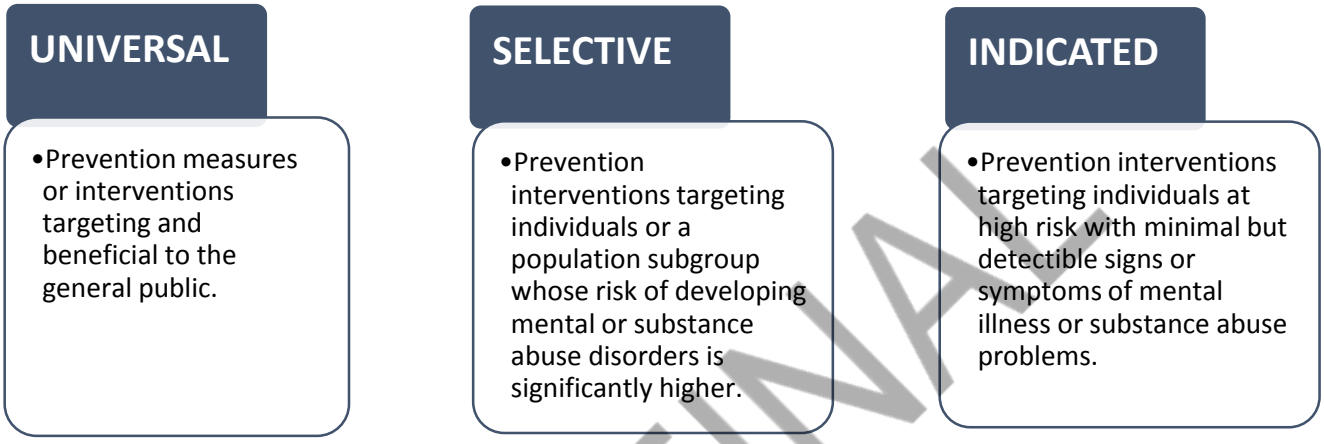
Community Context: In communities, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities

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.

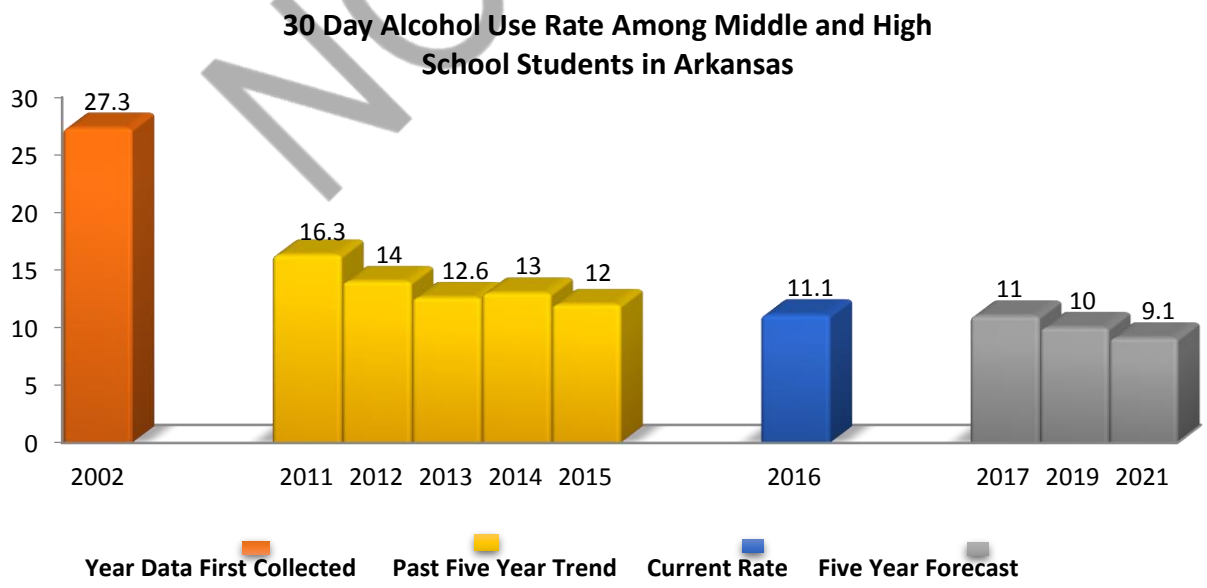
The following goals and objectives have been identified for the SFY 2019 to SFY 2023 Strategic Prevention Plan.

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/)

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

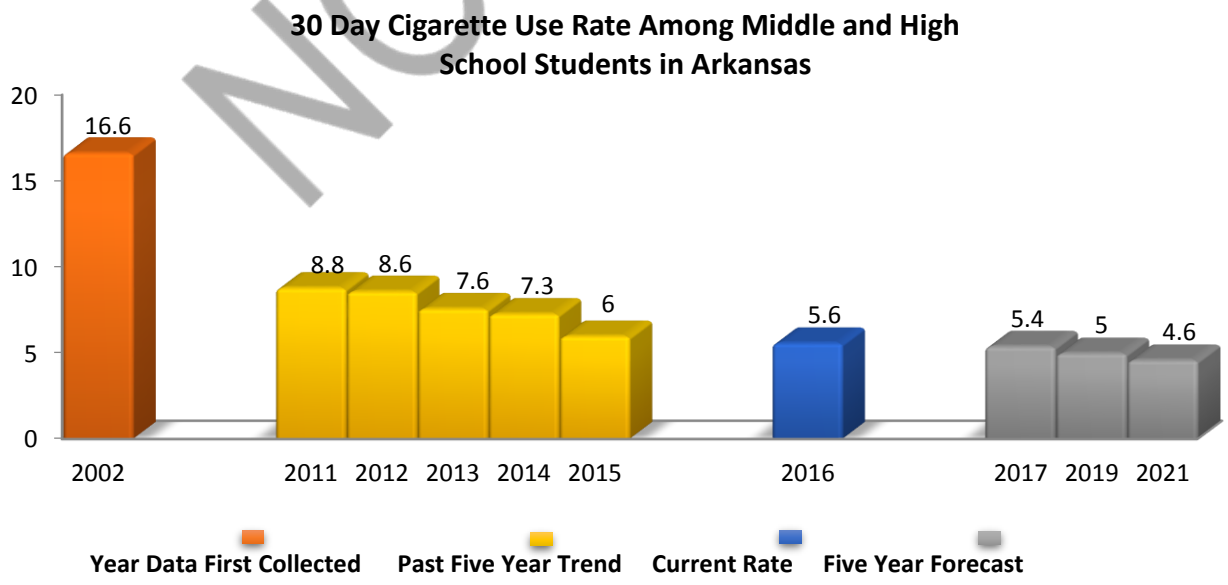
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate Information. Provide prevention training to PE and health teacher. Partner with community coalitions, policy makers, and other stakeholders to change community norms towards alcohol usage. Increase knowledge and skills by educating youth/parents on alcohol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

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



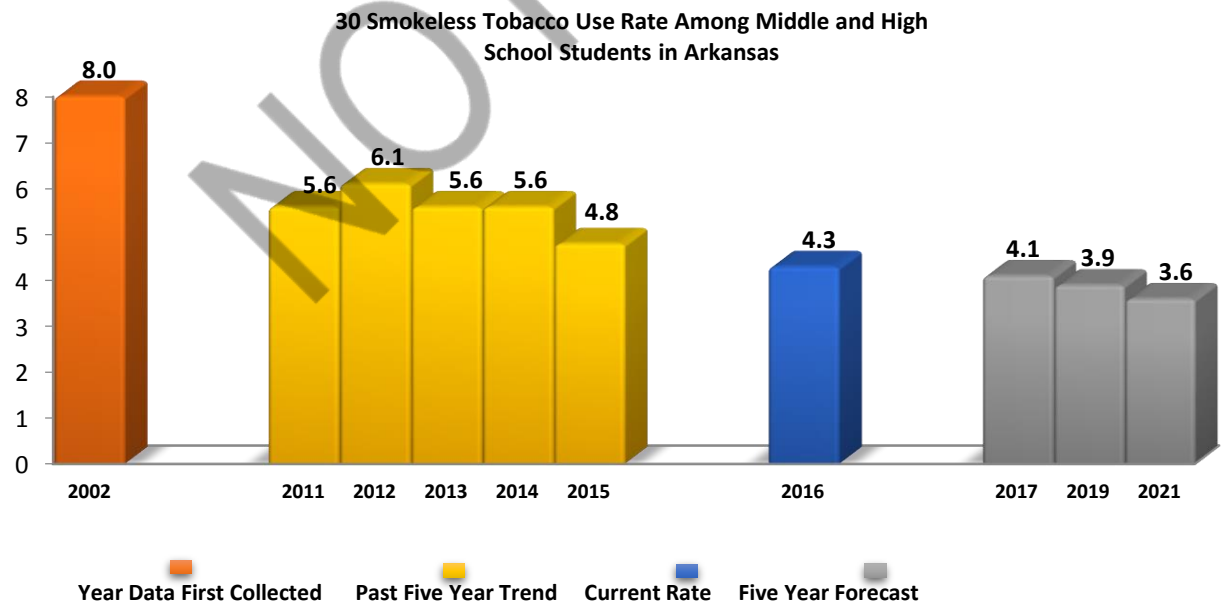
Source: Arkansas Prevention Needs Assessment (APNA) Survey. (https://arkansas.pridesurveys.com/)

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



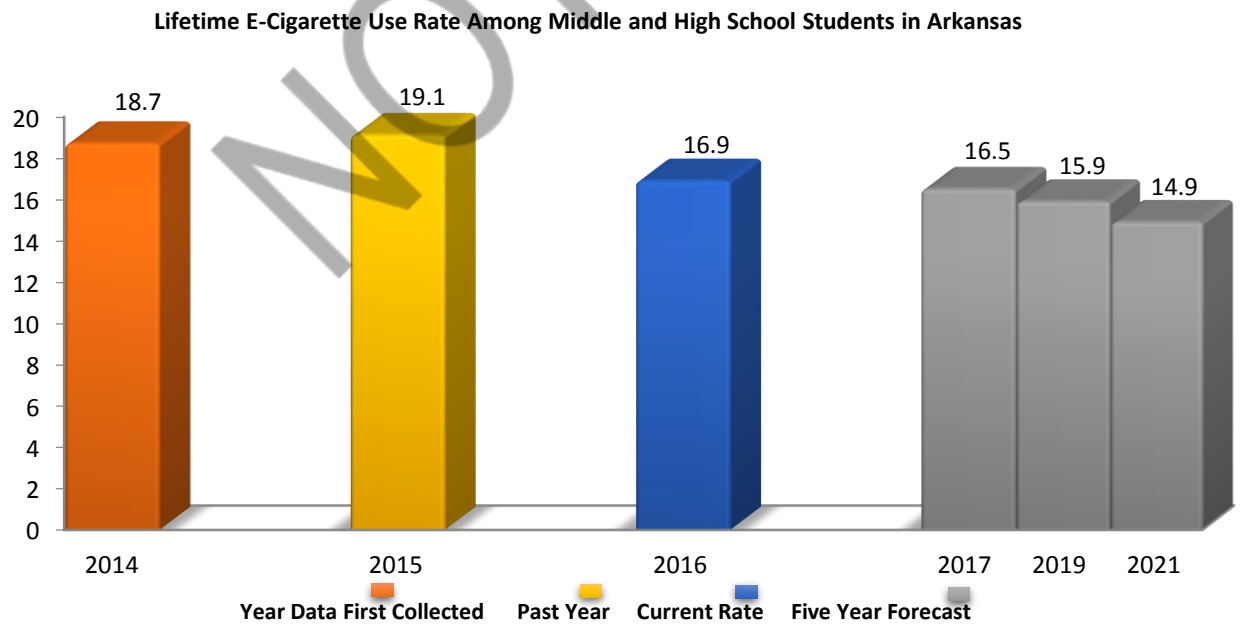
Source: Arkansas Prevention Needs Assessment (APNA) Survey. (https://arkansas.pridesurveys.com/)

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

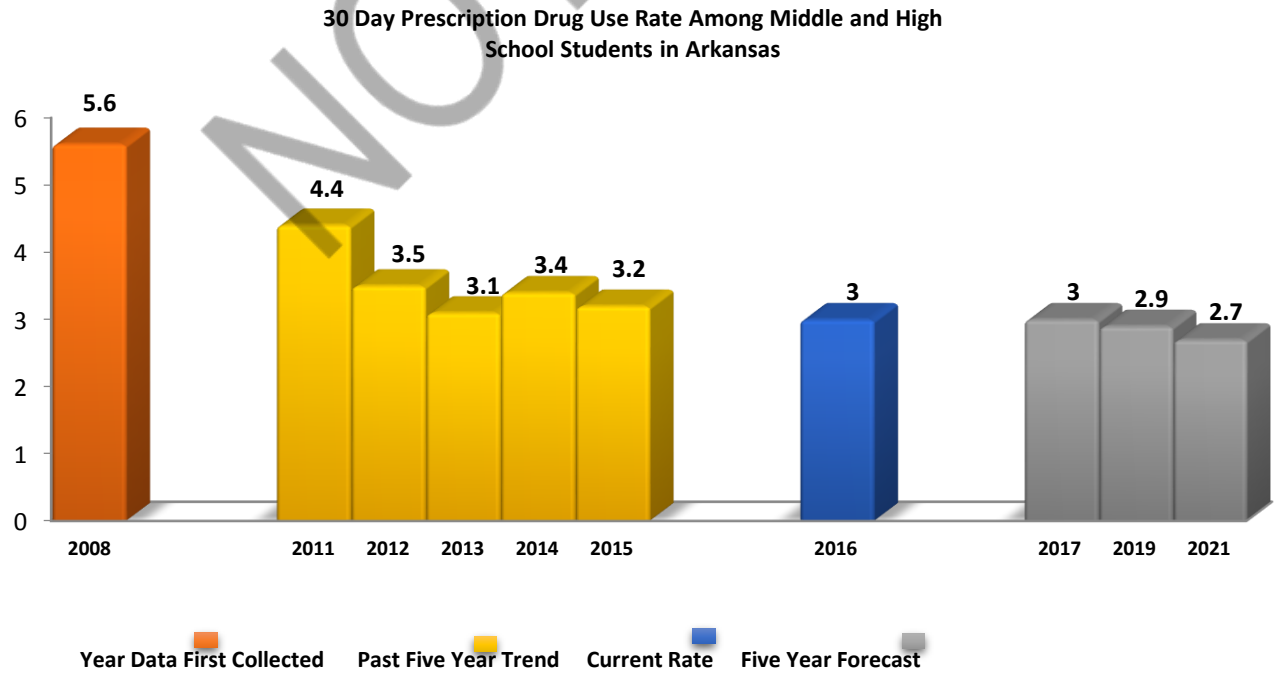
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.	Disseminate tobacco prevention Information.
Provide prevention training to counselors PE and health teacher.	Provide prevention training 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



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

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 couselors, 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.		

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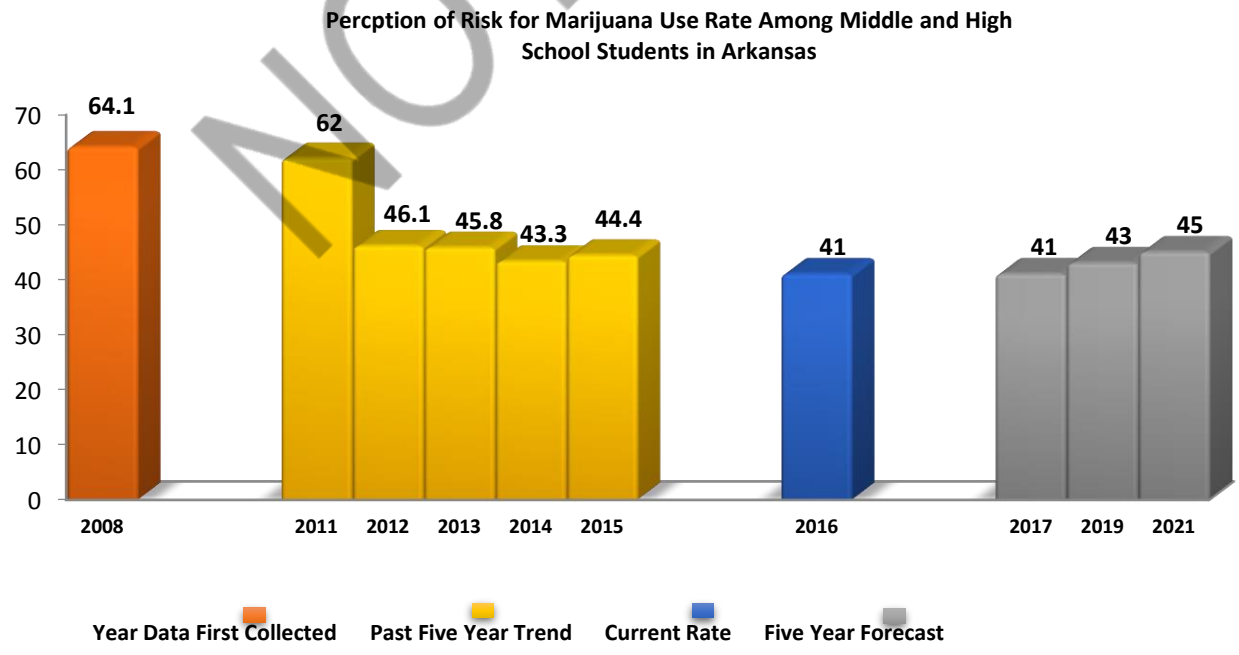
GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol use, binge drinking, marijuana and prescription drug use by Arkansans.

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

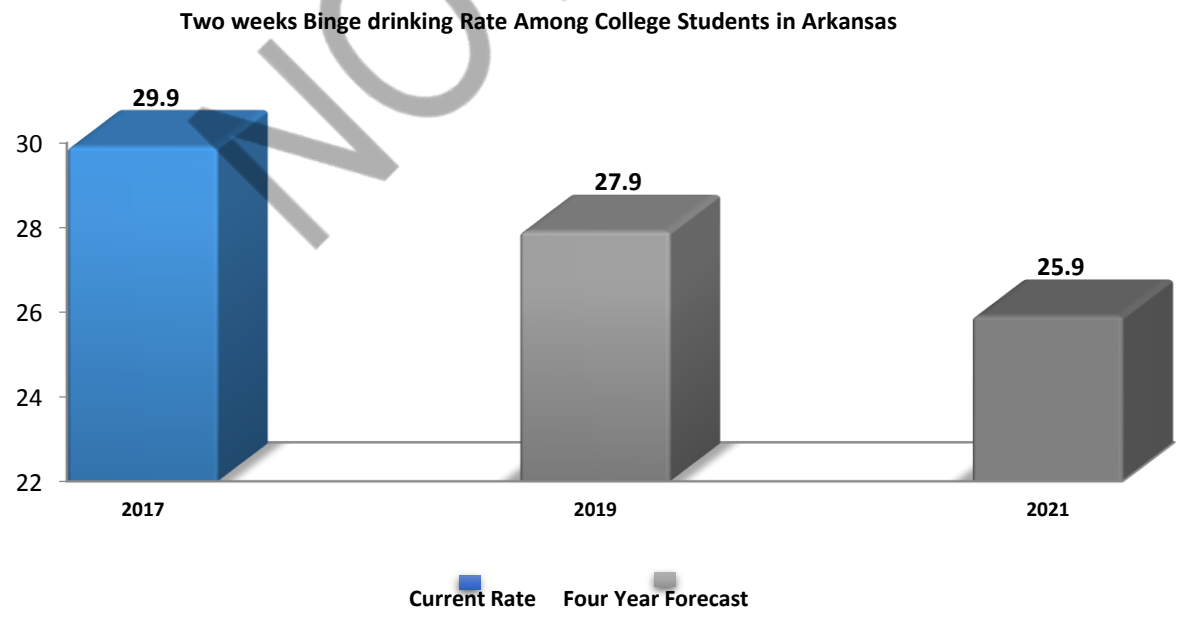
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Disseminate opioid abuse prevention Information. Increase knowledge and skills by educating communities on marijuana risks through trainings.	Disseminate opioid abuse prevention Information. Increase knowledge and skills by educating communities on marijuana risks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

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

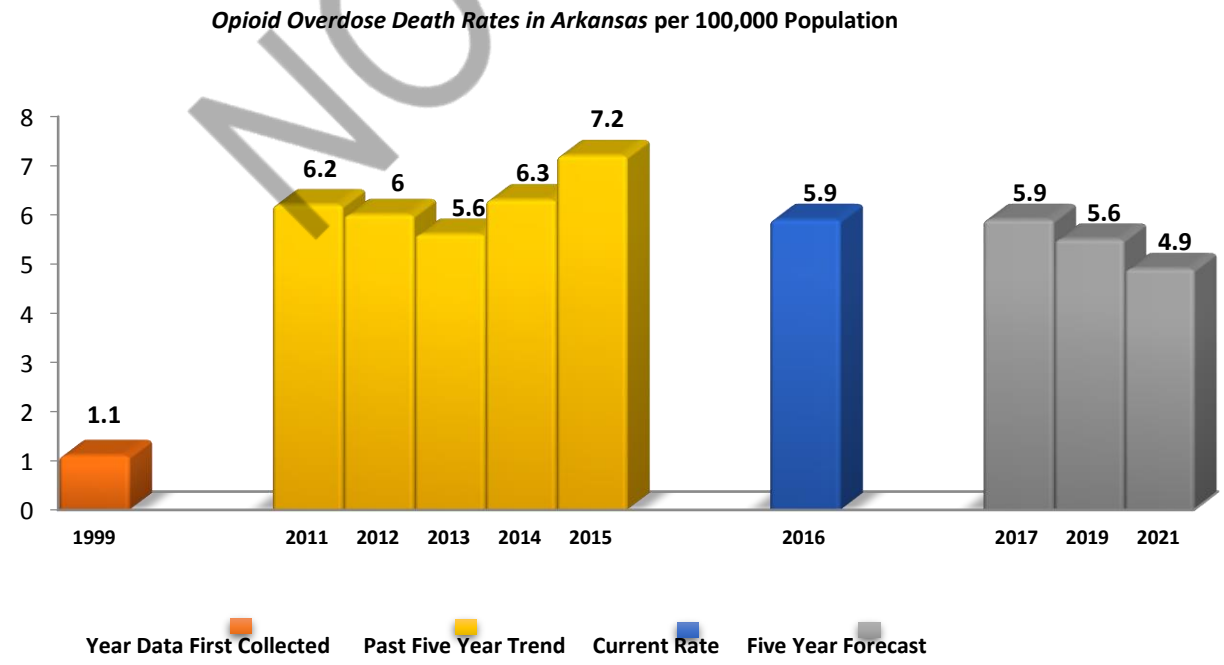
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Renew ACDEC contract. Expand ACDEC program by recruiting more schools. Promote student led wellness programs on college campuses. Collaborate with ACDEC to provide prevention trainings to college students.	Expand ACDEC program by recruiting more schools. Promote student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

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)



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

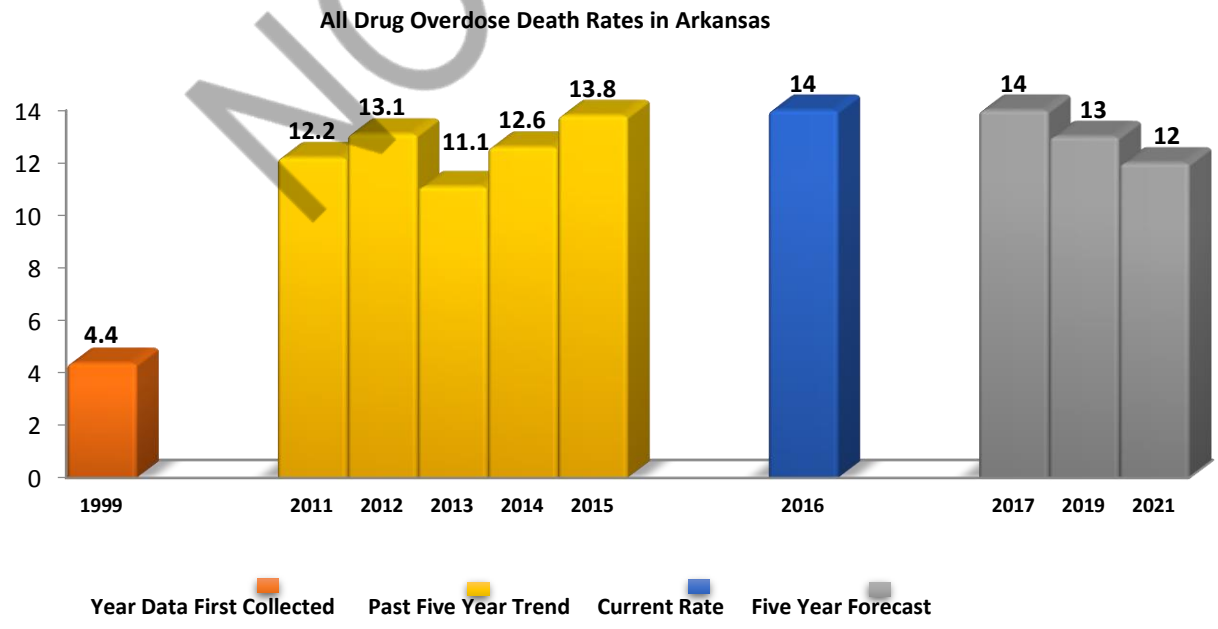
SFY 2019	SFY 2020	SFY 2021	SFY 2022
Establish MOU's with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate suicide prevention trainings.	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and coordinate 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)



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. 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	Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and conduct trainings on bullying and suicide prevention. Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials.	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 disseminate suicide prevention materials. Collaborate with ACDEC to establish collegiate recovery and prevention programs.	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 disseminate suicide prevention materials 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. Design and implement training and technical assistance system that will increase and enhance skills of providers to administer effective prevention services. Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders. Establish County Prevention Taskforces.	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. Develop/identify training curriculums and conduct TOTs.	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. Conduct training curriculums and conduct TOTs.	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. Conduct training curriculums and conduct TOTs.

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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. Increase collaboration among partner agencies to share data. Create marketing plan to promote available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.	Recruit more schools to participatie in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey. Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.	Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey. Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.	Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey. Disseminate 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 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. Measure short-term outcomes by reviewing the usage rates for selected substances.	Continuously measure process and outcome data to determine if forecasted benchmarks are met. Measure mid-term outcomes by reviewing the usage rates for selected substances.	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 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 populaces. The profile includes a general population profile, information about factors that may contribute to substance abuse, and in an effort to determine the effect of substance abuse in Arkansas, health and economic consequences. Specific county level data is included for each of the 75 counties as a resource for community leaders throughout Arkansas. This report is posted online at http://www.preventionworksar.org/.

Arkansas Prevention Needs Assessment

The Arkansas Prevention Needs Assessment (APNA) student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted on line for public access. The APNA data has become a major planning resource for communities, schools, and state agencies. APNA data is used by a variety of organizations for both state and community level planning. APNA Reports are accessible online at 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.	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. Prevention services was able to secure the following discretionary funds from the Substance Abuse and Mental Health Services Administration (SAMHSA): • 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	DAABHS remains the Single State Agency (SSA) with authority to oversee the Substance Abuse Block Grant (SABG). DAABHS has contracted the University of Arkansas Little Rock, MidSOUTH Center for Prevention and Training to manage the state's prevention program. The regions of service were restructured from 8 regions to 13 regions. MidSOUTH is also in contract with ACDEC.
Comprehensive data management system	WITS data management system was acquired by DAABHS and is currently being overseen by MidSOUTH. MidSOUTH and AFMC also developed a data reporting and analysis platform known as REDCap.
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
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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	djkelsay@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
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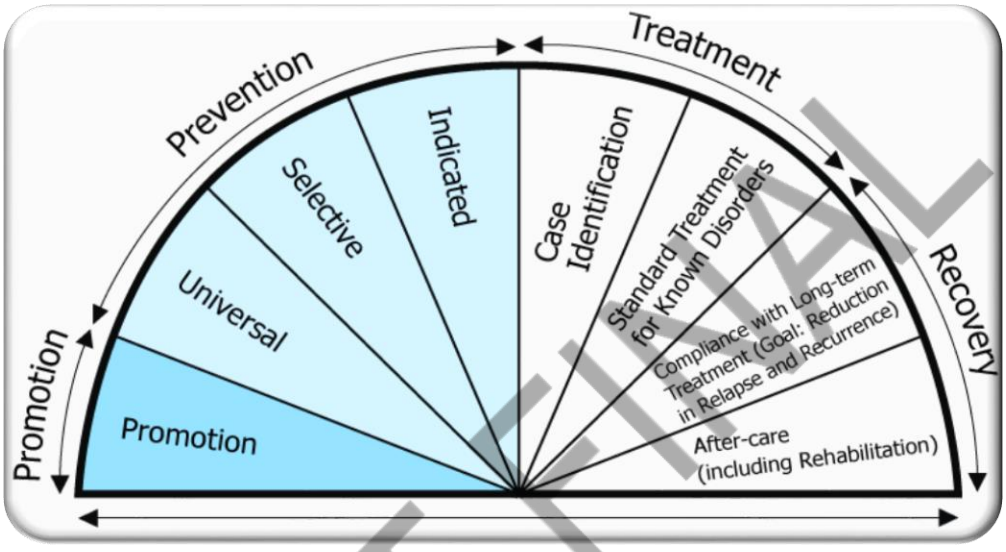
Gigi Peters	UA Little Rock/MidSOUTH Center for Prevention and Training	Executive Director, MidSOUTH	GAPeters@midsouth.ualr.edu
Joycelyn Pettus	Arkansas Department of Human Services	Grants Analyst	Joycelyn.Pettus@dhs.arkansas.gov
Gina Redford	Arkansas Foundation for Medical Care	Manager, Analytical Services	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 [illegible]	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.

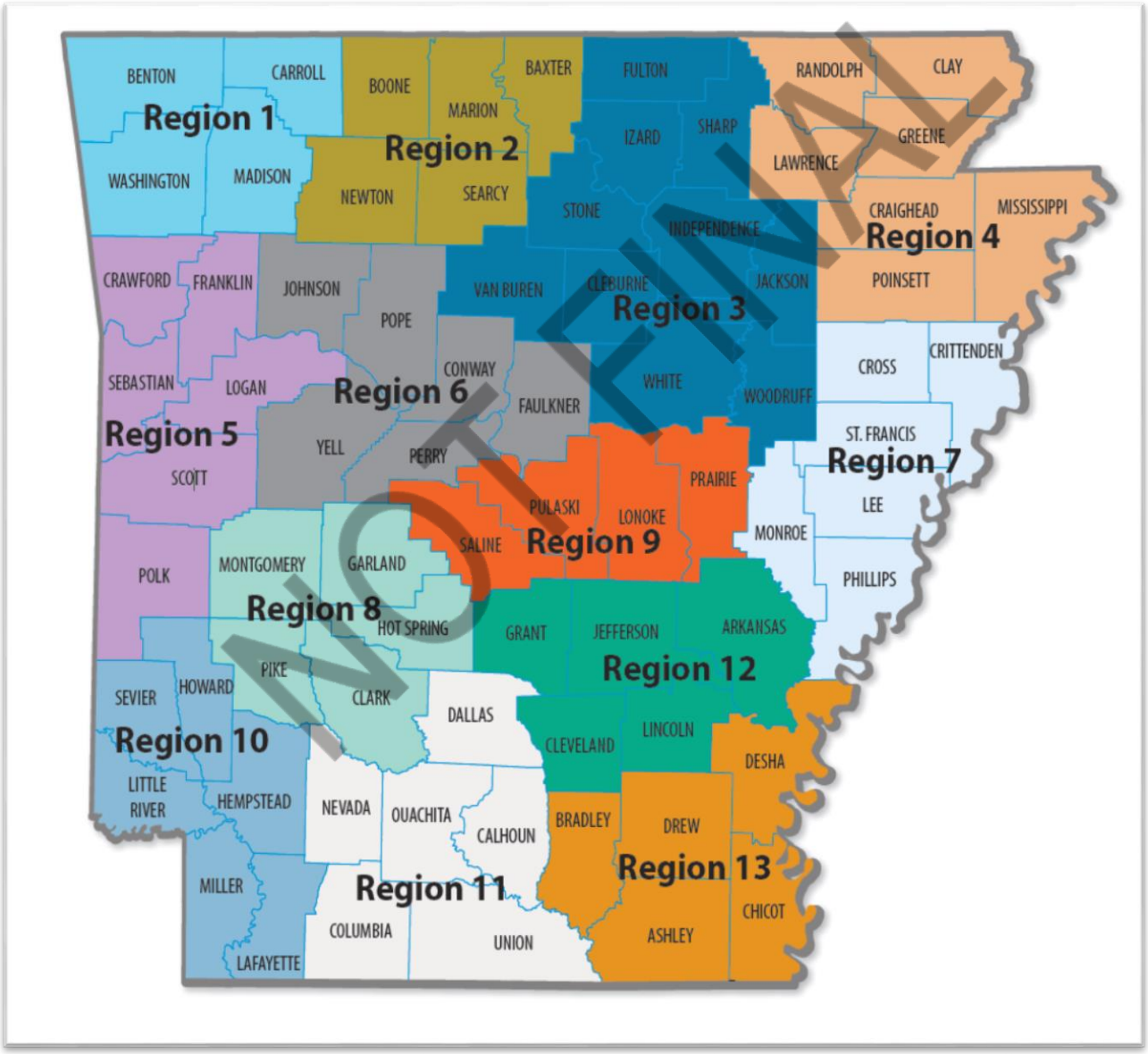
- **Prevention**—Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.

- **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.

APPENDIX v.

Arkansas Prevention Services Regions



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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-occuring 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 services are available through certified community providers and as such, must comply with State and federal requirements. DAABHS recognizes that in order to successfully treat individuals, community involvement is critical. Over the last nine years, DAABHS has developed and supported a System of Care encouraging community collaboration of families and agencies creating a coordinated network of services, supports, and social opportunities aimed at keeping individuals in their homes and out of inpatient settings. While this has primarily been aimed at children and youth historically, the implementation of PASSE Care Coordination has broadened the System of Care concepts to our adult SMI population. PASSE members, but also those without insurance or a payor source for needed services can access a broader scope of rehabilitative services, which now include Peer Support, Family Support Partners, Supportive Employment, Supportive Housing, and Adult Life Skills Development. Aftercare Recovery Services, another new service to our array, now 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.

An additional enhancement to our Medicaid system is coverage of outpatient substance use disorder assessment and treatment services via individual, group, and family behavioral health counseling, as well as psychoeducation and multi-family behavioral health counseling. Prior to Medicaid reimbursement for this, Arkansans with co-occurring substance use disorder issues often had to seek those services from different providers, thus making continuity of care more challenging in cases of a co-occurring mental health and substance use disorder needs. We expect to see a decrease in the need for residential level care with a more comprehensive array of outpatient services.

Telemedicine is more widely used and mandated by all CMHC providers via contract deliverables. Additionally, all CMHCs are 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 as well as certified Independently Licensed Clinicians. Due to lifting the moratorium of providers and provider sites July 1, 2018, and equalizing of the rates for BHA and ILPs, the number of ILPs enrolled as Medicaid providers has risen from 30 to over 250 in less than one year, thus dramatically increasing the number of certified providers across the state.

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-occuring M/SUDs (●) Yes ( ) No

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

3. Describe your state's case management services

Arkansas's transformation plan included the sun-setting of our Child and Adolescent (CASSP) program, largely based on Wraparound services, June 30, 2019. For our SED/SMI population, Care Coordination from the assigned PASSE replaces this service. This Care Coordinator, as previously discussed, will assist 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. 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.

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

CMHC providers are 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. Currently this system of utilization management results in an average length of stay for persons admitting under CMHC funding of 4.5 days and the first outpatient appointment is required to be within 7 days of hospital discharge.
With the implementation of our provider led model, and additional requirement was for each PASSE to develop, implement, and maintain a 24/7 mobile crisis team. The contact information for each PASSE's mobile crisis team is disseminated to all members upon enrollment and then each Care Coordinator includes a crisis plan in the Person Centered Service Plan.

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	117000	16767
2.Children with SED	70656	30547

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.

PREVALENCE:

Adults

The Behavioral Health Barometer, Arkansas, Volume 4 (indicators as measured through 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System) published in 2017 (looking at 2014-2015 data). Arkansas, annual average of about 117,000 adults 18 + had SMI in the last year.

Children (17 and under)

The statewide prevalence of Children with SED was compiled by NRI in 2017 using the official SAMHSA estimation methodology. This rate uses a combination of state civilian population and poverty data and a level of functioning score. The estimated prevalence for Arkansas is to 7% to 13% for ages 9 to 17.

The estimated statewide prevalence count of Children with SED was calculated by averaging the lower limit rate of prevalence estimate for LOF scores =<50 and the upper limit rate of estimate for LOF scores =<60, which is 10%. The population of children in Arkansas under the age of 18 for 2015 is 706,559. We applied this same estimated prevalence rate to the under 18 population count of 706,559. This resulted in an estimated prevalence count of 70,656 for children under 18. (706,559*10%=70,656).

INCIDENCE: To calculate the presented incidence data, the state totaled the counts of unique individuals identified as SMI/SED that received services through the state's public mental health system in SFY 2019.

- Numbers from Robbie Nix related to PASSE enrollment June 2019: SMI adults: 14,410, SED children 30,547
- Trish indicated there are approximately 2,000 adults outside of the PASSE who are SMI, but not eligible for PASSE enrollment.
- SPQM numbers indicate unduplicated client count of 357

14410 +2000 + 357 = 16,767 adults

• Prior to late 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 lower level behavioral health services funded by Medicaid on a fee-for-service basis. Due to this significant change, the way Arkansas determines a person to be SMI or SED is now determined by the outcome of the IA being a Tier 2 or Tier 3. Going forward, with this new method of determining SED/SMI we are projecting prevalence numbers to drop significantly in coming years.

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	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

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.

CMHC contracts have been revised to require agencies to have at least one physical location in every county of their Region. Additionally, to combat the challenges with transportation, and limited mental health professionals in our more rural areas, CMHCs are required to provide telemedicine services.

b. Describe your state's targeted services to the homeless population.

Arkansas annually receives approximately $302,000 in Projects Assisting Transition from Homelessness (PATH) grant. This money is sub-granted to 3 community mental health centers as part of a competitive application process. The sub-grantees are tasked with providing outreach, assessment, housing match, and assistance to obtain housing, as well as assistance with receiving social security income through the SOAR process. In 2018, the funds were used to assist 213 individuals in obtaining housing and mental health services. Of these, 57 were diagnoses with co-occurring substance use disorder and mental health disorders.

c. Describe your state's targeted services to the older adult population.

Older adults with behavioral health issues have access to the same services as the adult population.

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.

Criterion 5

Describe your state's management systems.

All Medicaid providers and Community Mental Health Centers are required to have and advertise an emergency number made available 24-7 to individuals who have a behavioral health emergency. Also, certified providers are required to ensure that staff have training to provide behavioral health crisis services. With the implementation of SFY2020 contracts for CMHCs, an added emphasis has been included in performance indicators which specifically require two types of outreach. The first is related to First Episode of Psychosis, which requires twice monthly outreach efforts targeted at high schools and colleges, PCP clinics, law enforcement, juvenile court/juvenile probation, homeless shelters, jails, and emergency departments. The second outreach requirement, which must take place at least once a month, must demonstrate an on-going public information and education campaign about available services, resources, hour of operation, contact information, and how to access the agencies' services, including Crisis Services.

As of July 1, 2019, DAABHS has implemented a Beneficiary Support Line at 1-844-763-0198. The line is open from 8am to 4:30 pm Monday through Friday. Beneficiaries or other community partners can access this number to get information about what services are available in all 75 counties. This line is initially answered by the Arkansas Foundation for Medical Care (AFMC) who accesses DAABHS database. For all calls needing second level or clinical assistance, the AFMC call center staff have a warm hand-off process directly to a DAABHS subject matter expert, including access directly to a licensed mental health clinician.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	( ) Yes (•) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. 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.

The four PWWDC programs are monitored by the Division of Provider and Quality Assurance that provide licensing and certification which ensures compliance to the licensure standards. Quarterly site visits are done to the PWWDC to ensure compliance with the contract program deliverables. If the provider is not providing the services that they are contracted to provide, then corrective actions plans are put in place.

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	( ) 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, older adults)?	(•) Yes ( ) No

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

The four PWWDC programs are monitored by the Division of Provider and Quality Assurance that provide licensing and certification which ensures compliance to the licensure standards. Quarterly site visits are done to the PWWDC to ensure compliance with the contract program deliverables. If the provider is not providing the services that they are contracted to provide, then corrective actions plans are put in place.

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.

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 the 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 SABG funds are NOT expended to provide (•) Yes ( ) No

individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?

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 SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

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

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 memebers, 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)** MAT — (●) 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 include 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.

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

Two per year

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) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [x] Other (please specify)

Council on Accreditation

Criterion 7&11

Group Homes

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

2. 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 opertunity 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) Preformance-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.

https://humanservices.arkansas.gov/about-dhs/daabhs/publications-documents

Footnotes:

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 2018-FFY 2019? ○ Yes ◉ No

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

None at this time

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 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.*
58 *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 guide how they will address individuals with trauma-related issues? ○ Yes ◉ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ◉ No

3. 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

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

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

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

With our new DAABHS resource database, we are identifying clinicians or clinics with staff with expertise in a variety of areas,

including those who are trauma-informed or certified.
AR Medicaid included a new Medicaid reimbursable mental health service that will be provided by certified infant mental health clinicians in SFY 2018. DAABHS, in conjunction with the University of Arkansas at Little Rock and Zero To Three, developed curriculum for training in infant mental health as well as certification process, which requires training in an evidenced-based dyadic treatment or TFCBT. UAMS continues to train and certify clinicians across the state in Trauma Focused Cognitive Behavioral Therapy.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ○ Yes ◉ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ◉ Yes ○ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ◉ Yes ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ○ Yes ◉ No

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

Juvenile Justice:
Department of Human Services (DHS) Systems of Care (SOC) Operation has a project in place in which they are working with the Division of Youth Services (DYS) targeting youth who have a Family In Need of Services (FINS) or are on probation. They are also including the DYS community based providers. Evidenced-based trainings are provided to improve outcomes of treatment to lessen involvement with the juvenile justice system and improve overall functioning. Trainings consisted of Collaborative Problem Solving and Cultural and Linguistic Competency. Trauma Focused Cognitive Behavioral Therapy certification is on-going as well as Team Up for Your Child-road Map to Services, and coaching process for wrap around service providers. A Trauma-Informed Care work group is on-going and continues to work on bringing together DHS divisions to ensure commitment to being a trauma-informed organization.

Juvenile Drug Courts:
These services are available in ten (10) different judicial districts. Services are provided by contracted licensed substance abuse providers. These contracts are awarded via bid process. Juveniles admitted to the Juvenile Drug Court program are provided a

number of services including outpatient therapy, case management, and urine analysis. The Arkansas Supreme Court Commission on Children, Youth and Families adopted Core Principles for Reducing Recidivism and Improving Outcomes for Youth in Juvenile Justice System. The Division of Behavioral Health Services has partnered with the Administrative Office of the Courts to support this initiative.

Criminal Justice Arkansas utilizes a Forensic Outpatient Restoration Program (FORP). Here, when there is concern that an individual is unfit to proceed within the legal system due to a possible mental health deficit. The individual is referred to the court where a judge orders a Forensic Evaluation. The evaluation is completed by a psychologist trained in forensics. If the individual is determined to be "unfit" to proceed," a report is presented to the court with this information and the individual can then be ordered to proceed in the FORP. The time frame for the restoration is ten (10) months and the individual is referred to his/her local community mental health center (CMHC) for a maximum duration of six months in order to complete the restoration process. The individual, to be restored, may either be in the county jail or on bond during the outpatient restoration process. Approximately sixty-percent (60%) of the individuals reside in jail, while approximately forty-percent (40%) are on bond. At any point, the process can be terminated for one of two reasons. Either the individual is restored by a passing score of 70% or higher on an educational exam or the individual appears to not be able to be restored due to malingering, lack of cooperation or the individual's mental health condition has elevated to the point that inpatient services are necessary. In either case, the individual is referred to the Arkansas State Hospital (ASH) where they are re-evaluated. This evaluation is utilized to determine if the individual needs further inpatient restoration in a more structured environment or to determine if the individual is ready to proceed through the legal system due to restoration. If found not restored but capable of restoration, the individual may be referred back to the CMHC for continuation of out-patients services. If the time-line is close to the sixth month window, the individual will, in most cases, remain at ASH for continued restoration services until the completion of the tenth month duration. The end result is that a report is sent to the courts declaring the individual as being: competent, competent/responsible, competent/not responsible or incompetent (unfit to proceed) as determined by the evaluator.

The implementation of FORP has drastically reduced the inpatient wait list at ASH and has allowed for treatment to be provided in the least restrictive setting and in a more expedient time frame. Training has been made available for law enforcement within the State of Arkansas. More importantly, this is a continued goal of organizations such as the Sheriff's Association, County Associations, and the Community Mental Health Centers. Further, the Arkansas Community Corrections Department now has over 35 trainers to provide Mental Health First Aid state-wide training to their staff. Also, Community Corrections is assisting parolees with signing up for various types of insurance upon release. They report that this has been successful with assisting with reducing recidivism as a result of access to behavioral health treatment.

In the past few years, the Behavioral Health Access Task Force, Arkansas' Behavioral Health Treatment Access Legislative Task Force was created as part of Act 895, known as the Criminal Justice Reform Act in the latest legislative session. The panel is comprised of lawmakers, advocates, constituents, stakeholders and agency heads, which are focusing on behavioral health services instead of longer sentences as an answer to keeping prison recidivism rates down in Arkansas. The overall responsibility and ultimate goal of the task force is to aide and assist persons in the criminal justice system who have a demonstrated a need for behavioral health treatment; and ensure he/she has access to treatment. The panel will work to keep former inmates from ending up back in prison . Instead of looking at longer sentences, one of the main focuses of the task force is that individuals with treatment needs have access to healthcare, specifically substance abuse and mental health, which could be a key piece to curbing the incarceration puzzle.

According to an Arkansas Community Correction report, there are over 53,000 parolees and probationers at any given time for oversight. Approximately 80 percent of them suffer substance abuse issues and of those approximately 42,000 people, another 20 to 30 percent also have mental health needs. The budget currently set for these types of services and to provide both mental health and substance abuse treatment is around $1.5 million. A way to adequately pay for services and competition for treatment slots that are available are described as fierce by some who provide services. At this point, the task force continues to have its work cut out for it, if it intends to make treatment the tactic to keep felons from ending up back behind bars.

Specialty Courts:
Act 895 also amended the statute outlining the drug court system in the state. The amendment expanded the definition of specialty courts to include other specialty courts, such as HOPE court, Veterans Court, juvenile drug court, etc. All specialty court programs operated by a circuit court or district court must be approved by the Supreme Court in the administrative plan submitted under Supreme Court Administrative Order No.14. The Administrative Office of the Courts shall evaluate and make finding with respect to all specialty court programs operated by a circuit court or district court in this state and refer the findings to the Supreme Court. An evaluation under this section shall reflect nationally recognized and peer-reviewed standards for each particular type of specialty court program. The office shall also establish, implement, and operate a uniform specialty court program evaluation process to ensure specialty court program resources are uniformly directed to high-risk and medium-risk offenders, and that specialty court programs provide effective and proven practices that reduce recidivism, as well as other factors such as substance dependency, among participants. They should also establish an evaluation process that ensures that any new and existing specialty court program that is a drug court meets standards for drug court operation and promulgate rules to be approved by the Supreme Court to carry out the evaluation process under this section.

A specialty court program shall be evaluated under the following schedule. (1) A specialty court program application submitted on or after the effective date of this act shall require evaluation of the specialty court program based on the proposed specialty court

program plan; (2) A specialty court program established on or after the effective date of this act shall be evaluated after its second year of funded operation; (3) A specialty court program in existence on the effective date of this act shall be evaluated under the requirements of this section prior to expending resources budgeted for fiscal year 2019; and (4) A specialty court program shall be reevaluated every two years after the initial evaluation. All of these "specialty courts" are utilized to screen and provide services to individuals with both mental health and/or substance abuse use disorders prior to adjudication.

Affordable Care Act – Medicaid – Arkansas Works:
The Department of Human Services has worked closely with Arkansas Community Corrections and the Arkansas Department of Corrections in-order to assist with in the enrollment of individuals transitioning out of prison on the state's traditional Medicaid, Arkansas Work's Expansion program or Private Options. With process tweaks, the agencies have been able to get individuals private insurance that reimburses for behavioral health services.

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

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

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

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

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

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

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

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, 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 MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ( ) Yes (●) No

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

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

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

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

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

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

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

Arkansas began implementing Crisis Stabilization Units (CSU) in 2017, with our first unit opening March of 2018, a second in August of 2018, third in July of 2019, and the fourth is scheduled to open in September of 2019. The CSUs interface with law enforcement per Act 423 which was passed in 2017. The Medicaid system has been enhanced by the addition of community support services and new services such as Acute Crisis Units, Therapeutic Communities, and outpatient Substance Use Disorder treatment services. Additionally, Medicaid now reimburses for Peer Support and Family Support partner services. The PASSEs are also required to have mobile crisis units for their members which require 24-hour accessibility 365 days a year. CMHC contracts have been updated to reflect more on-site crisis intervention services, emphasize diversion when appropriate, and hone in on ensuring appropriate aftercare services are implemented for each individual.

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

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing 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 guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, 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) 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.

Through the PATH grant, housing placement and recovery supports are provided to those individuals experiencing both SMI and homelessness.
Medicaid recipients who are attributed to a PASSE are eligible for Peer Support and Family Support services. In past years, federal System of Care Implementation and Expansion and BRSS TAC grant dollars have been used to ensure training for Family Support Partners and Youth Support Specialists. Numbers providing services have waned despite this now being a reimbursable service under Medicaid, Arkansas is exploring ways to promote these services as a critical part of recovery, and are cost efficient and proven effective. One way of emphasizing the importance is the addition of Peer Support services as a required service for CMHC contracts, along with Supportive Employment and Supportive Housing. For the first time, Arkansans with Medicaid, those who have no insurance, and those who are underinsured have access to these recovery-oriented services.
Individuals hospitalized at the Arkansas State Hospital have access to a Peer Support Partner during their inpatient stay. Training on Wellness Recovery Action Planning has been implemented with ASH staff and support groups of patients who meet regularly to work on their individual recovery plans.

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

The State is working with consumers, stakeholders and provider networks to ensure that treatment providers incorporate recovery programs to individuals while they are receiving other services. They are able to attend support group meetings (AA, NA). Once they have completed treatment residential or out-patients they will be encouraged to continue recovery programs. The State is reaching out to Peers to assist with recovery support services.

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

None at this time.

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

None at this time.

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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:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes	◉ No
Home and community based services.	○ Yes	◉ No
Peer support services.	○ Yes	◉ No
Employment services.	○ Yes	◉ 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?

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

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

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

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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).

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

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

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

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

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **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 and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and 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) Juvenile justice? (●) Yes ( ) No

c) 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

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. There are 544 sites certified across the state (as of 7-1-2019). There are approximately 65,000 children and youth being served through this program each year. Therapy services can be provided in a clinic, home, or school setting. Over 5,000 children and youth are provided services in a residential setting.
Juvenile Drug Court services are available in 10 judicial districts as well as the Substance Abuse Treatment Services Program that provides services to children and youth up to 21 years of age.

7. 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.

None at this time.

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges 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 items:

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

2. Describe activities intended to reduce incidents of suicide in your state.

Arkansas continues to have regular meetings by the Arkansas Suicide Prevention Council. The Council services as a central body on suicide prevention efforts across the state. A representative from DAABHS is a member of the Council and works collaboratively to set priorities for statewide, evidence-based suicide prevention in Arkansas.
The Arkansas Department of Health (ADH) Injury and Violence Prevention section implements several evidence-based programs to address the need for suicide prevention and intervention for youth 10-24 in the state. The DAABHS has worked collaboratively with ADH to facilitate the development of the state's Suicide Prevention Hotline.
One new addition to our CMHC contracts includes at least monthly outreach by each contractor in their region to provide education and information related to First Episode of Psychosis, specifically, but also about services they provide to the public, including Crisis Services.

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ○ Yes ◉ No

If so, please describe the population targeted.

None at this time.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

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

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?

PASSEs

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 Disabilites Education Act.

Arkansas continues with the process to transform our Medicaid system with a focus on enhancing services within the community, including recovery support services, as well as to ensure that individuals are receiving the appropriate level of care. An Independent Assessment evaluates functional strengths and deficits to determine whether and individual needs outpatient or intensive outpatient services within the community, or residential services. Also Crisis Stabilization Units, Peer Support, Family Support Partners, Supportive Housing, Supportive Employment, Partial Hospitalization, Adult Life Skills Development, and Aftercare Recovery Services have been established to assist with improving functioning and to divert from acute and residential settings when appropriate.

Arkansas has procured Community Mental Health Services for the first time with contracts beginning July 1, 2019. This has allowed for implementation of a more robust contract with deliverables targeting the enhancement of community-based services, including crisis systems and community education, as well as utilization of extended hours, requirement of a clinic in every county of their region, and the addition of either a Warm Line or Walk-in clinic.

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. These providers can also provide services through private insurance. 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.

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

None at this time.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse 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 SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as 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.**[69]

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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) was not directly involved in the development of the block grant. However, the ABHPAC Block Grant committee went through a lengthy analysis and review of the combined block grant application, existing block grants, and data that is included in developing the block grant.

The state of Arkansas has the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), which has the legislative mandated responsibility of "overseeing all planning, budgeting, and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement." The members of the AADACC are appointed by the Governor. The meetings are held quarterly. The Coordinating Council has a Treatment and Prevention Subcommittee that makes recommendations to the full council regarding substance abuse treatment and prevention. A representative from DAABHS chairs the Treatment and Prevention Subcommittee.

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

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. 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

3. 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 ABHPAC Council is comprised of consumers, youth, family members, providers, and representatives of state and private agencies. The council is federally mandated through PL 102-321 to review the state plans for the block grant and provide recommendations to the State; to serve as an advocate for adults with SMI, children with SED and other

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

None at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

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

Footnotes:

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.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Diana Alcorn-Payne	Family Members of Individuals in Recovery (to include family members of adults with SMI)		AR,	dianamariealcorn@gmail.com
Bridget Atkins	State Employees	Arkansas Department of Human Services, Division of Aging Adult and Behavioral Health Services	P.O. Box 1437 Little Rock AR, 72203 -1437	bridgt.atkins@dhs.arkansas.gov
Jeanne Baltz	Family Members of Individuals in Recovery (to include family members of adults with SMI)		AR,	jeannebaltz@gmail.com
Steven Blackwood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		AR,	srblackwood@gmail.com
Stephen Boren	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			borenstephen77@gmail.com
Pat Brannin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			pat_huckeby@yahoo.com
Casey Bright	Providers	Quapaw House Inc	812 Mountain Pine Road Hot Springs AR, 71913	caseybright@quapawhouseinc.org
Elizabeth Brooks	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			esuttonbrooks@gmail.com
Brittany Burgess	Providers	Branches Unite Inc	2518 S. CROSS ST Little Rock AR, 72206	bburgess@indaytrt.com
Loretta Cochran	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			lfcochran@gmail.com
Billie Denny	Family Members of Individuals in Recovery (to include family members of adults with SMI)			bjean52@yahoo.com
Linda Donovan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			lindaldonovan4945@msn.com

Kimberly Downie-Pierce	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kimberlydowniepierce@gmail.com
Rodney Farley	State Employees	Division of Developmental Disabilities Services	P.O. Box 1437 Little Rock AR,	rodney.farley@dhs.arkansas.gov
Edward French	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			french2511@gmail.com
Patricia Gann	State Employees	AR Department of Human Services, Division of Aging, Adult and Behavioral Health Services	P.O.Box 1437 Little Rock AR, 72203	patricia.gann@dhs.arkansas.gov
Erin Gildner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			erin.gildner@arkansas.gov
Carla Harper	Family Members of Individuals in Recovery (to include family members of adults with SMI)			carla.harper31@yahoo.com
Leslie Haynes	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			haylesness357@gmail.com
Tawana Hudson	Parents of children with SED/SUD			Tawnyahudson76@gmail.com
Gaye Jones-Washington	State Employees	Arkansas Rehabilitation Services	525 West Capital Little Rock AR, 72201	gaye.jones-washington@arkansas.gov
Lynn Kell	Family Members of Individuals in Recovery (to include family members of adults with SMI)			lynnjkell9@gmail.com
Elizabeth Kindall	State Employees	AR Department of Education	4 Capitol Mall Little Rock AR, 72201	elizabeth.kindall@arkansas.gov
Euphase King	Family Members of Individuals in Recovery (to include family members of adults with SMI)			euphasek@hotmail.com
Luke Kramer	Providers	The STARR Coalition	11700 Kanis Rd Little Rock AR, 72211	luke@thestarr.org
Buster Lackey	Providers	Nami Arkansas	1012 Autumn Rd Little Rock AR, 72211	buster.lackey@namiarkansas.org
Kirk Lane	State Employees	Arkansas State Police	1 State Police Plaza Drive Little Rock AR, 72209	kirk.lane@asp.arkansas.gov
Angie Lassiter	Parents of children with SED/SUD			angie.lassiter@ymail.com
DeAngleo Lee	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			leerobert1940@gmail.com
Stephanie Martin	Providers	Summit Community Care	650 S Shackleford Rd Little Rock AR, 72211	stephanie.martin@anthem.com
Scott Mashburn	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			s.mashburn@sbcglobal.net
Janis Matlock	State Employees	AR Department of Human Services, Division of Aging, Adult and Behavioral Health Services	P.O. Box 1437 Little Rock AR, 72201	janis.matlock@dhs.arkanas.gov

Nicole May	Providers	Empower Healthcare Solution	1401 West Capital Little Rock AR, 72201	nicole.may@empowerhcs.com
Alan McClain	State Employees	AR Department of Education	4 Capital mall Little Rock AR, 72201	alan.mcclain@arkansas.gov
Shawn McCowan	Providers	Nami Arkansas	1012 Autumn Rd Little Rock AR, 72211	shawn.mccown@namiarkansas.org
Shirley Morris	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			shirleymorris2016@gmail.com
Linda Nelson	Family Members of Individuals in Recovery (to include family members of adults with SMI)			lindanelson1006@gmail.com
Shanta Nunn-Baro	State Employees	North Little Rock Housing Authority	4901 Fairway, Suite A North Little Rock AR, 72116	shanta.baro@nlrha.org
Bob Parker	State Employees	AR Department of Corrections	6814 Princeton Pike Pine Bluff AR, 71602	bob.parker@arkansas.gov
Miriam Pearsall	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			mlpearsa@gmail.com
Dena Perry	State Employees	AR DHS/Division of Medical Services	P.O. Box 1437 Little Rock AR, 72201	dena.perry@dhs.arkansas.gov
Lonnie Phillips	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			coconigeria29@yahoo.com
Stephanie Pifer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			stephepifer@gmail.com
Kay Procop	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kayprocop@yahoo.com
Randall Rainwater	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			rainwaterrandal@gmail.com
Darnell Rice	Others (Advocates who are not State employees or providers)			ricedarnell7@gmail.com
Ardelia Rodgers	Providers	Centers For Youth and Families	6501 W 12th St Little Rock AR, 72204	arodgers@cfyf.org
Chad Rodgers	Providers	Arkansas Foundation for Medical Care	1020 W 4th St Little Rock AR, 72201	Crodgers@afmc.org
Georgia Rucker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			msrucker04@gmail.com
John Ryan	Providers	AR Total Care	PO Box 25010 Little Rock AR, 72221	jryan@centene.com
Brian Scott	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			brodsco67@gmail.com
Bill Shumaker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			williamshumaker@gmail.com

Kim Siebert	Parents of children with SED/SUD			kim.seibert2000@yahoo.com
Diane Skaggs	Providers	Mental Health Council of Arkansas	501 Woodlane St Little Rock AR, 72201	dskaggs@mhca.org
Angie Smith	Others (Advocates who are not State employees or providers)			Aysmith1972@gmail.com
Eddie Smith	Others (Advocates who are not State employees or providers)			cmeddie24c@gmail.com
Sherry Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			mssherry00@gmail.com
Season Sutherland	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			sunshine197544.35@gmail.com
Kelli Taylor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kelliedtaylor@yahoo.com
Ben Udochi	State Employees	Arkansas Community Correction	105 West Capital Little Rock AR, 72201	ben.udochi@arkansas.gov
Kellie VanCuren	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kellievancuren@gmail.com
Cassandra Wade	Providers			cassandrawade01@yahoo.com
Pat Warner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			patwarner1@yahoo.com
Ray Warner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			raydog1322@gmail.com
Anne Wells	State Employees	AR Division of Children and Family Services	P.O. Box 1437, Little Rock AR, 72203	anne.wells@dhs.arkansas.gov
Kim Weser	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kjsmadonna@yahoo.com
Elaine Williams	Providers			janette.williamssmith@yahoo.com
Janette Williams-Smith	Parents of children with SED/SUD			janette.williassmith@yahoo.com
Derrick Wright	State Employees	Springdale Police Department		dewright@springdalear.gov

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

1. State Education Agency - Elizabeth Kindall
2. State Vocational Rehabilitation -- Gaye Jones-Washington (Alan McClain)
3. State Criminal Justice - Ben Udochi
4. State Social Services Agency - Anne Wells
5. State Mental Health Agency - Janis Matlock, Bridget Atkins, Patricia Gann

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**69**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	28	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	7	
Parents of children with SED/SUD*	4	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**42**	**60.87%**
State Employees	14	
Providers	13	
Vacancies	0	
Total State Employees & Providers	**27**	**39.13%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

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:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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Footnotes: