



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

TO: Interested Parties

FROM: Rachael Veregge, Policy & Research Analysis Manager

DATE: July 30, 2021

RE: Public Comment Period

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Attached is the Federal Fiscal Year 2022 Combined Substance Abuse and Mental Health Block Grant Behavioral Health Assessment and Plan application for the Division of Aging, Adult and Behavioral Health Services.

The public comment period for this grant application is August 1, 2021 through August 15, 2021.

Copies of the application can be found on our website:

<https://humanservices.arkansas.gov/divisions-shared-services/aging-adult-behavioral-health-services/reports-publications/>

Please forward all comments regarding this application to Rachael Veregge via email to

[Rachael.Veregge@dhs.arkansas.gov](mailto:Rachael.Veregge@dhs.arkansas.gov).

# Arkansas

## UNIFORM APPLICATION

FY 2022/2023 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 07/30/2021 3.25.12 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 2022

End Year 2023

#### 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 PO Box 1437 Slot W-241

City Little Rock

Zip Code 72203-1437

Telephone 501-686-9981

Fax 501-686-9182

Email Address kirk.lane@asp.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 Health Services

Mailing Address PO Box 1437 Slot W-241  
City Little Rock  
Zip Code 72203-1437  
Telephone 501-686-9981  
Fax 501-686-9182  
Email Address jay.hill@dhs.arkansas.gov

### III. Third Party Administrator of Mental Health Services

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

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

### V. Date Submitted

Submission Date

Revision Date

### VI. Contact Person Responsible for Application Submission

First Name Rachael

Last Name Veregge

Telephone 5013206431

Fax

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 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
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Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
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Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## 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 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<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>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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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.
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- to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
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  13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
  14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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  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>
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### 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<sup>1</sup>: Jay Hill

Title: Division Director, DAABHS

Date Signed: 07/16/2021  
mm/dd/yyyy

<sup>1</sup>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:**





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

December 7, 2020

Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane, Rm. 17E20  
Rockville, MD 20857

RE: Designation of SSA

To Whom It May Concern,

The Governor of the State of Arkansas, Asa Hutchinson, has previously designated the Division of Aging, Adult and Behavioral Health Services as the state authority for mental health and substance abuse services. See attached letter from Governor Hutchinson.

As the Director of the Division of Aging, Adult and Behavioral Health Services, I delegate authority to the current State Drug Director, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

A handwritten signature in blue ink, appearing to read "Jay Hill", with a small blue arrow pointing to the right above the signature.

Jay Hill



**STATE OF ARKANSAS**

ASA HUTCHINSON  
GOVERNOR

August 1, 2017

Jay Hill  
Director  
Division of Aging, Adult and Behavioral Health Services  
Arkansas Department of Human Services  
305 South Palm Street  
Little Rock, AR 72205

RE: Designation of Authority

Dear Mr. Hill:

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

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

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Asa Hutchinson", is written over a horizontal line.

Asa Hutchinson

cc: Cindy Gillespie, DHS Director

## State Information

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

#### Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
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.
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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.
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- 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.
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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<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

**Footnotes:**



**STATE OF ARKANSAS**

ASA HUTCHINSON  
GOVERNOR

August 1, 2017

Jay Hill  
Director  
Division of Aging, Adult and Behavioral Health Services  
Arkansas Department of Human Services  
305 South Palm Street  
Little Rock, AR 72205

RE: Designation of Authority

Dear Mr. Hill:

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

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

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Asa Hutchinson", is written over a horizontal line.

Asa Hutchinson

cc: Cindy Gillespie, DHS Director

## State Information

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

#### Fiscal Year 2022

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

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

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 Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to



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

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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.
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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: Jany Hill

Signature of CEO or Designee<sup>1</sup>: Jany Hill

Title: Division Director, DAABHS Date Signed: 07/16/2021  
mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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**Footnotes:**

# **American Rescue Plan Act (ARPA)**

## ***Supplemental Funding Proposal for***

### ***Arkansas Mental Health Block Grant Program***

Total amount of funding: \$12,487,030.00

Arkansas is appreciative of the additional ARPA funding from SAMHSA and would like to use the majority of the available funding to focus on supporting development of a comprehensive **behavioral health crisis continuum**. While portions of this crisis system exist currently, there are many gaps in the continuum and areas of the state where the crisis system is very scarce in resources. The rural nature of Arkansas and a workforce shortage throughout much of the state impacts the consistency and comprehensiveness of services throughout the state. In order to address the multi-factorial issues, the plan encompasses a wide range of activities to develop the workforce, identify existing resources, provide state-wide resource coordination, assure quality adherence to standards, and promote ease of access to services.

#### **Gaps identified include:**

- Inadequate pool of Peer Recovery Specialists
- Lack of focused, specialized training in service areas such as crisis, courts, etc.
- Lack of coordinated, state-wide consistency in use of peer services
- Lack of coordinated, state-wide training of providers in appropriate use of peer services
- Inadequate coordination of services and resources within and between agencies to include coordination with 988 implementation planning, existing support lines and crisis lines, housing opportunities, employment opportunities, social services, healthcare, and EMS
- Lack of immediate access to services in many parts of the state

#### **Solutions to address identified gaps:**

- Support workforce development of Peer Recovery Specialists by providing funding for training, certification, supervision, testing fees including recruiting from underserved areas of the state.
- Support crisis services in rural/underserved areas of the state by providing funding for Peer Recovery support teams to respond to individuals seeking crisis services and to contact individuals prior to reaching crisis levels by their service in court rooms, jails, child welfare settings and hospitals.
- Fund employment of an American Sign Language mental health interpreter and Spanish interpreter (or contract for services) to provide full access to crisis services including conception and implementation of programs.
- Provide consistent coordination between 988 implementation, community resource identification, coordination within and outside of department for

resource identification, disseminate updated information to 988 and mental health support lines.

- Develop and implement informational outreach to assure all Arkansans, particularly the SMI and SED populations, know how and where to access behavioral health services.
- Fund trainers and provide scholarships on Evidence Based Practices from nationally recognized speakers related to trauma focused care and first episode psychosis recognition and treatment.
- Provide scholarships for a wide variety of Arkansans to learn Mental Health First Aid to enhance ability to recognize and respond to mental health needs.
- Develop and implement a pilot program using evidence-based practices for FEP and EMSI individuals.
- Incorporate peers into the mental health and substance abuse informational line and 988 to follow up after any crisis contacts to improve likelihood of follow up with treatment and/or community resources. Follow up for 6 months post crisis.
- Fund position within NAADAC, the Association for Addiction Professionals, to assist in the certification, training and tracking of Peer Recovery Specialists.
- Fund position to coordinate training of EBP trauma programs and monitor pilot FEP program.

<b>Area to be developed, enhanced, improved</b>	<b>Identified Gap</b>	<b>Project</b>	<b>Purpose</b>	<b>Estimated Costs</b>
<b>Crisis Continuum Services</b>	<p>The crisis continuum in Arkansas is lacking some key components including:</p> <ul style="list-style-type: none"> <li>• adequate pool of Peer Specialists</li> <li>• inadequate training &amp; supervision for specialty crisis services by Peers</li> <li>• poor resource coordination between 988, various crisis hotlines, healthcare, housing and EMS</li> </ul>	<p>Expand access to Peer services to align with national recommendations for a robust crisis response system</p> <p>Provide funding and supervision of peers employed in clinical, judicial, correctional, law enforcement and child welfare settings</p> <p>Utilize peers to provide coordination between services and to provide a connection for those seeking behavioral health services</p>	<p>To evaluate, develop and enhance the key components of a continuum of services for Arkansans to access services in a timely and effective manner; anywhere, anytime, for anyone.</p>	<b>\$5,500,000.00</b>

<b>Area to be developed, enhanced, improved</b>	<b>Identified Gap</b>	<b>Project</b>	<b>Purpose</b>	<b>Estimated Costs</b>
<b>Crisis Continuum Services continued</b>	<ul style="list-style-type: none"> <li>limited availability of ASL interpreter for deaf mental health services and for Spanish speaking individuals</li> </ul>	Fund ASL interpreter for deaf mental health team  Expand access to interpreter services to respond to, and prevent, crisis situations.	To evaluate, develop and enhance the key components of a continuum of services for Arkansans to access services in a timely and effective manner; anywhere, anytime, for anyone.	<b>\$480,000.00</b>
	<ul style="list-style-type: none"> <li>Many residents are unsure of where and how to obtain behavioral health services</li> </ul>	Informational outreach and development of portal for updated treatment providers and community supports		<b>\$2,000,000.00</b>
<b>Enhance evidence-based practice</b>	Arkansas lacks a sufficient base of professional clinical staff trained in evidence-based practices, particularly trauma focused care.  Many Arkansans working with the public have little to no knowledge of mental health needs and how to handle and refer an individual in mental health crisis	Contract with nationally recognized EBP training providers to provide scholarships to training and fidelity checks.  Mental Health First Aid	To provide fidelity-based, evidence-based training to improve effectiveness and consistency of quality treatment across the state.	<b>\$1,000,000.00</b>
<b>Pilot Program FEP ESMI</b>	Arkansas lags behind other states in reaching, identifying and providing EBP services to FEP, ESMI individuals	Develop and implement Pilot program with EPB for FEP, ESMI individuals.	Comprehensive identification and treatment of individuals experiencing a first episode psychosis and/or early signs of serious mental illness  FEP set-aside of 10%	<b>\$1,248,000.00</b>

<b>Area to be developed, enhanced, improved</b>	<b>Identified Gap</b>	<b>Project</b>	<b>Purpose</b>	<b>Estimated Costs</b>
<b>Crisis set-aside 5%</b>	Lack of follow-up with services post crisis	Develop and implement program for peers to be incorporated into mental health/substance abuse informational line as a warm line and follow up after crisis contacts for 6 months  Fund position at NAADAC to oversee peer certification	To assure continued connection and increase likelihood of follow-up with services following crisis situations	<b>\$1,288,679.00</b>
<b>Admin support</b>		Administrative Costs  Fund 3 positions within DAABHS to oversee ARPA programs	5% set-aside	<b>\$970,351.00</b>
			<b>Total</b>	<b>\$12,487,030.00</b>

# State Information

## Disclosure of Lobbying Activities

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

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

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Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

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Signature:	Date:
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<b>Footnotes:</b>
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## 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 of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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#### Footnotes:

NOT FINAL

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

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

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

The provision of block grant funded substance abuse services is facilitated agreements with seven (7) substance abuse treatment providers and thirteen (13) prevention providers covering the state. The DAABHS fulfills its responsibility for the provision of public mental health services by operating a 220-bed psychiatric facility, the Arkansas State Hospital (ASH), and a 290-bed skilled nursing facility, the Arkansas Health Center (AHC), utilizing state general revenue, Medicaid, and other local funding streams. The provision of block grant funded mental health services is facilitated through contracting services with twelve (12) local, private, nonprofit Community Mental Health Centers (CMHCs). For those persons without any insurance coverage, basic counseling level services are funded with state general revenue dollars through twenty-six (26) contractors across the state to ensure easy and quick access. Each contracted provider of behavioral health services is expected to assess the diversity of their region and population served. Based on this self-assessment, providers are expected to assure that staff are trained on the specific treatment needs, cultural and ethnic differences, and disparities within their community while providing behavioral health services to fill in the gaps not covered by the Outpatient Behavioral Health Services (OBHS) program operated by the Division of Medical Services (DMS), the state Medicaid Authority, a division within DHS.

### Background on Behavioral Health Services in Arkansas

Arkansas Act 433 of 1971 authorized the creation of a Division of Mental Health (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, crisis intervention and stabilization along with supportive services including supportive housing, supportive work, and behavioral health care. The CMHC was the designated leader to ensure these individuals have the community resources, including social resources, to feel secure and



safe in the community. These community resources include local acute hospitalization for indigent adults who need psychiatric hospitalization.

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 13 CMHCs and over 351 behavioral health agencies and 498 independently licensed practitioners certified Medicaid mental and behavioral health providers serving Arkansas Medicaid members. In 2017 special language was removed from Arkansas statutes 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 have been the focus of the mental health block grant funds in past years. Further, the DAABHS contracted providers must ensure they utilize contracted funds as the payor of last resort and to assist its clients to enroll in the healthcare coverage programs for which the client may be eligible.

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

DAABHS provides funding for the purchase of local acute care (psychiatric) 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 contracted CMHCs to deliver services to individuals that are Seriously Mental Ill or Seriously Mentally Ill with co-occurring substance abuse disorders, and who are

homeless or at imminent risk of becoming homeless. There are currently three (3) CMHCs providing PATH services which include outreach, housing match services, assessment, and assistance with SSI/SSDI application.

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

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

In 2019, DAABHS implemented new contracts funded solely by state general revenue. The Therapeutic Counseling Services contracts ensure rapid access to basic level counseling services (an initial mental health evaluation/diagnosis, individual, group, family, multi-family, and psychoeducation services). Twenty-six (26) providers ensure coverage across all seventy-five counties. These contracts only cover persons without health insurance coverage for these services if they are medically necessary.

#### Substance Abuse Prevention and Treatment Background

DAABHS is responsible for administering a comprehensive and coordinated program for the prevention and treatment of alcohol and drug abuse in Arkansas. As the Single State Authority, DAABHS distributes federal funds from the Substance Abuse Prevention and Treatment Block Grant (SABG). DAABHS provides oversight for 215 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 Planning. 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.

NOT FINAL

## 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 of care 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 of care.

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, SUD prevention, and SUD treatment goals at the state level.

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#### Footnotes:

NOT FINAL

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

The US Census Bureau reports that as of July 1, 2019 the population of Arkansas is estimated to be 3,017,804. Of the 75 counties in Arkansas, 55 are considered rural. Children in Arkansas, those 18 years of age and younger, comprise 23.2% of the state's population while the those 65 and older, comprise 17.4% 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 (79.0%). 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 23.0% had received a bachelor's degree or higher. The median household income was \$47,597 from 2015-2019. The percentage of Arkansans living below the poverty level in 2019 was 16.2%, compared to 10.5% for the United States.<sup>1</sup>

Arkansas ranks 48 in the United State in overall health. The health of women and children in Arkansas rank 49<sup>th</sup> and seniors rank 45<sup>th</sup> in the nation. Since 2018, obesity increased 6% from 35.0% to 37.1%; diabetes increased 14% from 12.2% to 13.9%; infant mortality increased 4% from 7.8 to 8.1; children in poverty increased 4% from 23.8 to 24.7%; the incidence of suicide increased 14% from 187 to 21.3%.<sup>2</sup> 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 2019, heart disease, cancer, chronic lower respiratory disease, stroke and accidents are the top five causes of death in Arkansas, which can be exacerbated by alcohol, tobacco, and other substances.

The 2020 Arkansas State Epidemiological Outcomes Workgroup's Annual Profile of Substance Use<sup>3</sup> provides a report on substance abuse in Arkansas prepared by the University of Arkansas for Medical Sciences (UAMS) for the Arkansas Department of Human Services, Division of Aging, Adult and Behavioral Health Services to provide a demographic breakdown of population, education, economy and health to highlight the past successes and areas of focus for the future. Findings from this report are summarized as follows:

### Alcohol

- The prevalence of current alcohol use among Arkansas 8th, 10th and 12th graders was slightly less than that among US youth in 2019 Tobacco
- The percentage of youth reporting current alcohol use ranged from 4.0% (Region 13: Chicot County) to 17.2% (Region 12: Arkansas County)
- Reported alcohol use appears to be highest in the central-eastern (Arkansas, Prairie and Cleveland Counties) and southwestern (Little River County) parts of the state
- Reported alcohol use was also more prevalent in northern, western and south-central counties than northwest, eastern and southwest-central counties

These data suggest that many regions – the majority of which are more rural – have more problematic alcohol use than other parts of the state should consider more focused or intensive alcohol use prevention strategies.

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<sup>1</sup> U.S. Census Bureau. Quick Facts: Arkansas. <https://www.census.gov/quickfacts/AR>. Accessed March 26, 2021.

<sup>2</sup> American's Health Rankings. 2019 Annual Report, State Summary: Arkansas. <https://assets.americashealthrankings.org/app/uploads/arkansas-health-summary-2019.pdf> Accessed March 26, 2021.

<sup>3</sup>Arkansas State Epidemiological Outcomes Workgroup Annual Profile of Substance Use <https://drive.google.com/file/d/1OudTx79G6xzQ47JE6HQeX9QYw0Y9TR98/view>, Accessed March 26, 2021.

### Cigarettes

- The prevalence of current cigarette use among Arkansas 8th, 10th and 12th graders was slightly more than that among US youth in 2019
- The percentage of youth reporting past 30-day cigarette use ranged from 2 0% (Region 7: St Frances County) to 10 3% (Region 13: Chicot County)
- Reported cigarette use appears to be highest in the north-central part of the state (Regions 2 and 3)
- Reported cigarette use was also more prevalent in central northern, central eastern and certain southern and western counties than in other areas of the state

These data suggest that many regions – the majority of which are more rural – have more problematic alcohol use than other parts of the state should consider more focused or intensive alcohol use prevention strategies.

### Smokeless Tobacco

- The prevalence of current smokeless tobacco use among Arkansas 10th and 12th graders, but not 8th graders, was slightly greater than that among their US counterparts in 2019.
- The percentage of youth reporting past 30-day smokeless tobacco use ranged from 1 3% (Region 7: Lee County) to 10 0% (Region 3: Izaard County)
- The concentration of higher smokeless tobacco use appears to be greatest in the north-central part of the state (Regions 2, 3 and 4)
- Reported smokeless tobacco use was also more prevalent in certain northern, western and southeastern counties than the rest of the state

These data suggest that several regions – many of which are more rural – have more problematic smokeless tobacco use than other parts of the state should consider more focused or intensive smokeless tobacco use prevention strategies.

### Marijuana

- The prevalence of current marijuana use among Arkansas 8th, 10th and 12th graders was less than that among US youth in 2019 Opioids
- The percentage of youth reporting past 30-day marijuana use ranged from 1 6% (Region 11: Columbia County) to 9 7% (Region 5: Sebastian County)
- Marijuana use appears most prevalent in the central and central eastern (Regions 7, 9 and 12) and west and southwestern parts of the state (Regions 5 and 10)
- At the same time, prevalence of marijuana use was also higher than the midpoint of the range (4 0%) in the northwest and certain northern counties (Regions 1, 2 and 3) and at least one county in every region indicated marijuana use prevalence above the median

These data suggest that marijuana use is prevalent throughout the state. These data suggest that statewide marijuana use prevention efforts are needed, with additional intensity in regions where marijuana use is more prevalent.

### Prescription Drugs

- 2019 data regarding the prevalence of current prescription drug use among Arkansas 8th, 10<sup>th</sup> and 12th graders relative to US youth are not available, although lifetime misuse of prescription pain medicine among Arkansas high school students was reportedly higher than among US youth (YRBSS, 2019).
- The percentage of youth reporting past 30-day prescription use ranged from 0 0% (Region 7: Lee County) to 3 8% (Region 3: Woodruff County)
- Although prescription drug use prevalence is greatest in the northeastern part of the state (e g , Regions 3 and 4), the vast majority of counties report a prescription drug use prevalence above the midpoint in the range (1 6%), particularly in central (Regions 6, 9, 12), western (Regions 5 and 10) and southern (Region 11) parts of the state
- Few counties reported prescription drug use prevalence below 1 6% and these were mainly in the western-southern part of the state (Regions 5, 8 and 12)

These data suggest that, while the prevalence of prescription drug use itself is relatively low, greater prevalence of use is widely distributed across the state. These findings also suggest statewide prescription drug use prevention efforts should continue, with more intensive efforts in northeastern regions of the state.

### Heroin

- In 2019, Arkansas high school students ranked 5th in the US for lifetime heroin use, with 4 7% of Arkansas students reporting lifetime heroin use versus 1 8% nationally (YRBSS, 2019)
- The prevalence of current heroin use among Arkansas 10th and 12th graders, but not 8th graders, was slightly greater than that among their US counterparts
- The percentage of youth reporting past 30-day heroin ranged from 0 0% in 14 counties scattered in the north, southwestern and central eastern parts of the state to 0 6% (Region 5: Crawford County and Region 13: Desha County)
- Only about 12 counties reported heroin use above the midpoint in the range (2 0%) and these appear to be near state borders on all sides
- Most counties reported current heroin use prevalence below 0 2%

These data suggest that, while the prevalence of current heroin use itself is relatively low across most of the state, pockets of greater prevalence of use is observed in typically rural counties. These findings suggest heroin use prevention efforts should focus on those affected counties.

The Annual SEOW report also provides information on perception of risk or harm associated with drug druse. This perception has been found to be a key factor against drug use.

### Perceived Moderate or Great Risk of Daily Alcohol Use

- The percentage of Arkansas youth perceiving at least moderate risk of daily alcohol use ranged from 42 1% (Region 7: Lee County) to 74 8% (Region 6: Pope County)
- The vast majority of counties showed that over 58 5% of youth perceived at least moderate risk of daily alcohol use
- Counties with less than 58 5% of youth perceiving at least moderate risk of daily alcohol use are along the eastern border of the state (Regions 7 and 13) and one county in Region 11



Although these data show that in most counties a majority of youth perceive at least moderate risk of daily alcohol use, there is still room for improvement. In addition, these findings suggest that more intensive efforts to help change perceptions of daily alcohol use-associated harm among youth in Regions 7, 11, and 13 are warranted.

#### Perceived Moderate or Great Risk of Smoking

- The percentage of Arkansas youth who perceive at least moderate risk of smoking ranged from 46.4% (Region 7: Lee County) to 87.9% (Region 6: Pope County)
- In the vast majority of counties, over 68.6% of youth perceived at least moderate risk of smoking
- Counties in which fewer than 68.6% of youth perceived at least moderate risk of daily alcohol use are along the eastern border of the state (Regions 7 and 13)

These data suggest that, while the vast number of counties show that more than two-thirds of youth perceive at least moderate risk of smoking, there is still room for improvement. More intensive efforts to help change perceptions of daily alcohol use-associated harm among youth in Regions 7 and 13 are warranted.

#### Perceived Moderate or Great Risk of Trying Marijuana Once or Twice

- The percentage of Arkansas youth perceiving at least moderate risk of trying marijuana once or twice ranged from 29.1% (Region 7: Lee and St. Francis Counties) to 55.7% (Region 3: Fulton County)
- In the majority of counties, between 44.4% and 55.7% of youth perceived at least moderate risk of trying marijuana once or twice
- Counties with less than 44.4% of youth perceiving at least moderate risk of trying marijuana once or twice are located along the eastern border of the state (Regions 3, 4, 7 and 13) as well as central (Regions 8 and 9), south central (Region 12), and southeastern (Regions 10 and 11)

These data suggest that perception of marijuana-associated harms is relatively low overall, indicating that statewide prevention programs focused on educating youth on the dangers of marijuana use need to continue. In addition, these findings indicate that more intensive efforts may be needed in select regions, particularly in those along the eastern border of the state, are warranted.

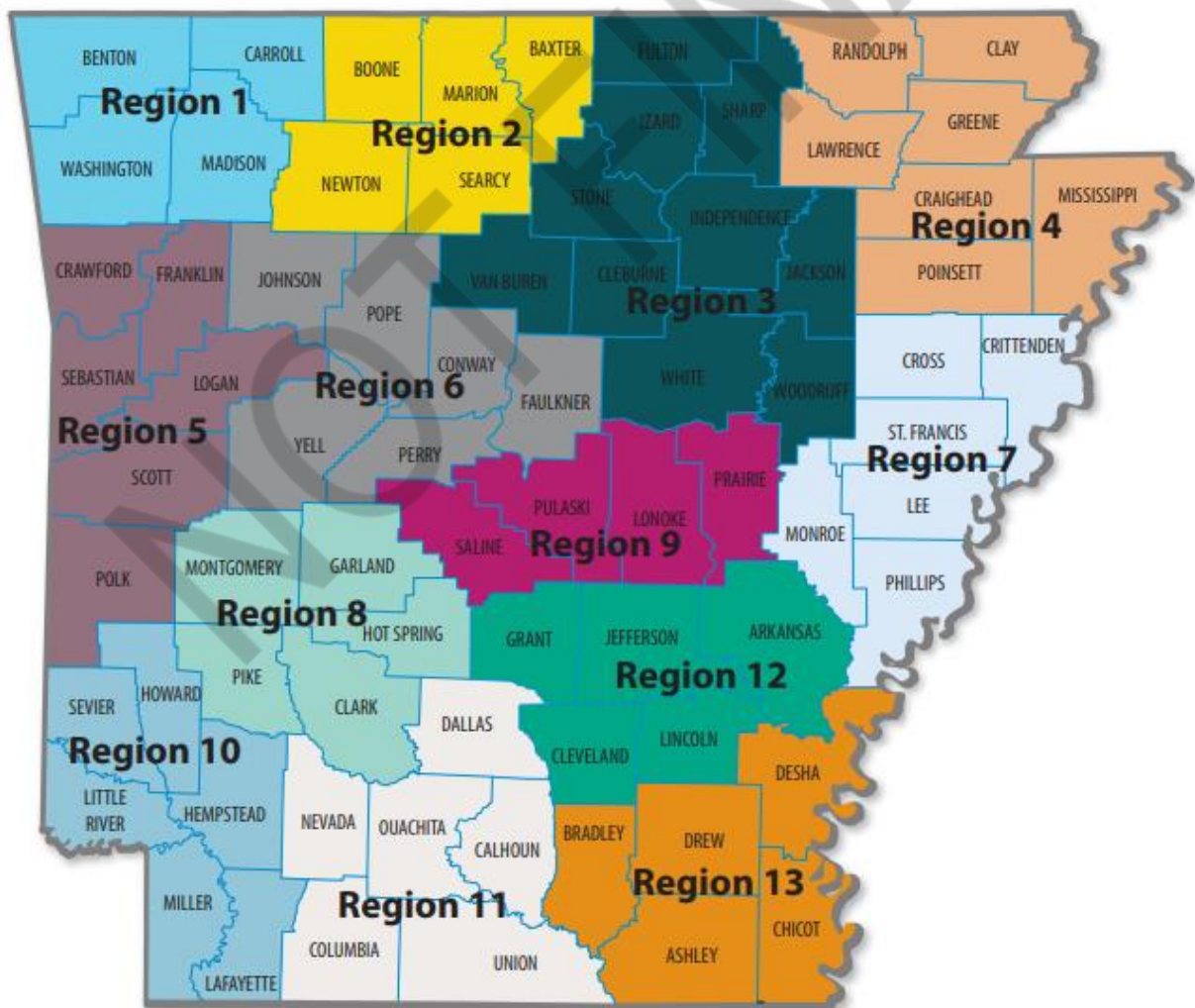
#### Perceived Moderate or Great Risk of Trying Prescription Drugs Once or Twice

- The percentage of Arkansas youth perceiving at least moderate risk of trying prescription drugs once or twice ranged from 47.4% (Region 7: Lee County) to 90.3% (Region 5: Franklin County)
- The majority of counties had over 68.8% of youth who perceived at least moderate risk of trying prescription drugs
- Counties in which less than 68.8% of youth perceived at least moderate risk of trying prescription drugs are along the eastern border of the state (Regions 7 and 13)

While the majority of counties had more than two-thirds of youth perceive at least moderate risk of trying prescription drugs, there is still room for improvement. More intensive efforts to change perceptions of prescription-drug-use-associated harm among youth in Regions 7 and 13 are warranted.

Arkansas is divided into 13 regions as listed below:

<b>Region 1</b>	Stone	Sebastian	Montgomery	Nevada
Benton	Van Buren	<b>Region 6</b>	Pike	Ouachita
Carroll	White	Conway	<b>Region 9</b>	Union
Madison	Woodruff	Faulkner	Lonoke	<b>Region 12</b>
Washington	<b>Region 4</b>	Johnson	Prairie	Arkansas
<b>Region 2</b>	Clay	Perry	Pulaski	Cleveland
Baxter	Craighead	Pope	Saline	Grant
Boone	Greene	<b>Region 7</b>	<b>Region 10</b>	Jefferson
Marion	Lawrence	Crittenden	Hempstead	Lincoln
Newton	Mississippi	Cross	Howard	<b>Region 13</b>
Searcy	Poinsett	Lee	Lafayette	Ashley
<b>Region 3</b>	Randolph	Monroe	Little River	Bradley
Cleburne	<b>Region 5</b>	Phillips	Miller	Chicot
Fulton	Crawford	St Francis	Sevier	Desha
Independence	Franklin	<b>Region 8</b>	<b>Region 11</b>	Drew
Izard	Logan	Clark	Calhoun	
Jackson	Polk	Garland	Columbia	
Sharp	Scott	Hot Spring	Dallas	



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

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

- Transitional services for youth entering adulthood
- Focus on special populations such as LGBTQ, aging and the military.
- To address the need for statewide crisis services, contracts with CMHCs now require a clinic site in each of Arkansas' 75 counties. Additionally, a requirement of the PASSE are statewide mobile crisis units.
- To address access to services for those individuals who live in rural areas, the contract in place with all CMHCs require each to offer telemedicine to clients as needed beginning July 1, 2017, along with the requirement of clinics in every county of their coverage area.
- Arkansas continues to address behavioral health services within the criminal justice system for adults. With the implementation of Act 423, the Criminal Justice Efficiency and Safety Act of 2017, Arkansas now has over provided crisis intervention training to over 400 police officers. Crisis Stabilization Units are in place as a jail diversion option. DAABH receives referrals from the court system from prosecuting attorneys and defense attorneys via the treatment referral report.
- Incorporating multiple data systems that do not interface with one another and cross multiple Divisions within DHS.

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

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

- Another area of concern is the small number of clinicians trained in the evidence based FEP models. While Arkansas has in the past trained clinicians in these models, many have retired, moved, or changed their practice leaving only a minimal workforce with these skills. Additional training will move the state closer to implementing a full, Coordinated Specialty Care model to fidelity.
- **Access** – COVID-19 restrictions have significantly impacted the ability of Arkansas to provide appropriate services in an appropriate setting for forensic clients who have failed restoration efforts. Currently these clients have few choices between the highest level of care (inpatient, State Hospital) to a low level of care such as outpatient services with few controls deemed necessary to ensure client and community safety. Since COVID has caused hospitals and many other programs to cease taking admissions and delay discharges, these options have become even more limited. Many of the failed restoration clients are identified as SMI and require significant community resources. Arkansas needs additional treatment options to address the continued needs of the failed restoration population which will also free up some of the acute care and state hospital beds for those in behavioral health crisis.
- The COVID-19 pandemic and resultant isolation of children from resources that would typically recognize early signs of abuse/neglect have produced more incidences of child trauma. Arkansas has limited resources to receive and evaluate these children and families. One such entity is a network of Child Advocacy Centers who are at risk of becoming overwhelmed with heightened numbers of children and families requiring assistance. The Children’s Advocacy Centers of Arkansas provides help for victims and families at no charge to the family. The vast majority, if not all, of the children served through these centers would meet SED criteria.
- **Crisis Continuum Development** – many SMI/SED residents of Arkansas have their first interactions during a behavioral health crisis with personnel outside of the behavioral health system such as EMS, fire department volunteers, county sheriff’s department deputies, etc. We propose to offer funding for 3-4 non-profit behavioral health providers to assess the types of first responders most often activated in their area, fund the development of crisis intervention teams comprised of a medical personnel (EMT/nurse) and a behavioral health peer and/or paraprofessional well-trained in crisis intervention and assessment to respond in person to non-life-threatening situations to provide crisis intervention, referral and warm hand-off to needed services. A part of this system would be to provide tablets or real-time video equipment to access behavioral health professionals as needed for assessment and/or consultation. A component of program evaluation would be established to review the success in responding appropriately, providing needed services, and averting locked, higher levels of care than needed. Utilizing this data, additional areas of the state could be incorporated into the program through cost sharing of savings and/or fee-for-service programs.



# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1

**Priority Area:** Substance Abuse Prevention

**Priority Type:** SAP

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

**Goal of the priority area:**

Goal 1: 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.

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

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.

GOAL 4: Evaluate Arkansas' substance abuse prevention system.

**Strategies to attain the goal:**

1. Disseminate information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on how alcohol affects 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.
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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 2019 = 9.7%

**First-year target/outcome measurement:** SFY 2021 = 9.0%

**Second-year target/outcome measurement:** SFY 2023 = 8.8%

**Data Source:**

Arkansas Prevention Needs Assessment (APNA) Survey  
Description of

**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.

<b>Indicator #:</b>	2
<b>Indicator:</b>	Lower the reported 30 day cigarette usage rate among middle and high school students
<b>Baseline Measurement:</b>	SFY 2019 = 3.3%
<b>First-year target/outcome measurement:</b>	SFY 2021 = 3.2%
<b>Second-year target/outcome measurement:</b>	SFY 2023 = 3.1%

**Data Source:**

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**Indicator #:** 3

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

**Baseline Measurement:** SFY 2019 = 3.1%

**First-year target/outcome measurement:** SFY 2021 = 3.0%

**Second-year target/outcome measurement:** SFY 2023 = 2.9%

**Data Source:**

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**Indicator #:** 4

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

**Baseline Measurement:** SFY 2019 = 24.7%

**First-year target/outcome measurement:** SFY 2021 = 22.8%

**Second-year target/outcome measurement:** SFY 2023 = 21%

**Data Source:**

Arkansas Prevention Needs Assessment (APNA) survey

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**Indicator #:**

5

**Indicator:**

Lower the reported 30 day e-cigarette usage among middle and high school students

**Baseline Measurement:**

SFY 2019 = 11.1%

**First-year target/outcome measurement:**

SFY 2021 = 11%

**Second-year target/outcome measurement:**

SFY 2023 = 10.8%

**Data Source:**

Arkansas Prevention Needs Assessment (APNA) Survey

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<b>Indicator #:</b>	6
<b>Indicator:</b>	Lower the reported 30 day rate for misuse of prescription drugs
<b>Baseline Measurement:</b>	SFY 2019 = 2.3%
<b>First-year target/outcome measurement:</b>	SFY 2021 = 2.2%
<b>Second-year target/outcome measurement:</b>	SFY 2023 = 2.1%

**Data Source:**

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**Indicator #:** 7

**Indicator:** Sustain or lower the reported 30 day methamphetamine usage among middle and high school students

**Baseline Measurement:** SFY 2019 = 0.2%

**First-year target/outcome measurement:** SFY 2021 = 0.1%

**Second-year target/outcome measurement:** SFY 2023 = 0.1%

**Data Source:**

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**Indicator #:** 8

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

**Baseline Measurement:** SFY 2019 = 44.2%

**First-year target/outcome measurement:** SFY 2021 = 45.6%

**Second-year target/outcome measurement:** SFY 2023 = 47%

**Data Source:**

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**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 #:** 9

**Indicator:** Gather past 2-week binge drinking rate among college students

**Baseline Measurement:** Establish baseline data

**First-year target/outcome measurement:** reduce baseline data by 3%

**Second-year target/outcome measurement:** reduce baseline data by 5%

**Data Source:**

Collegiate Substance Abuse Assessment Survey

**Description of Data:**

Developed & implemented by UALR SRC starting SFY 2021.

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

Potential data issues could include lack of participation in the survey, data loss, skewed data due to the composition of the sample population

**Indicator #:** 10

**Indicator:** Lower the rate of intentional overdose deaths from drugs

**Baseline Measurement:** 2019 = 7%

**First-year target/outcome measurement:** 2021 = 6.5%

**Second-year target/outcome measurement:** 2023 = 6%

**Data Source:**

Arkansas Opioid Response Dashboard

**Description of Data:**

This Dashboard was created by the AFMC with data sourced from the Arkansas Department of Health. The data measures crude rate per 100,000 of opioid related deaths in each Arkansas county

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

Data issues could include small opioid overdose death rates being reported, with some counties reporting zero deaths. Basing opioid abuse prevention efforts on this measure may lead to inaccuracies.

**Indicator #:** 11

**Indicator:** Lower the rate of All Drug Overdose Death Rates

**Baseline Measurement:** 2018 = 14.3%

**First-year target/outcome measurement:** 2021 = 13%

**Second-year target/outcome measurement:** 2023 = 12%

**Data Source:**

Arkansas Opioid Response Dashboard

**Description of Data:**

Dashboard created by the AFMC with data sourced from the Arkansas Department of Health.

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

The data measures crude rate per 100,000 of drug overdose related deaths in each Arkansas county. Data issues could include small drug overdose death rates being reported, with some counties reporting zero deaths. Basing drug abuse prevention efforts on this measure may lead to inaccuracies.

**Priority #:** 2

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

**Priority Type:** SAT

**Population(s):** PWWD, PWID

**Goal of the priority area:**

Increase state capacity to provide SUD treatment in Arkansas

**Strategies to attain the goal:**

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 Counselor

**Baseline Measurement:** 38

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

**Second-year target/outcome measurement:** 5% increase from baseline 5% increase from baseline baseline5%

**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

**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 and Drug Counselor

**Baseline Measurement:** 8

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

**Second-year target/outcome measurement:** baseline 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

**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:** 8

**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

**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, PWID, Other (Rural)

**Goal of the priority area:**

Maintain or expand access to SUD treatment programs in Arkansas

**Strategies to attain the goal:**

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 programs offered through state licensed providers. licensed providers.

**Baseline Measurement:** 14,799

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

**Second-year target/outcome measurement:** baseline3% 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 . 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 citizen of Arkansas.

**Strategies to attain the goal:**

Develop and implement evidenced based programs to expand and improve our continuum of care for SED/SMI populations.

#### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Increase the number of Peer Support Specialists certified in Arkansas.

**Baseline Measurement:** establish baseline

**First-year target/outcome measurement:** 20% increase from baseline

**Second-year target/outcome measurement:** 50% increase from baseline

**Data Source:**

NAADAC reporting via Oak Tree database

**Description of Data:**

Oak Tree database is an electronic system which tracks and manages applications, training hours, and supervision hours.

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

none identified at this time.

**Indicator #:** 2

**Indicator:** Develop and implement 3-4 pilot programs to improve Crisis Services via using training teams to ensure same day/next day access. (CASH Act funding source)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Implement 2 pilot programs within the first year.

**Second-year target/outcome measurement:** Implement 2 additional pilot programs within the second year.

**Data Source:**

Report mechanism will be developed to track staff training, crisis calls and outreach efforts. Fidelity tool will be selected based on model chosen to implement. Number of individual accessing same day services, next day services, or not meeting goal of same day/next day services and why.

**Description of Data:**

Report will be developed to track staff training, outreach efforts and recruitment, and discharge data.

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

None

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**Indicator #:** 3

**Indicator:** Develop and implement 1 pilot programs to improve identification of persons experiencing a first episode of psychosis and ensure quality treatment services are provided via an evidence-based model. (Using American Rescue Act funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Pilot program recipient will be identified, 50% of the staff will undergo FEP specific training, and outreach efforts will identify at least 20 individuals appropriate for this pilot program.

**Second-year target/outcome measurement:** Additional staff will be trained, outreach efforts will identify at least 15 new individuals appropriate for this pilot program, and fidelity of program elements will be monitored.

**Data Source:**

Report mechanism will be developed to track staff training, outreach efforts and recruitment. Fidelity tool will be selected based on model chosen to implement. Number of participants completing the program and discharging to lower or higher level of care.

**Description of Data:**

Report will be developed to track staff training, outreach efforts and recruitment, and discharge data.

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

none at this time.

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**Indicator #:** 4

**Indicator:** Develop state-wide media campaign for Crisis Services and FEP services to reflect the "someone to call, someone to talk to, and somewhere to go" philosophy. (Using American Rescue Act funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** 50% saturation of the state

**Second-year target/outcome measurement:** 100% saturation of the state

**Data Source:**

Contractor will report reach in each media platform.

**Description of Data:**

Number of website hits, time spent on website, social media follows and reposts, reactions. For print media, circulation. For billboards, traffic patterns.

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

none at this time.

**Priority #:** 5

**Priority Area:** Training Needs for Mental Health Staff

**Priority Type:** MHS

**Population(s):** SMI, SED

**Goal of the priority area:**

Ensure quality mental health services for all citizen of Arkansas

**Strategies to attain the goal:**

Select models and trainers to implement evidence-based training in each area, develop an advertising campaign, track number of trainings and number trained.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Implement Trauma-focused Cognitive Behavioral Therapy trainings (ARPA Funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Implement 2 TFCBT training courses and supervision cohorts

**Second-year target/outcome measurement:** Implement 2 additional TFCBT training courses and supervision cohorts

**Data Source:**

Reporting will be provided by entity performing the training

**Description of Data:**

Data will be made available regarding the number of trainings held, the number of persons attending/completing training, and the number of persons who complete all supervision requirements to become TFCBT certified.

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

none identified at this time.

**Indicator #:** 2

**Indicator:** Implement evidence based First Episode of Psychosis trainings (CASH Act Funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Implement 4 evidence based FEP training courses

**Second-year target/outcome measurement:** Implement 4 additional evidence based FEP training courses

**Data Source:**

Reporting will be provided by entity performing the training

**Description of Data:**

Data will be made available regarding the number of trainings held, the number of persons attending/completing training.

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



None identified at this time

**Indicator #:** 3

**Indicator:** Implement Mental Health First Aid trainings (ARPA Funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Implement 2 TFCBT training courses and supervision cohorts

**Second-year target/outcome measurement:** Implement 2 additional TFCBT training courses and supervision cohorts

**Data Source:**

Reporting will be provided by entity performing the training

**Description of Data:**

Data will be made available regarding the number of trainings held, the number of persons attending/completing training, and the number of persons who complete all supervision requirements to become TFCBT certified.

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

none identified at this time

**Indicator #:** 4

**Indicator:** Implement Diversity Training and Mental Health First Aid trainings for the Division of Aging, Adult and Behavioral (ARPA Funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** Implement 2 TFCBT training courses and supervision cohorts

**Second-year target/outcome measurement:** Implement 2 additional TFCBT training courses and supervision cohorts

**Data Source:**

Reporting will be provided by entity performing the training

**Description of Data:**

Data will be made available regarding the number of trainings held, the number of persons attending/completing training, and the number of persons who complete all supervision requirements to become TFCBT certified.

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

None at this time

**Priority #:** 6

**Priority Area:** Mental Health Data Needs

**Priority Type:** MHS

**Population(s):** SMI, SED

**Goal of the priority area:**

Obtain more useful data regarding mental health services being provided

**Strategies to attain the goal:**

Work with behavioral health team members, data team members, and contractors to determine what data needs to be collected, and what data is useful to help determine program needs and gaps.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Improve data collection on Client and Community Services Report to identify SMI/SED persons served under CMHC contract.

**Baseline Measurement:** establish baseline with new report

**First-year target/outcome measurement:** Establish workgroup to evaluate current reports, identify relevant and useful data points, and to make revisions to reports. Contractors/providers will be trained by DAABHS staff on how to properly complete reports.

**Second-year target/outcome measurement:** Revised Client and Community Service report will be incorporated into the Arkansas Behavioral Health Analytics database with the assistance of Deloitte staff. Contractors/providers will be trained by DAABHS and Deloitte staff on how to properly complete these electronic reports.

**Data Source:**

Meetings will be coordinated with DHS staff, stakeholder staff, and data systems development staff

**Description of Data:**

Meeting minutes and report revisions will be recorded to track progress and implementation of new and improved reporting.

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

none at this time.

**Indicator #:** 2

**Indicator:** Will develop data points related to Peer Services and the implementation of this service for our broader, behavioral health system to evaluate effectiveness (e.g increased access, more rapid access), and consumer satisfaction.

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** develop reporting mechanism and satisfaction survey with stakeholder input with goal of having results from at least 50 satisfaction surveys by the end of the first year.

**Second-year target/outcome measurement:** Will continue to monitor data to evaluate effectiveness (e.g. increased access to services, more rapid access to services), and having results of at least 100 additional satisfaction surveys by the end of the second year.

**Data Source:**

Reporting and surveys to be developed with a vendor.

**Description of Data:**

Reporting and surveys to be developed with a vendor.

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

none identified at this time

**Indicator #:** 3

**Indicator:** Develop evaluation program for new Crisis Intervention Teams (CASH Act Funds)

**Baseline Measurement:** Establish Baseline

**First-year target/outcome measurement:** development of pre and post data which will illustrate success rate, or areas for improvement, regarding adequacy and appropriateness of Crisis Intervention Teams. Will have results from at least 75 individuals by the end of the first year.

**Second-year target/outcome measurement:** Will have results from at least 125 individuals by the end of the second year

**Data Source:**

Data tool and distribution will be established through use of a vendor selected by DAABHS.

**Description of Data:**

Data tool and distribution will be established through use of a vendor selected by DAABHS.

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

none identified at this time

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**Footnotes:**

NOT FINAL

## 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 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SABG) <sup>a</sup>	J. ARP Funds (SABG) <sup>b</sup>
1. Substance Abuse Prevention <sup>c</sup> and Treatment	\$18,269,243.80		\$0.00	\$11,314,266.00	\$0.00	\$0.00	\$0.00		\$9,380,699.54	\$8,140,591.45
a. Pregnant Women and Women with Dependent Children <sup>c</sup>				\$11,314,266.00					\$9,380,699.54	\$8,140,591.45
b. All Other	\$18,269,243.80									
2. Primary Prevention <sup>d</sup>	\$7,424,289.40		\$0.00	\$5,698,697.00	\$0.00	\$0.00	\$0.00		\$2,662,090.42	\$2,260,000.00
a. Substance Abuse Primary Prevention	\$7,424,289.40			\$5,698,697.00					\$2,662,090.42	\$2,260,000.00
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										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	\$1,352,522.80								\$633,831.05	\$547,399.60
10. Crisis Services (5 percent set-aside)										
<b>11. Total</b>	<b>\$27,046,056.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$17,012,963.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$12,676,621.01</b>	<b>\$10,947,991.05</b>

<sup>a</sup> The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

<sup>b</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

<sup>c</sup> Prevention other than primary prevention

<sup>d</sup> The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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### 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 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG) <sup>b</sup>
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 <sup>c</sup>										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) <sup>d</sup>		\$1,258,104.00						\$722,933.00		\$1,248,703.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care					\$1,363,136.00					
8. Ambulatory/Community Non-24 Hour Care		\$10,413,587.00		\$2,079,824.00	\$50,666,153.00			\$6,144,934.00		\$10,613,946.00
9. Administration (excluding program/provider level) <sup>f</sup> MHBG and SABG must be reported separately		\$280,300.00								
10. Crisis Services (5 percent set-aside) <sup>g</sup>		\$629,052.00						\$361,466.00		\$624,351.00
<b>11. Total</b>	<b>\$0.00</b>	<b>\$12,581,043.00</b>	<b>\$0.00</b>	<b>\$2,079,824.00</b>	<b>\$52,029,289.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$7,229,333.00</b>	<b>\$0.00</b>	<b>\$12,487,000.00</b>

<sup>a</sup> The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

<sup>b</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

<sup>d</sup> Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

<sup>e</sup> While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

<sup>f</sup> Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

<sup>g</sup> Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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### 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	220	206
2. Women with Dependent Children	370	353
3. Individuals with a co-occurring M/SUD	3,125	2,976
4. Persons who inject drugs	3,612	3,440
5. Persons experiencing homelessness	1,102	1,049

**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: 10/1/2021      Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
1 . Substance Use Disorder Prevention and Treatment <sup>3</sup>	\$9,134,621.90	\$9,380,699.54	\$8,140,591.45
2 . Primary Substance Use Disorder Prevention	\$3,712,144.70	\$2,662,090.42	\$2,260,000.00
3 . Early Intervention Services for HIV <sup>4</sup>			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)	\$676,261.40	\$633,831.05	\$547,399.60
<b>6. Total</b>	<b>\$13,523,028.00</b>	<b>\$12,676,621.01</b>	<b>\$10,947,991.05</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

<sup>3</sup>Prevention other than Primary Prevention

<sup>4</sup>For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); 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 published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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'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: 10/1/2021      Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19 <sup>1</sup>	ARP <sup>2</sup>
1. Information Dissemination	Universal	\$959,600	\$425,934	\$271,200
	Selective	\$399,865	\$425,934	\$203,400
	Indicated	\$88,312	\$212,967	\$203,400
	Unspecified			
	<b>Total</b>	<b>\$1,447,777</b>	<b>\$1,064,835</b>	<b>\$678,000</b>
2. Education	Universal	\$270,645	\$212,967	\$180,800
	Selective	\$111,782	\$212,967	\$135,600
	Indicated	\$24,908	\$106,484	\$135,600
	Unspecified			
	<b>Total</b>	<b>\$407,335</b>	<b>\$532,418</b>	<b>\$452,000</b>
3. Alternatives	Universal	\$147,625	\$106,484	\$180,800
	Selective	\$61,518	\$106,484	\$135,600
	Indicated	\$13,586	\$53,242	\$135,600
	Unspecified			
	<b>Total</b>	<b>\$222,729</b>	<b>\$266,210</b>	<b>\$452,000</b>
4. Problem Identification and Referral	Universal	\$24,604	\$53,242	\$45,200
	Selective	\$10,253	\$53,242	\$33,900
	Indicated	\$2,264	\$26,621	\$33,900
	Unspecified			
	<b>Total</b>	<b>\$37,121</b>	<b>\$133,105</b>	<b>\$113,000</b>
	Universal	\$861,143	\$212,967	\$180,800

5. Community-Based Process	Selective	\$358,853	\$212,967	\$135,600
	Indicated	\$79,254	\$106,484	\$135,600
	Unspecified			
	<b>Total</b>	<b>\$1,299,250</b>	<b>\$532,418</b>	<b>\$452,000</b>
6. Environmental	Universal	\$147,625	\$53,242	\$45,200
	Selective	\$61,518	\$53,242	\$33,900
	Indicated	\$13,586	\$26,621	\$33,900
	Unspecified			
	<b>Total</b>	<b>\$222,729</b>	<b>\$133,105</b>	<b>\$113,000</b>
7. Section 1926 Tobacco	Universal	\$49,208		
	Selective	\$20,506		
	Indicated	\$4,529		
	Unspecified			
	<b>Total</b>	<b>\$74,243</b>	<b>\$0</b>	<b>\$0</b>
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Prevention Expenditures</b>		<b>\$3,711,184</b>	<b>\$2,662,091</b>	<b>\$2,260,000</b>
<b>Total SABG Award<sup>3</sup></b>		<b>\$13,523,028</b>	<b>\$12,676,621</b>	<b>\$10,947,991</b>
<b>Planned Primary Prevention Percentage</b>		<b>63.84 %</b>	<b>68.10 %</b>	<b>78.86 %</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

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

<sup>3</sup>Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

NOT FINAL

## Planning Tables

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

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
Universal Direct	\$850,081	\$532,418	\$135,600
Universal Indirect	\$1,610,328	\$1,064,836	\$135,600
Selective	\$1,025,294	\$798,627	\$113,000
Indicated	\$226,441	\$266,209	\$67,800
<b>Column Total</b>	<b>\$3,712,144</b>	<b>\$2,662,090</b>	<b>\$452,000</b>
<b>Total SABG Award<sup>3</sup></b>	<b>\$13,523,028</b>	<b>\$12,676,621</b>	<b>\$10,947,991</b>
<b>Planned Primary Prevention Percentage</b>	<b>27.45 %</b>	<b>21.00 %</b>	<b>4.13 %</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

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

<sup>3</sup>Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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### Footnotes:

## 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 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
Targeted Substances			
Alcohol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Bath salts, Spice, K2)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Targeted Populations			
Students in College	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

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

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**Footnotes:**

NOT FINAL

# Planning Tables

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

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated <sup>1</sup>	D. COVID-19 <sup>2</sup>	E. ARP <sup>3</sup>
1. Information Systems		\$142,760.00		\$5,500.00	\$6,100.00
2. Infrastructure Support		\$715,954.18		\$980,166.42	\$553,900.00
3. Partnerships, community outreach, and needs assessment		\$2,713,250.00		\$1,596,424.00	\$1,550,000.00
4. Planning Council Activities (MHBG required, SABG optional)					\$10,000.00
5. Quality Assurance and Improvement					
6. Research and Evaluation		\$86,250.00		\$20,000.00	\$20,000.00
7. Training and Education	\$160,103.00	\$53,930.52		\$60,000.00	\$120,000.00
<b>8. Total</b>	<b>\$160,103.00</b>	<b>\$3,712,144.70</b>	<b>\$0.00</b>	<b>\$2,662,090.42</b>	<b>\$2,260,000.00</b>

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

<sup>2</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

<sup>3</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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**Footnotes:**

NOT FINAL

## Planning Tables

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

MHBG Planning Period Start Date: 07/01/2021

MHBG Planning Period End Date: 06/30/2022

Activity	FFY 2022 Block Grant	FFY 2022 <sup>1</sup> COVID Funds	FFY 2022 <sup>2</sup> ARP Funds	FFY 2023 Block Grant	FFY 2023 <sup>1</sup> COVID Funds	FFY 2023 <sup>2</sup> ARP Funds
1. Information Systems						
2. Infrastructure Support		\$500,000.00			\$500,000.00	
3. Partnerships, community outreach, and needs assessment	\$98,000.00	\$125,000.00	\$50,149.00	\$98,000.00	\$100,000.00	\$50,149.00
4. Planning Council Activities (MHBG required, SABG optional)	\$42,000.00			\$42,000.00		
5. Quality Assurance and Improvement		\$25,000.00			\$25,000.00	
6. Research and Evaluation						
7. Training and Education	\$25,000.00	\$3,414,668.00	\$522,500.00	\$25,000.00	\$2,464,658.00	\$522,500.00
<b>8. Total</b>	<b>\$165,000.00</b>	<b>\$4,064,668.00</b>	<b>\$572,649.00</b>	<b>\$165,000.00</b>	<b>\$3,089,658.00</b>	<b>\$572,649.00</b>

<sup>1</sup> The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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

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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.<sup>22</sup> 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.<sup>23</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>24</sup>

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.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> 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.<sup>27</sup> 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.<sup>28</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>29</sup> 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.<sup>30</sup> 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<sup>31</sup> and ACOs<sup>32</sup> 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.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup> 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.<sup>39</sup> 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.<sup>40</sup>

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.<sup>41</sup> 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.

<sup>22</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/million-hearts-initiative>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>24</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses>; Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <https://www.samhsa.gov/find-help/disorders>

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchhstp/socialdeterminants/index.html>

<sup>26</sup> <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>29</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>30</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <https://www.cchpca.org/topic/overview/>;

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

<sup>33</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>35</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>36</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>37</sup> 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

<sup>38</sup> 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

<sup>39</sup> 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, [https://www.cibhs.org/sites/main/files/file-attachments/samhsa\\_bhwork\\_0.pdf](https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.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>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>

<sup>41</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/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. Additionally, nursing homes have been added more recently. Telehealth was expanded during the COVID-19 pandemic and were adopted as permanent after positive feedback from providers and individuals in service. Arkansas' Medicaid expansion was recently revised to include several "Life 360 Homes" which integrate physical and behavioral health for several priority populations including maternal and infant health, rural health, behavioral health and chronic disease. It is designed to address the social determinants of health and behavioral health in an integrated, whole person approach.
2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.  
  
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. The State is encouraging providers to be more capable and willing to provide services to individuals with co-occurring mental health and substance abuse conditions by removing some of the structural and financial barriers. Telehealth substance abuse services are now allowed for payment for Medicaid beneficiaries and contract services. Arkansas has recently begun a coordinated effort to develop the peer recovery support network and provides for certification, national association membership, career ladder and supervision in an effort to greatly increase the workforce and provide integration of mental health and substance abuse peers.
3.
  - a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ☒ Yes ☐ No
  - b) and Medicaid? ☒ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services provided 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?  
The Arkansas Legislature recently enacted laws which severely restrict and/or inhibit treatment options for the LGBTQ+ population.
10. Does the state have any activities related to this section that you would like to highlight?  
Arkansas Medicaid, in consultation with DDS and DAABHS, established a new Medicaid provider type "CSSP – Community Support System Provider" of home and community based services to attempt to develop a provider network to serve both behavioral health and DD/ID individuals and "break down silos". This provider type is new but has experienced a fair growth rate at this point.  
Please indicate areas of technical assistance needed related to this section  
None at this time.

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**Footnotes:**

Question #6; Only Certified Community Behavioral Health Center providers screen for physical health issues

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>42</sup>, [Healthy People, 2020](#)<sup>43</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>44</sup>, 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)<sup>45</sup>.

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."<sup>46</sup>

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<sup>47</sup>. 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<sup>48</sup>. 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.

<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**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?

SUD providers capture some gender identity information. At this time, MH providers do not capture this information.

Please indicate areas of technical assistance needed related to this section

  - Development of data driven plans to address and reduce disparities in access, service use and out-comes for subpopulations.
  - Development and implementation of workforce-training plans to build capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally competent outreach, engagement, prevention, treatment and recovery services for diverse populations.
  - Development of a plan to identify, address and monitor linguistic disparities/language barriers.

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**Footnotes:**



## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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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, ( $V = Q \div C$ )

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,<sup>49</sup> The New Freedom Commission on Mental Health,<sup>50</sup> the IOM,<sup>51</sup> NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>52</sup> 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."<sup>53</sup> 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](#))<sup>54</sup> 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](#))<sup>55</sup> 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.

<sup>49</sup> 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

<sup>50</sup> 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.

<sup>51</sup> 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.

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

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> [https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019\\_0.pdf](https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
  - g) ☒ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, 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 2022 and FFY 2023 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 somewhat new services in our state for SMI population and are still not widely implemented. Providers are 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 to locate persons experiencing their first psychotic break.

As previously stated, we are aware of training needs and plan to coordinate evidence-based training for clinicians on a state-wide basis, not only limited to CMHC staff. Additionally, a pilot program is also being planned using ARPA funding.

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 did expect that with increased community outreach and education the number of individuals receiving services for ESMI would increase over the last two years. However, our numbers remain low. We have broadened target areas for outreach and are hopeful that our pilot program, and training to implement evidence-based services will provide some renewed vigor to our programs regarding the need for outreach.

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

Schizophrenia, Schizophreniform, Bipolar Disorder, Schizoaffective Disorder, Psychosis NOS, Delusional Disorder, Major Depression with Psychotic features, and Unspecified Schizophrenia.

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

Arkansas would find great value in any technical assistance available regarding selecting evidence-based curriculum as well as implementing a pilot program.

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**Footnotes:**

## Environmental Factors and Plan

### 5. Person Centered Planning (PCP) - Required MHBG

#### Narrative Question

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



## Environmental Factors and Plan

### 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?

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

Please indicate areas of technical assistance needed related to this section

None at this time.

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#### Footnotes:

NOT FINAL

## Environmental Factors and Plan

### 7. Tribes - Requested

#### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf)<sup>56</sup> 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.

<sup>56</sup> <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)

Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas

<http://preventionworksar.org>

☒ National survey on Drug Use and Health (NSDUH)

☒ Behavioral Risk Factor Surveillance System (BRFSS)

☒ Youth Risk Behavioral Surveillance System (YRBS)

☒ Monitoring the Future

☒ Communities that Care

☒ State - developed survey instrument

☐ Others (please list)

Arkansas Prevention Needs Assessment Students Survey; Arkansas State Epidemiological Outcomes Workgroup Annual Profile of substance Use; AR State of Well-being

<http://preventionworksar.org>

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds? ☒ Yes ☐ No

If yes, (please explain)

Funds allocation is based on needs assessment data. The state routinely uses needs assessment data to help define needs and assess priorities and make decisions about the allocation of SABG primary prevention funds. Data from relevant needs assessment data from the state SEOW epidemiological profile, APNA students survey, and other surveillance instruments from other state and regional administrative agency databases are used for this process. The process includes an examination/determination of:

i. the size/magnitude of the issue(s),

ii. community readiness,

iii. trends over time,

iv. changeability,

v. preventability

vi. resource availability/gaps

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

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;
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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  
 State works with AR Prevention Certification Board (APCB), which is affiliated with the International Certification & Reciprocity Consortium. The state partners with APCB in the state by recruiting and providing required trainings and workshops for people in the certification process.
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  
 Annual Workforce Needs Assessment Evaluation and post-survey effectiveness of training and future training needs along with Regional and Statewide Prevention Conferences.  
 ? Technical assistance, capacity building, and fiscal resources are provided by state prevention coordinators to regional prevention providers and coalitions.  
 ? Training and technical assistance offered are focused on current and emerging priorities. These are intended to develop and enhance the skills necessary to effectively advance prevention services on the local, regional and statewide levels.  
 ? All staff of state, regional and local prevention providers working under the SABG are required to attend the Substance Abuse Prevention Skills Training (SAPST). This training is offered multiple times per year as needed.  
 ? The state also contracts with WYSEC for evaluation and technical assistance to the state and regional prevention providers.  
 ? Methods of providing TA services include in-person, virtually, emails, peer-to-peer learning opportunities, guidance documents and resource identification.
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No  
 If yes, please describe mechanism used  
 Annual workforce needs assessment surveys are conducted to assess competencies, proficiencies, knowledge, skills and readiness of the prevention providers to implement substance abuse prevention initiatives. The state offers statewide and regional trainings to increase the capacity of the prevention workforce based on the workforce needs assessment.



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
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 workgroup is comprised of state prevention staff and evaluators. The group recommends that prevention providers use evidence based practices from the Wyoming Prevention Depot - Evidence-Based Prevention Programs & Services (<https://wyomingpreventiondepot.org/>). The group also recommends programs from Evidence-Based Practices Resource (<https://www.samhsa.gov/resource-search/ebp>).

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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:  
Arkansas aims to identify those who have indulged in the first use of ATOD. This is to assess if their behavior can be reversed through education.
  - 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 prevention services not funded through other means?

☐ Yes ☒ No

If yes, please describe

NOT FINAL

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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:)
- 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):

NOT FINAL

**Footnotes:**

NOT FINAL



# REVISED ARKANSAS STRATEGIC PREVENTION PLAN

ST FINAL

SFY 2019-2023

Strategic Five Year Plan

**ARKANSAS  
DEPARTMENT OF**



NOT FINAL

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

## OFFICE OF THE STATE DRUG DIRECTOR

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



Pictured above, Arkansas State Drug director, Kirk Lane

*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.*

# ARKANSAS DEPARTMENT OF HUMAN SERVICES

## DIVISION OF AGING, ADULT AND BEHAVIORAL HEALTH SERVICES

### VISION

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

### MISSION

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

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## INTRODUCTION

### BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH: PREVENTION WORKS!

This document is an update to the Arkansas FY2019-2023 Prevention Plan. 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 gives 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) and a Regional Lead Agency (RLA), staffed by Regional Lead Representatives (RLRs), 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 continue to 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 multidisciplinary response.



Under the auspices of the Coordinating Council, DAABHS/MidSOUTH will continue to 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.

**PROMOTE**

**PREVENT**

**PROTECT**

## RISK AND PROTECTIVE FACTORS

Many of the problem behaviors faced by youth – delinquency, substance abuse, violence, school dropout, and teen pregnancy – share many common risk factors. Thus, reducing those common risk factors will have the benefit of reducing several problem behaviors. Much of Arkansas' prevention work is based on the risk and protective factor approach to prevention of problem behaviors developed from the work of Drs. J. David Hawkins and Richard F. Catalano and their colleagues at the University of Washington. This approach addresses risk and protective factors that exist in multiple contexts:



**Individual Context:** Individuals come to the table with biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence. But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

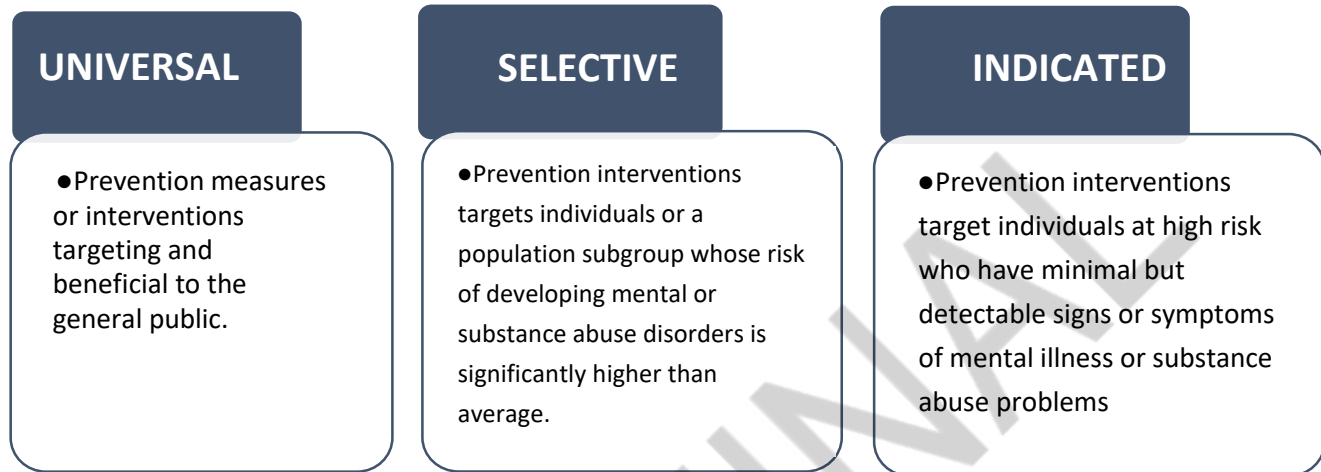
**Family Context:** In families, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement

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

**Societal Context:** In society, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth. Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include a school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

## PREVENTION CATEGORIES

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



**UNIVERSAL:** These interventions are targeted and are beneficial to the general public or a general population.

Two subcategories further define universal interventions:

- **Universal Indirect** provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.
- **Universal Direct** interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting classes, and community workshops.

**SELECTIVE:** This category of prevention interventions targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average.

Examples of selective interventions include:

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

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

Examples include:

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

## STRATEGIC PREVENTION FRAMEWORK

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

The Strategic Prevention Framework (SPF) implements a five-step process known to promote youth development, reduce risk-taking behaviors, and prevent problem behaviors across the life span. It is designed to build on science-based theories and evidence-based practices. To be effective, the SPF supports that prevention programs must engage individuals, families, and entire communities to achieve population level change.



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

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

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

## CENTER FOR SUBSTANCE ABUSE PREVENTION'S STRATEGIES

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

**Information Dissemination:** This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two. *Examples: clearinghouse/information resource centers, media campaigns, speaking engagements, and health fairs.*

**Education:** This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress and problem-solving, and interpersonal communication. Organizational infrastructure, planning, and evaluation skills are part of capacity development education. There is more interaction between facilitators and participants than in the information strategy. *Examples: Coalition training and peer leader/helper programs.*

**Alternatives:** This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and other drugs. *Examples: Recreation activities, drug-free dances and parties, and community service activities.*

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

**Community-based Process:** This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses grassroots empowerment models using action planning and collaborative systems planning. *Examples: Community teambuilding, multi-agency coordination and collaboration, and accessing services and funding.*

**Environmental:** This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. *Examples: Modifying alcohol and tobacco advertising practices, product pricing strategies, and promoting the establishment of review of alcohol, tobacco, and drug use policies.*



## GUIDING PRINCIPLES FOR PREVENTION

1. **Prevention is prevention is prevention!!!** That is, the common components of effective prevention for the individual, family, or community within a public health model are the same – whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes, substance abuse or mental illness.
2. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse. Prevention activities range from deterring diseases and behaviors that contribute to them, to delaying the onset of disease and mitigating the severity of symptoms, to reducing the related problems in communities. This concept is based on the Institute of Medicine (IOM) model that recognizes the importance of a whole spectrum of interventions.
3. Cultural competence and inclusiveness in working with populations of diverse cultures and identities is necessary to provide effective substance abuse prevention programming.
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies. For example, youth who have relationships with caring adults, good schools, and safe communities develop optimism, good-problem-solving skills, and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence, and hope.
5. Prevention begins within communities by helping individuals learn that they can have an impact on solving their local problems and setting local norms. Prevention emphasizes collaboration and cooperation, both to conserve limited resources and to build on existing relationships within the community. Community groups are routinely used to explore new, creative ways to use existing resources. All sectors of the community, especially parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health and health care communities are critical partners in substance abuse prevention efforts.
6. The Spectrum of Prevention is a broad framework that includes seven strategies designed to address complex and significant public health problems. These include a.) influencing policy and legislation, b.) mobilizing neighborhoods and communities, c.) fostering coalitions and networks, d.) changing organizational practices, e.) educating providers, f.) promoting community education, and g.) strengthening individual knowledge and skills.

## GUIDING PRINCIPLES FOR PREVENTION

7. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on those common risk factors that can be altered. For example, family conflict, low levels of basic school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors. Risk and protective factors exist in individual, the family, the community and the broader environment.
8. Systems of prevention services work better than prevention silos. Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnership enables communities to leverage scarce resources and make prevention everybody's business. Prevention efforts are more likely to succeed if partnerships with communities and practitioners focus on building capacity to plan, implement, monitor, evaluate, and sustain effective prevention.
9. Substance abuse prevention shares many elements of commonality with other related fields of prevention. Collaboration and cross training across the prevention field is needed to maximize resources (both human and material).
10. Prevention specialists need a set of core competencies and a commitment to lifelong learning to stay current with the rapidly evolving knowledge and skill base in the field.
11. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts. A strategic prevention framework can facilitate community identification of needs and risk factors, adopt assessment tools to measure and track results, and target outcomes to be achieved. A data-driven strategic approach maximizes the chances for future success and achieving positive outcomes.
12. Evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.

## GOALS AND OBJECTIVES



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

Goals and objectives serve to ensure that strategies and activities selected for implementation will meet the needs identified during the assessment and capacity building phase of a planning effort. Most of the goals set for the 2012 Strategic Prevention Plan were either met or mostly met (see List of 2012 goals and progress in appendix i and ii).

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

The indicators to be measured are:

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

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

Due to the effects of the COVID-19 pandemic, SFY 2020 has been identified as a possible outlier in the data for the above measures, and as such, any use of this year's data for analysis should be done within this context.

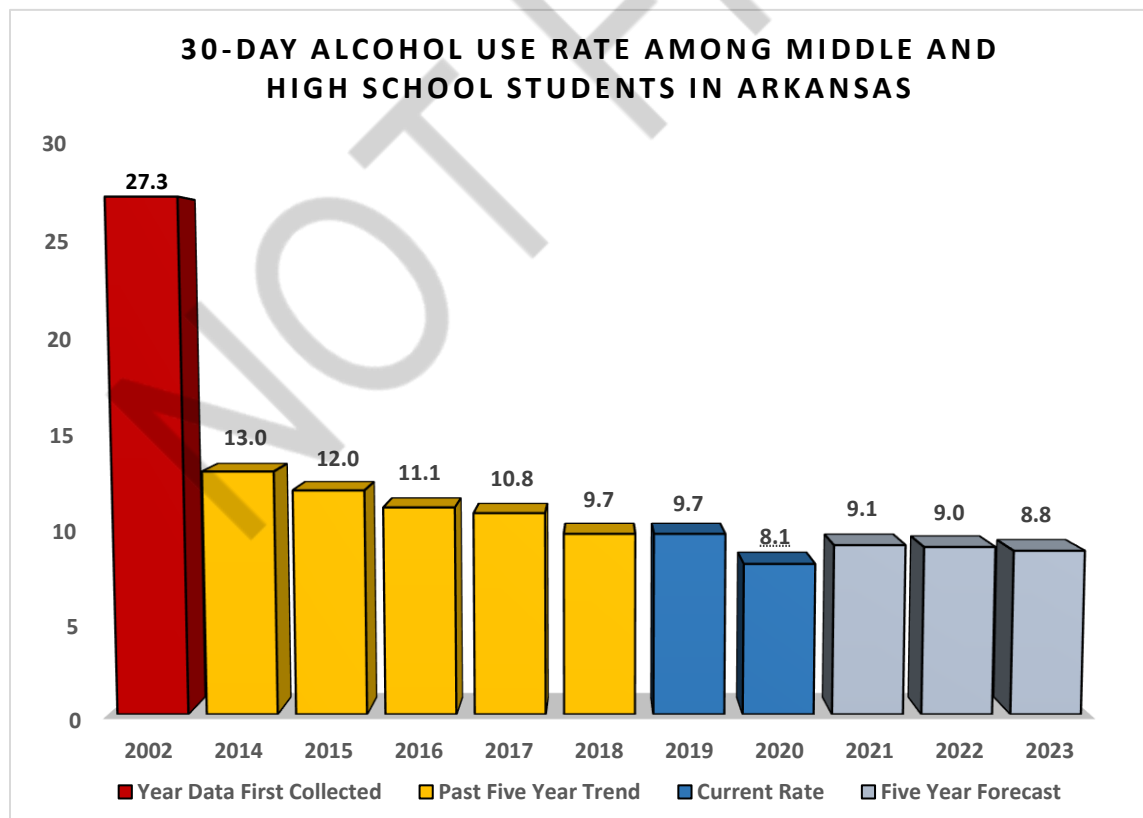
The following goals and objectives have been identified for the SFY 2019 to SFY 2023 Strategic Prevention Plan.

**GOAL 1: Support implementation of prevention programs and strategies that increase perception of risk and decrease alcohol, tobacco, marijuana, prescription drug, and methamphetamine 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 9.7% in 2019 to 8.8% by 2023.

Year	2002	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	27.3	13.0	12.0	11.1	10.8	9.7	9.7	<u>8.1</u>	9.1	9.0	8.8

Table 1/Exhibit 1: Archival, past five years, current and forecasted 30-day alcohol usage rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.



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.
10. Train and educate youth leaders.

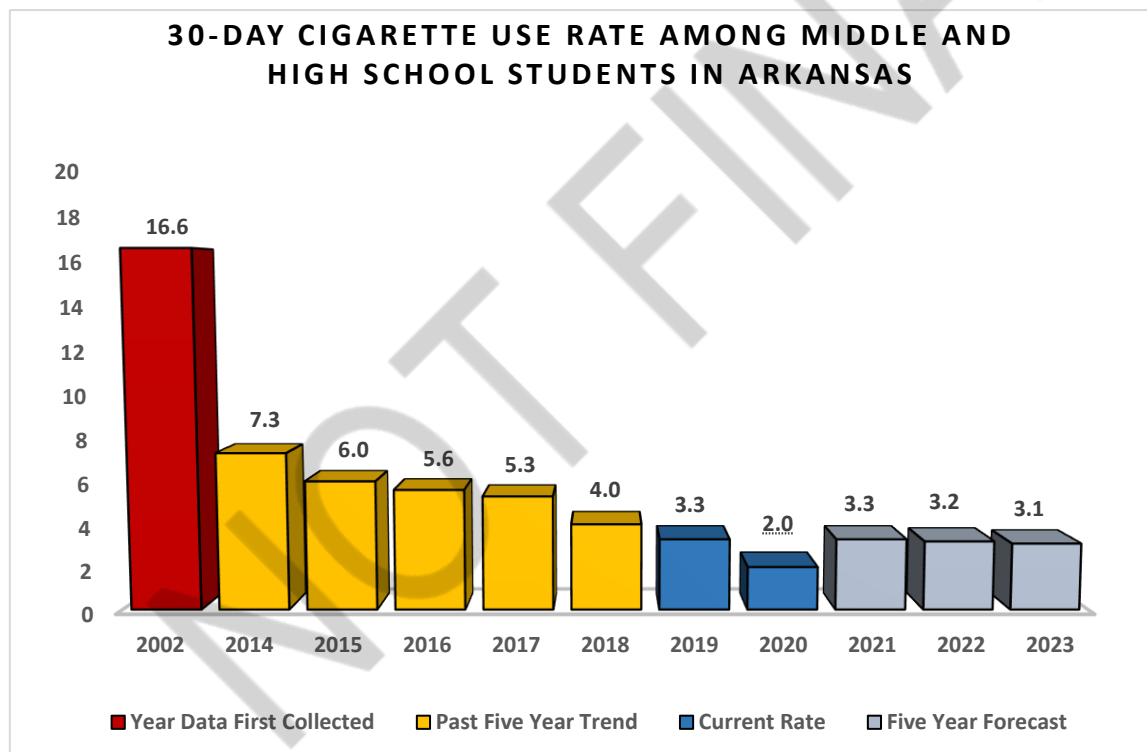
## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Disseminate Information.	Disseminate Information.	Disseminate Information.	Disseminate Information.	Disseminate Information.
Provide prevention training to PE and health teacher.	Provide prevention training to PE and health teachers.	Partner with local policy makers and law enforcement to enforce the social host law.	Partner with local policy makers and law enforcement to enforce the social host law.	Partner with local policy makers and law enforcement to enforce the social host law.
Partner with community coalitions, policy makers, and other stakeholders to change community norms towards alcohol usage.	Partner with local policy makers and law enforcement to enforce the social host law	Increase knowledge and skills by educating youth/parents on alcohol risks.	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.	Develop youth coalitions and leadership opportunities.
Increase knowledge and skills by educating youth/parents on alcohol risks.	Increase knowledge and skills by educating youth/parents on alcohol risks.			

**OBJECTIVE 1.2a:** Lower the reported 30-day cigarette usage rate from 3.3% in 2019 to 3.1% in 2023 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2002	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	16.6	7.3	6.0	5.6	5.3	4.0	3.3	<u>2.0</u>	3.3	3.2	3.1

Table2/Exhibit 2: Archival, past five years, current and forecasted 30-day cigarette usage rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.



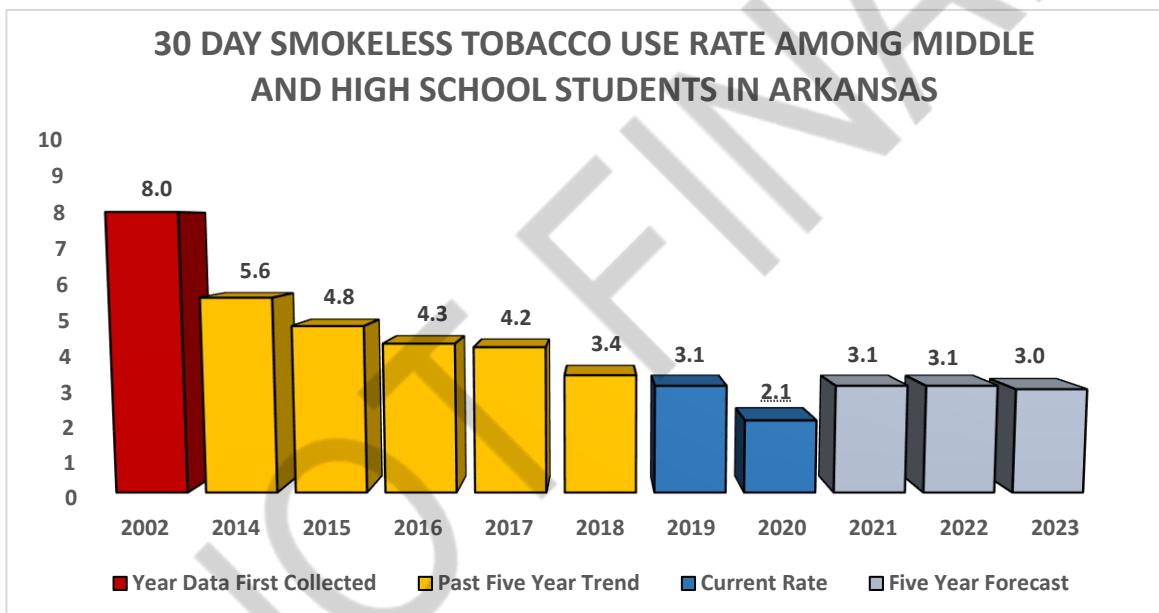
Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)



**OBJECTIVE 1.2b:** Lower the reported 30-day smokeless tobacco usage rate from 3.1% in 2019 to 3.0% by 2023 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2002	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	8.0	5.6	4.8	4.3	4.2	3.4	3.1	<u>2.1</u>	3.1	3.1	3.0

Table3/Exhibit 3: Archival, past five years, current and forecasted 30-day smokeless tobacco usage rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used as a reference for current rate.

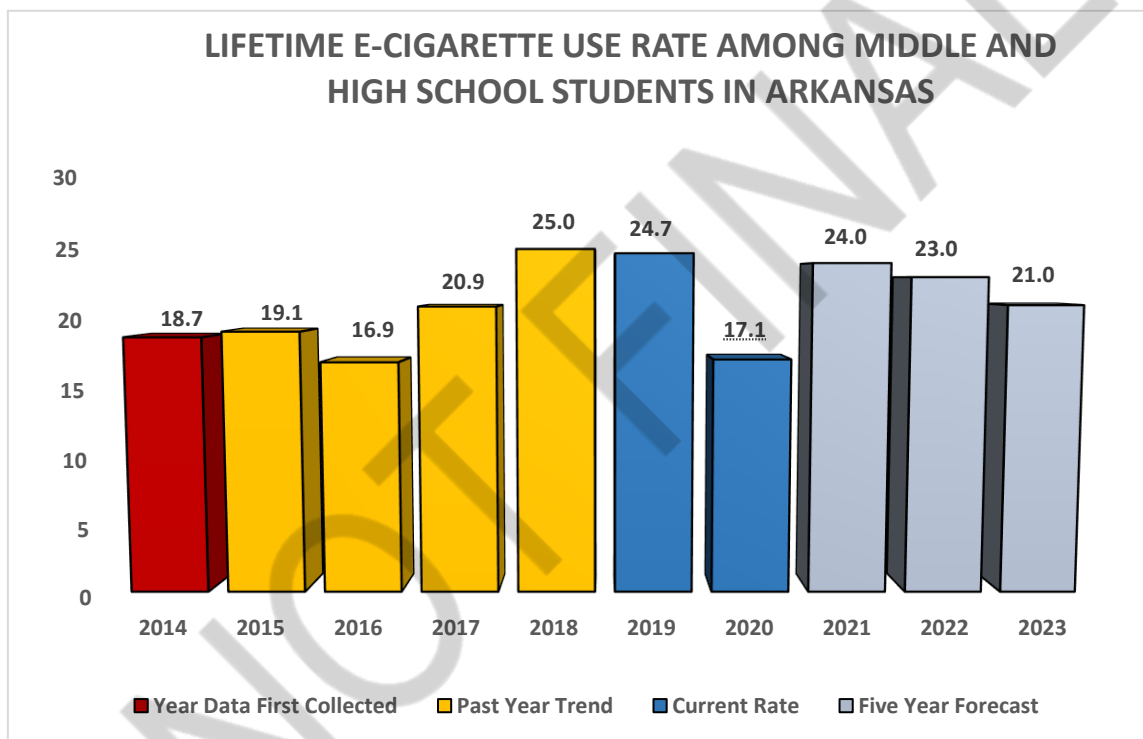


Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

**OBJECTIVE 1.2c:** Lower the lifetime e-cigarette usage rate from 24.7% in 2019 to 21.0% in 2023 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	18.7	19.1	16.9	20.9	25.0	24.7	<u>17.1</u>	24.0	23.0	21.0

Table 4/Exhibit 4: Archival, past five years, current and forecasted lifetime e-cigarette usage rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.

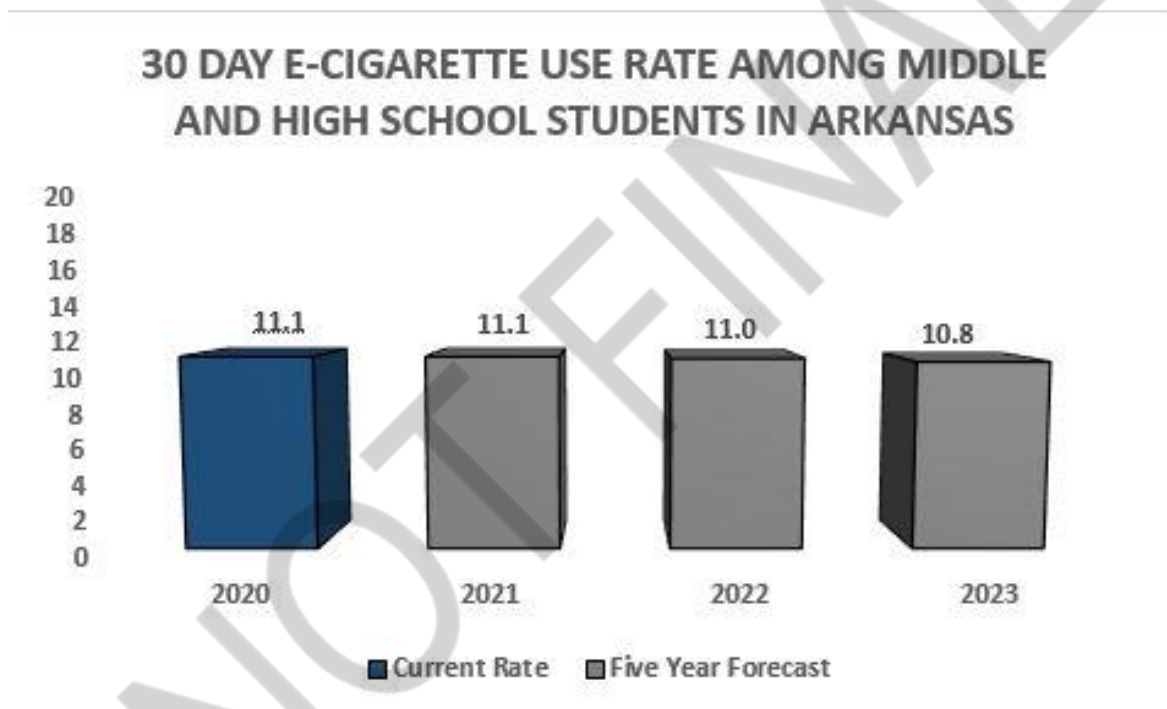


Source: Arkansas Prevention Needs Assessment (APNA) Survey. (<https://arkansas.pridesurveys.com/>)

OBJECTIVE 1.2d: Lower the reported 30-day e-cigarette usage rate from 11.1% in 2020 to 10.8% by 2023 among middle and high school students according to the Arkansas Prevention Needs Assessment.

Year	2020	2021	2022	2023
Rate (%)	<u>11.1</u>	11.1	11.0	10.8

Table: Table5/Exhibit 5: Current and forecasted 30-day e-cigarette usage rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used as a reference for current rate.



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).
8. Promote awareness of the new federal tobacco law (Tobacco 21) and SYNAR protocols that reflect this change.

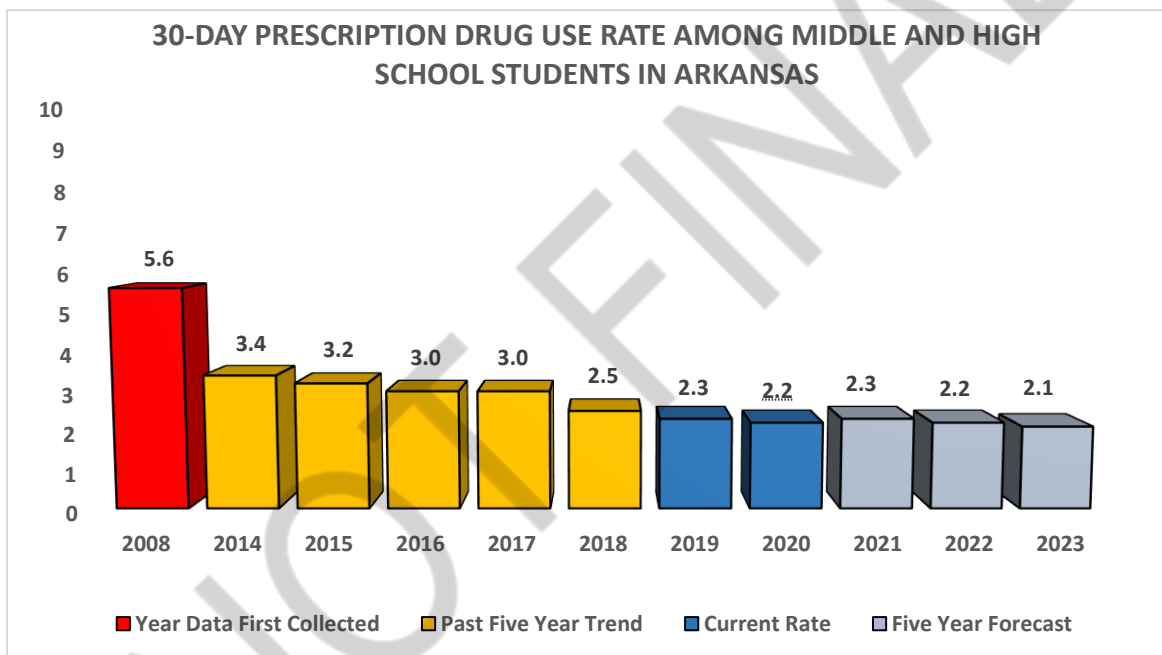
## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Disseminate tobacco prevention Information.	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 school staff/faculty.	Provide prevention training to school staff/faculty.	Provide prevention training to school staff/faculty.
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/nicotine harms using evidence based substance abuse prevention curriculum.	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.	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.
Establish MOU's with ADH Tobacco Prevention and Cessation Program to provide tobacco prevention services in the communities through coordinated trainings.	Develop MOU with Arkansas Tobacco Control to leverage resources through coordination tobacco merchant trainings.			

**OBJECTIVE 1.3:** Lower the reported 30-day rate for misuse of prescription drugs according to the Arkansas Prevention Needs Assessment from 2.3% in 2019 to 2.1% by 2023.

Year	2008	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	5.6	3.4	3.2	3.0	3.0	2.5	2.3	<u>2.2</u>	2.3	2.2	2.1

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. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used as a reference for current rate.



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 continue to 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 school staff/faculty.
5. Continue efforts to promote drug take back days and medicine drop boxes to reduce access to unused/expired 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 Talk to Your Doctor.
9. Support research, prescriber education, and public education for non-opioid methods of pain treatments or alternative prescribing.

## ACTION TIMEFRAME

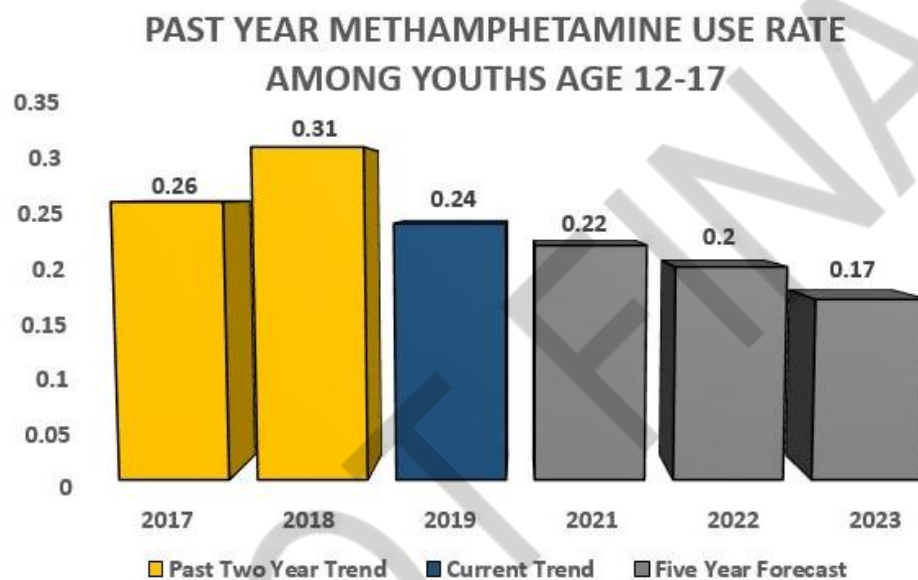
SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.	Disseminate opioid abuse prevention Information.
Provide opioid 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.	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.	Continue efforts to promote drug take back.	Partner with Criminal Justice Institute to provide prescribers training.	Partner with Criminal Justice Institute to provide prescribers training.	Partner with Criminal Justice Institute to provide prescribers training.
Coordinate with ADH to encourage prescribers use of prescription drug monitoring programs.	Coordinate with ADH to encourage prescribers use of prescription drug monitoring programs.		Partner with Criminal Justice Institute to provide prescribers training.	



OBJECTIVE 1.4a: Lower the reported past year methamphetamine usage rate from 0.24% in 2019 to 0.17% through 2023 among youths age 12-17 in Arkansas according to National Survey on Drug Use and Health (NSDUH).

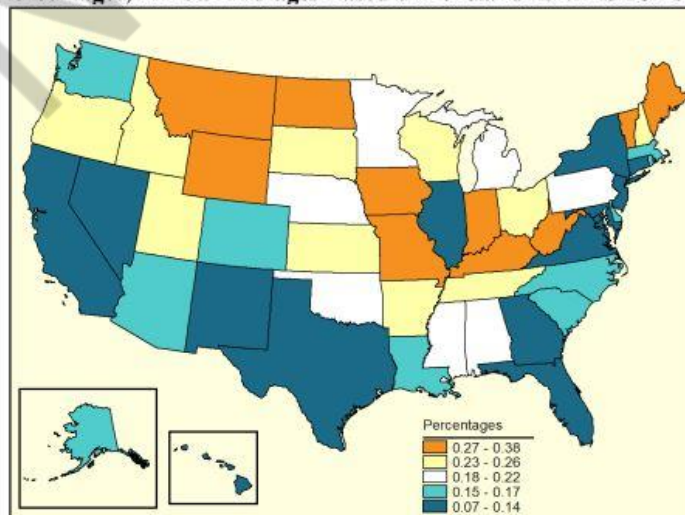
Year	2017	2018	2019	2021	2022	2023
Rate (%)	0.26	0.31	0.24	0.22	0.2	0.17

Table 6/Exhibit 6: Archival, past two years, current and forecasted past year methamphetamine drug usage rate among youths age 12-17 in Arkansas. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used as a reference for current rate.



Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

**Figure 11b Methamphetamine Use in the Past Year among Youths Aged 12 to 17, by State: Percentages, Annual Averages Based on 2018 and 2019 NSDUHs**

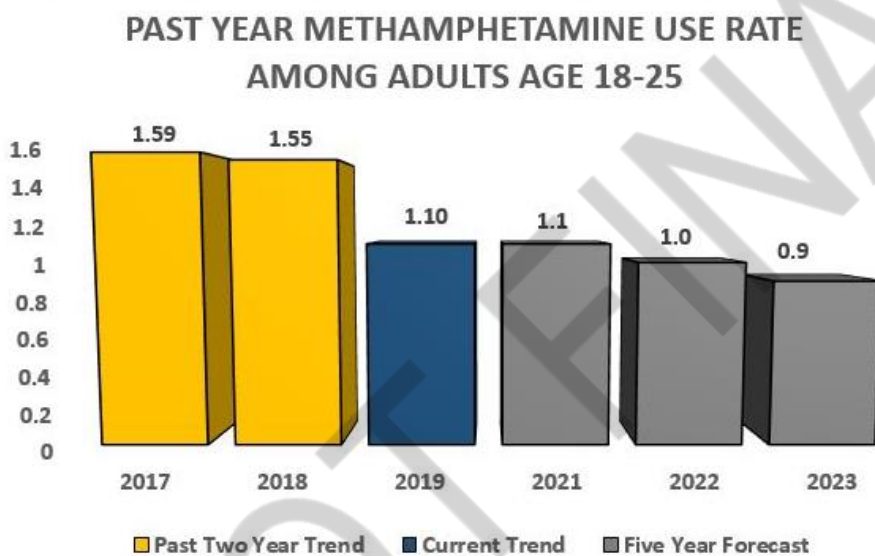


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2018 and 2019.

OBJECTIVE 1.4b: Lower the reported past year methamphetamine usage rate from 1.1% in 2019 to 0.9% by 2023 among Arkansas adults age 18-25 according to National Survey on Drug Use and Health (NSDUH).

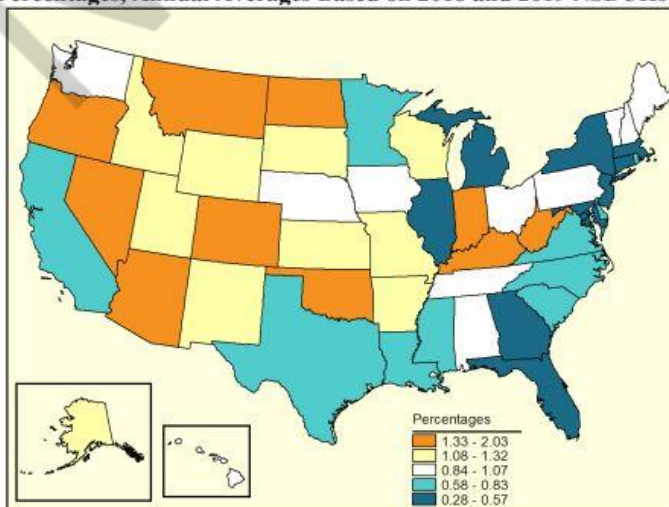
Year	2017	2018	2019	2021	2022	2023
Rate (%)	1.59	1.55	1.10	1.1	1.0	0.9

Table 7/Exhibit 7: Archival, past two years, current and forecasted past year methamphetamine drug usage rate among Arkansas adults age 18-25. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used a reference for current rate.



Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

**Figure 11c Methamphetamine Use in the Past Year among Adults Aged 18 to 25, by State: Percentages, Annual Averages Based on 2018 and 2019 NSDUHs**



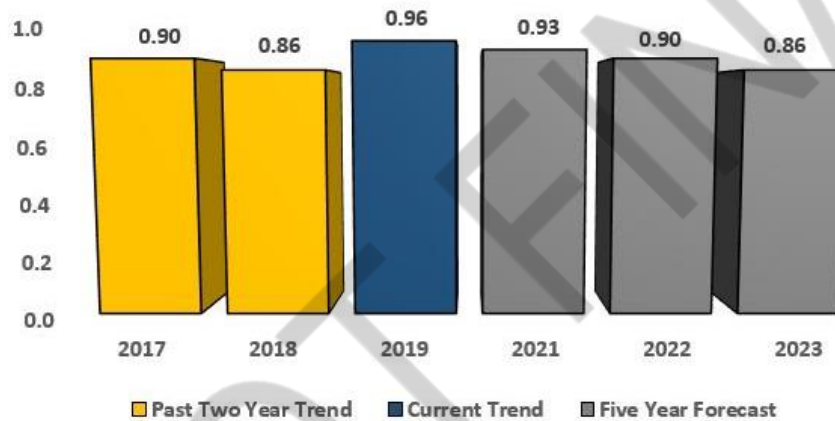
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2018 and 2019.

**OBJECTIVE 1.4c:** Lower the reported past year methamphetamine usage rate from 0.96% in 2019 to 0.86% by 2023 among Arkansas adults age 26 or older according to National Survey on Drug Use and Health (NSDUH).

Year	2017	2018	2019	2021	2022	2023
Rate (%)	0.90	0.86	0.96	0.93	0.90	0.86

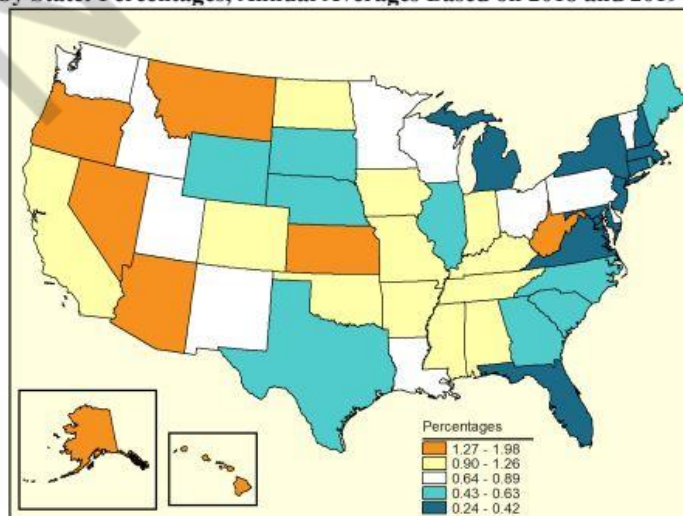
Table 7/Exhibit 7: Archival, past two years, current and forecasted past year methamphetamine drug usage rate among Arkansas adults age 26 or older. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used as a reference for current rate.

### PAST YEAR METHAMPHETAMINE USE RATE AMONG ADULTS OVER 26



Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

**Figure 11d Methamphetamine Use in the Past Year among Adults Aged 26 or Older, by State: Percentages, Annual Averages Based on 2018 and 2019 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2018 and 2019.

## 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 of methamphetamine use in Arkansas.
2. Raise awareness about the dangers of methamphetamine use through a statewide media RAAD (Rise Above Alcohol and Drugs) campaign.
3. Disseminate information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on how methamphetamine affects the body and brain.
4. Partner with community coalitions, policy makers, law enforcement and other stakeholders to increase community awareness of the dangers of methamphetamine usage.

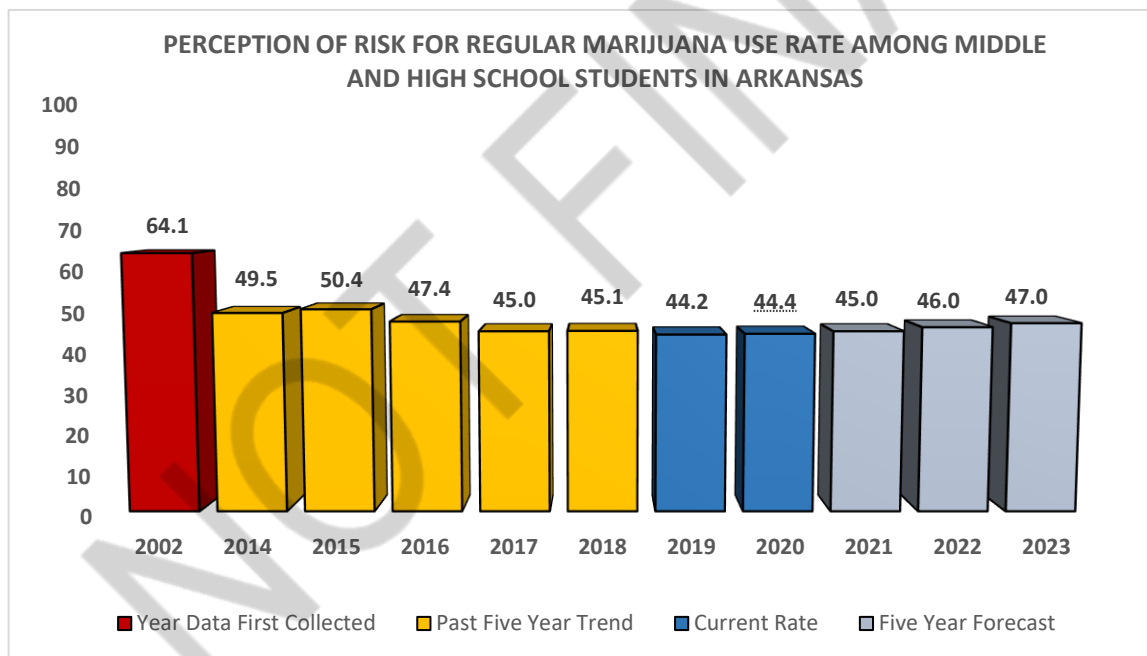
## ACTION TIMEFRAME

SFY 2021	SFY 2022	SFY 2023
<p>Disseminate methamphetamine prevention information.</p> <p>Launch statewide media campaign (RAAD).</p> <p>Collaborate with community coalitions and law enforcement agencies to combat the effects of methamphetamine use within the community.</p>	<p>Disseminate methamphetamine prevention information.</p> <p>Launch statewide media campaign (RAAD).</p> <p>Collaborate with community coalitions and law enforcement agencies to combat the effects of methamphetamine use within the community.</p>	<p>Disseminate methamphetamine prevention information.</p> <p>Launch statewide media campaign (RAAD).</p> <p>Collaborate with community coalitions and law enforcement agencies to combat the effects of methamphetamine use within the community.</p>

**OBJECTIVE 1.5:** Increase the reported perception of risk for marijuana use among Arkansas youth from 44.2% in 2019 to 47.0% by 2023 according to the Arkansas Prevention Needs Assessment.

Year	2002	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate (%)	64.1	49.5	50.4	47.4	45.0	45.1	44.2	<u>44.4</u>	45.0	46.0	47.0

Table 8/Exhibit 8: Archival, past five years, current and forecasted perception of risk for marijuana rate among middle and high school students in Arkansas. SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.



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 staff/faculty.
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 continue to 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	SFY 2023
Disseminate marijuana prevention Information.	Disseminate marijuana prevention Information.	Disseminate marijuana prevention Information.	Disseminate marijuana prevention Information.	Disseminate marijuana prevention Information.
Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.	Increase knowledge and skills by educating communities on marijuana risks through trainings.
	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.	Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage.



**OBJECTIVE 1.6a:** Gather past 2-week college student binge drinking rate data from the newly developed Collegiate Substance Abuse Assessment Survey implemented by UALR SRC starting FFY 2021.

Year	2021	2022	2023
Rate (%)	-	-	-

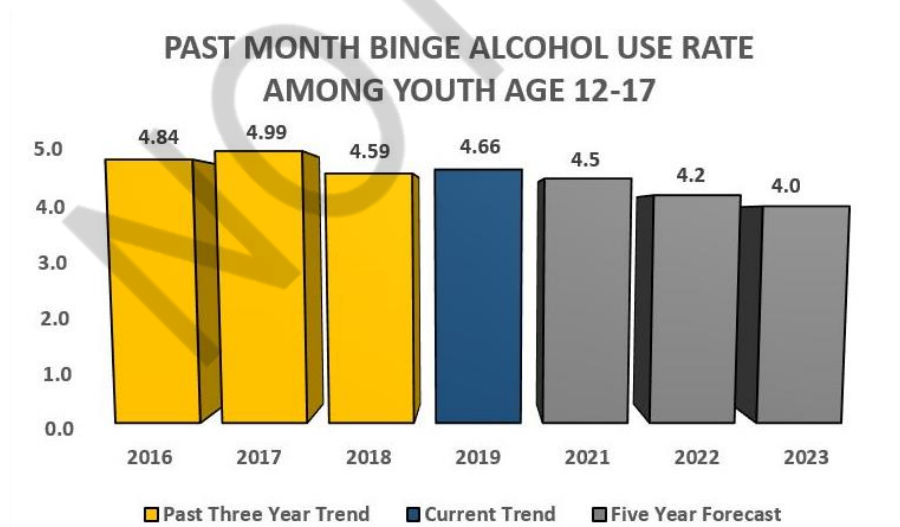
Table 9/Exhibit 9

Previous Source: CORE survey is available online at <http://core.siu.edu/>. Going forward, the past 2-week college student binge drinking measure will be sourced from the Collegiate Substance Abuse Assessment Survey conducted by the UALR SRC. Data will be available for this measure starting SFY 2021.

**OBJECTIVE 1.6b:** Lower the reported past month binge alcohol usage rate from 4.66% in 2019 to 4.0% by 2023 among youths age 12-17 in Arkansas according to National Survey on Drug Use and Health (NSDUH).

Year	2016	2017	2018	2019	2021	2022	2023
Rate (%)	4.84	4.99	4.59	4.66	4.5	4.2	4.0

Table 10/Exhibit 10: Archival, past three years, current and forecasted past month binge alcohol usage rate among Arkansas youth age 12-17. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used a reference for current rate.

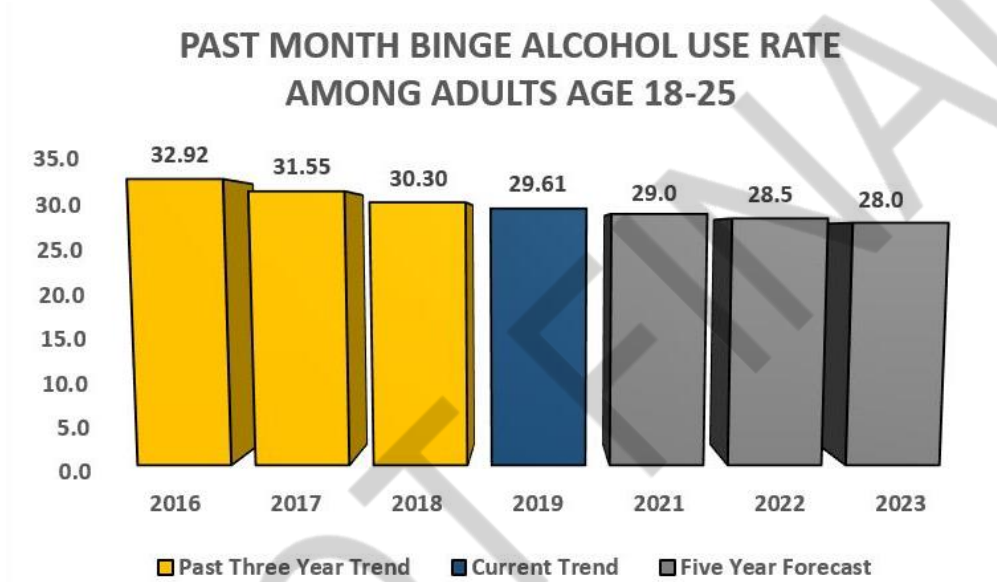


Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

OBJECTIVE 1.6c: Lower the reported past month binge alcohol usage rate from 29.61% in 2019 to 28.0% by 2023 among Arkansas adults age 18-25 according to National Survey on Drug Use and Health (NSDUH).

Year	2016	2017	2018	2019	2021	2022	2023
Rate (%)	32.92	31.55	30.30	29.61	29.0	28.5	28.0

Table 10/Exhibit 10: Archival, past three years, current and forecasted past month binge alcohol usage rate among Arkansas adults age 18-25. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used as a reference for current rate.

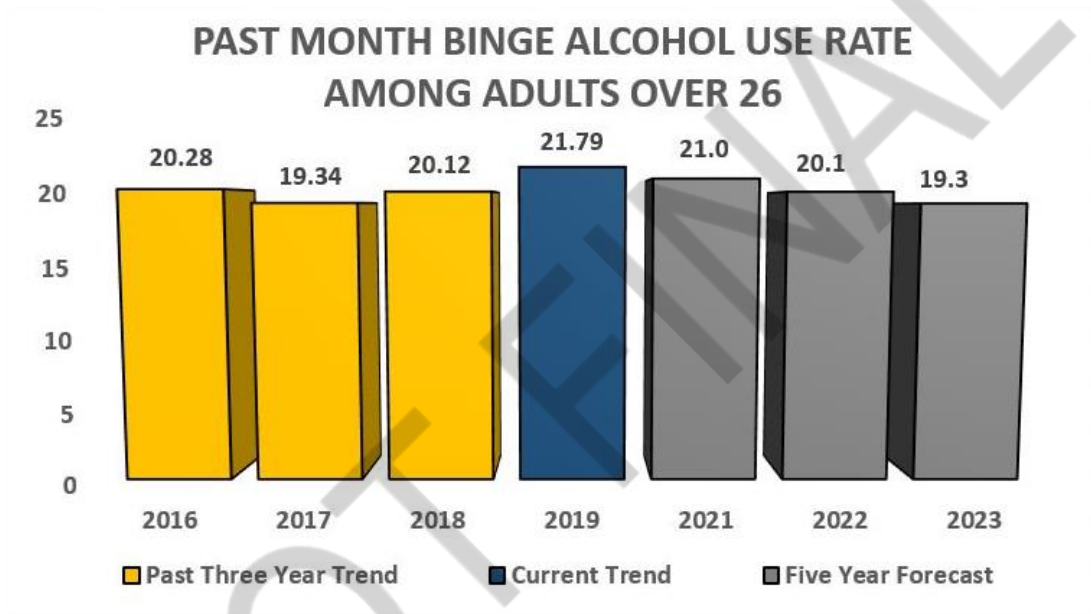


Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

**OBJECTIVE 1.6d:** Lower the reported past month binge alcohol usage rate from 21.79% in 2019 to 19.3% by 2023 among Arkansas adults age 26 or older according to National Survey on Drug Use and Health (NSDUH).

Year	2016	2017	2018	2019	2021	2022	2023
Rate (%)	20.28	19.34	20.12	29.61	21.0	20.1	19.3

Table 10/Exhibit 10: Archival, past three years, current and forecasted past month binge alcohol usage rate among Arkansas adults age 26 or older. SFY 2020 data has yet to be released for this measure. Hence, SFY 2019 rate is being used a reference for current rate.



Source: National Survey on Drug Use and Health (NSDUH). <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

## STRATEGIES

1. DAABHS/MidSOUTH will continue to 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. Collaborate with Arkansas Collegiate Network (ACN).
3. Encourage collaborative efforts to promote the implementation of newly developed Collegiate Substance Abuse Assessment Survey by colleges and universities statewide.
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

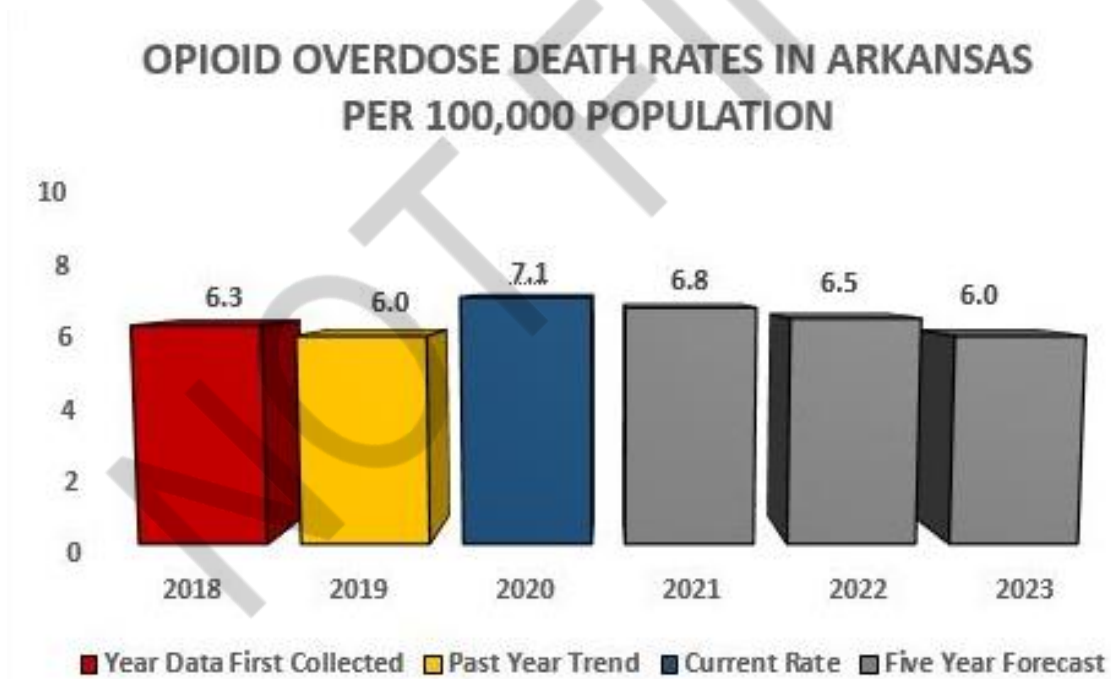
SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
<p>Renew ACDEC contract.</p> <p>Expand ACDEC program by recruiting more schools.</p> <p>Promote student led wellness programs on college campuses.</p> <p>Collaborate with ACDEC to provide prevention trainings to college students.</p>	<p>Expand ACN program by recruiting more schools.</p> <p>Promote student led wellness programs on college campuses.</p> <p>Collaborate with ACN to provide prevention trainings to college students.</p>	<p>Promote student led wellness programs on college campuses.</p> <p>Collaborate with ACN to provide prevention trainings to college students.</p> <p>Partner with ACN and school policy makers to implement Social Host laws on university campuses.</p>	<p>Promote student led wellness programs on college campuses.</p> <p>Collaborate with ACN to provide prevention trainings to college students.</p> <p>Partner with ACN and school policy makers to enforce Social Host laws on university campuses.</p>	<p>Promote student led wellness programs on college campuses.</p> <p>Collaborate with ACN to provide prevention trainings to college students.</p> <p>Partner with ACN and school policy makers to enforce Social Host laws on university campuses.</p>

## 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 Arkansas Foundation for Medical Care (AFMC) from 7.0% in 2019 to 6.5% by 2023.

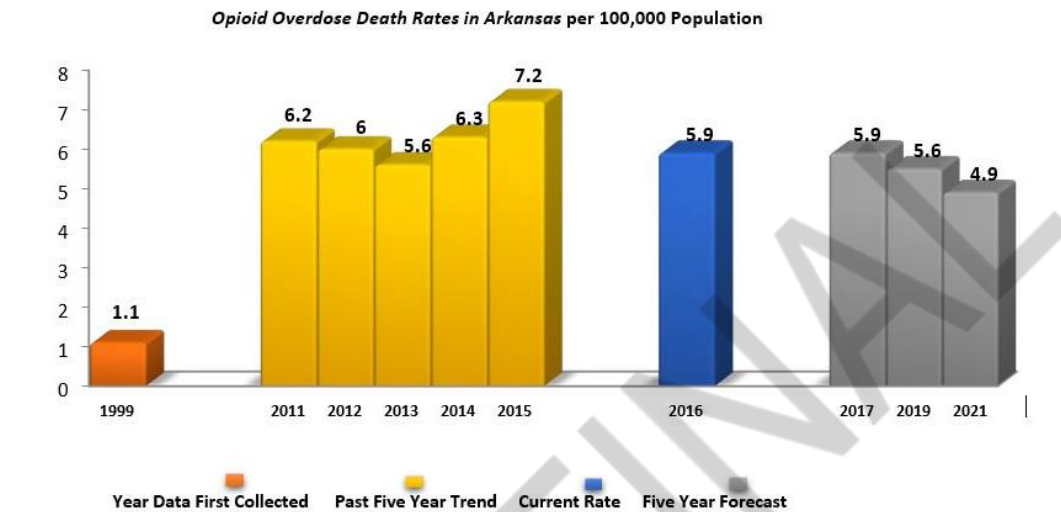
Year	2018	2019	2020	2021	2022	2023
Rate (%)	6.3	7.0	<u>7.1</u>	6.8	6.5	6.0

Table 11/Exhibit 11: Archival, past five years, current and forecasted Opioid Overdose Death Rates in Arkansas per 100,000 Population (Age-Adjusted). SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.



Source: AFMC. <https://www.arcgis.com/apps/MapSeries/index.html?appid=2977d338de974451af5ce8ff24d2a30c/>

In 2018, the opioid overdose death rate measure was sourced from the Arkansas Opioid Response Dashboard produced by the AFMC. Previous years were sourced from The Kaiser Family Foundation.  
<https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/>.



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



## STRATEGIES

1. DAABHS/MidSOUTH will continue to collaborate with University of Arkansas Criminal Justice Institute (CJI) to train first responders, physicians, and other health workers on prescribing practices.
2. DAABHS/MidSOUTH will continue to collaborate with CJI to identify high risk communities and develop awareness campaigns on the dangers of opioid drug abuse.
3. DAABHS/MidSOUTH will continue to collaborate with Arkansas Department of Health Injury and Violence Prevention section to provide training on bullying, mental health first aide and suicide prevention.
4. Expand the establishment of collegiate recovery and prevention programs.
5. Work with State Opioid Response (SOR1, SOR2) administrators to strengthen the peer recovery system .

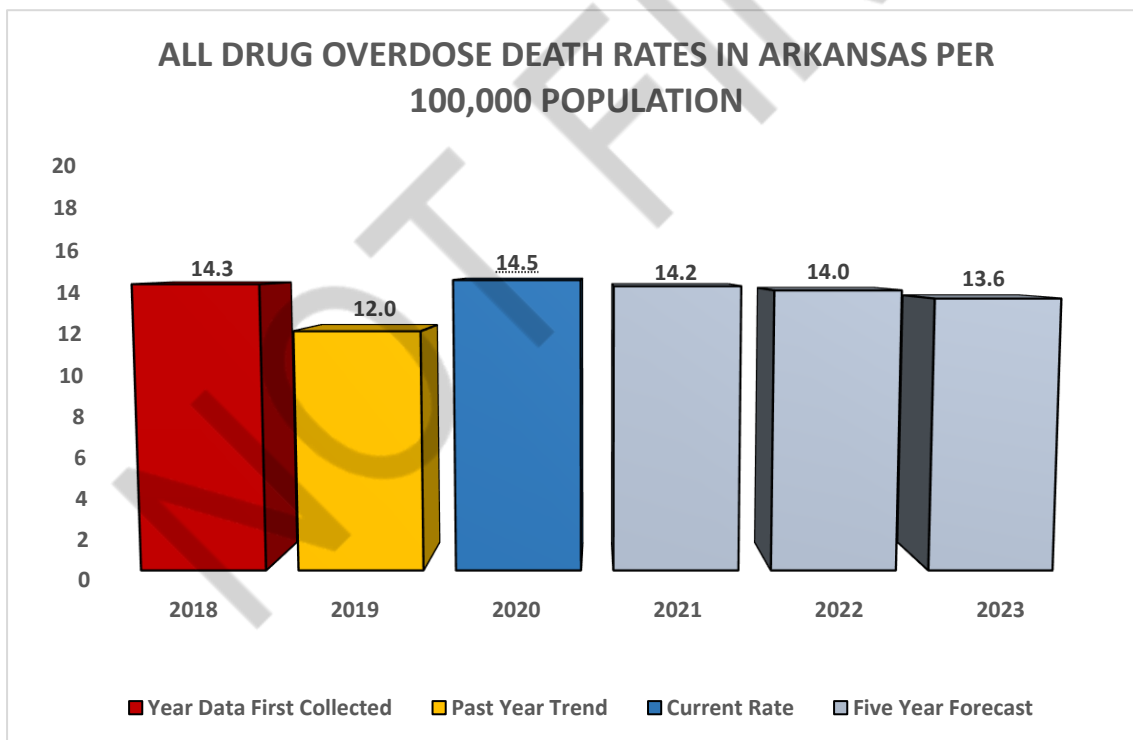
## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
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.	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 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.	Promote self-guided NARCAN training on AR Take Back to ACN member schools.	Promote self-guided NARCAN training on AR Take Back to ACN member schools.
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.	Promote self-guided NARCAN training on AR Take Back to ACN member schools.		

**OBJECTIVE: 2.2:** Lower the rate of All Drug Overdose Death Rates in Arkansas as reported by the AFMC from 15.3% in 2018 to 13.6% by 2023.

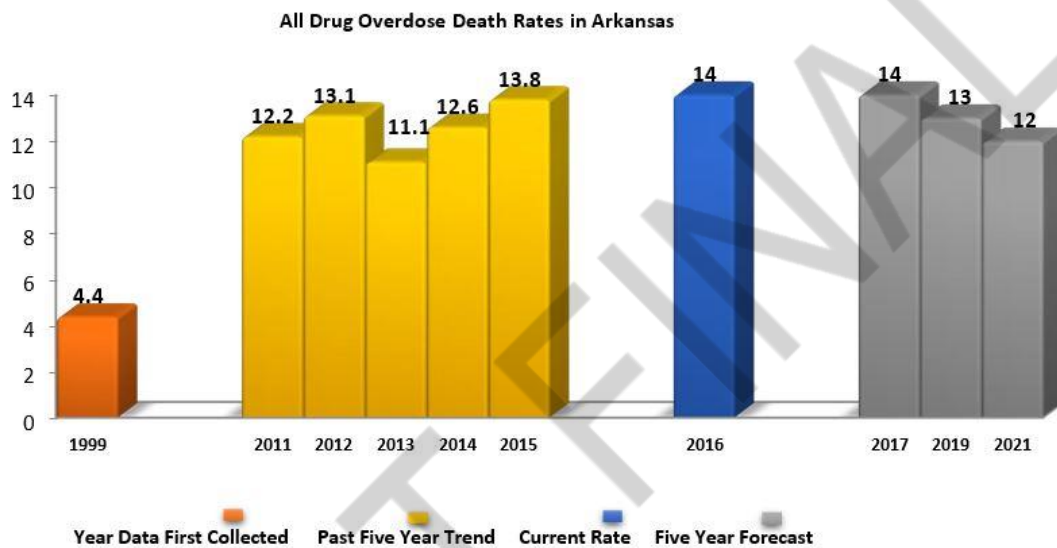
Year	2018	2019	2020	2021	2022	2023
Rate (%)	14.3	12.0	<u>14.5</u>	13.8	13.2	12.0

Table 12/Exhibit 12: Archival, past five years, current and forecasted *Opioid Overdose Death Rates* in Arkansas per 100,000 Population (Age-Adjusted). SFY 2020 has been underlined in both the table above and graph below to mark this year as a possible outlier due to the effects of the COVID-19 pandemic. Hence, SFY2019 rate is being used a reference for current rate.



Source: AFMC. <https://www.arcgis.com/apps/MapSeries/index.html?appid=2977d338de974451af5ce8ff24d2a30c/>

Previous Source: The Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/>. Going forward, the all drug overdose death rate measure will be sourced from the Arkansas Opioid Response Dashboard produced by the AFMC.



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

## STRATEGIES

1. Disseminate Information through speaking engagements, brochures, newsletters, media campaigns/radio/TV public service announcements, health fairs, and social media on the dangers of drug use.
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. Offer community alternative activities such as: drug free dances and parties, youth/adult leadership activities, community drop-in centers, and community service activities.
3. Provide prevention training to school staff/faculty.
4. DAABHS/MidSOUTH will continue to partner with community coalitions, policy makers, and other stakeholders to increase community awareness of drug misuse.
5. 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.
6. Encourage ACN to establish collegiate recovery and prevention programs.

## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
<p>Establish MOU's between Arkansas Department of Health Injury and Violence Prevention section on collaborative efforts.</p> <p>Collaborate with ADH Injury and Violence Prevention section to provide training on suicide screenings to community providers and promote suicide awareness.</p> <p>Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials.</p>	<p>Coordinate with ADH Injury and Violence Prevention section to disseminate suicide prevention information and conduct trainings on bullying and suicide prevention.</p> <p>Collaborate with ADH Injury and Violence Prevention section to disseminate suicide prevention materials.</p>	<p>Collaborate with ACN to establish collegiate recovery and prevention programs. Increase knowledge and skills by educating communities on marijuana risks through trainings.</p> <p>Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage. Promote student led wellness programs on college campuses.</p>	<p>Collaborate with ACN to establish collegiate recovery and prevention programs. Increase knowledge and skills by educating communities on marijuana risks through trainings.</p> <p>Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage. Promote student led wellness programs on college campuses.</p>	<p>Collaborate with ACN to establish collegiate recovery and prevention programs. Increase knowledge and skills by educating communities on marijuana risks through trainings.</p> <p>Partner with community coalitions, policy makers, and other stakeholders to change community norms towards marijuana usage. Promote student led wellness programs on college campuses.</p>

**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), Regional Lead Agencies (RLAs), 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 prevention providers.
2. DAABHS/MidSOUTH will continue to 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.
7. Provide capacity building training to providers and partners to develop sustainability plans for each region.

## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
<p>Enhance capacity of the Regional Prevention Provider system by increasing funding allocation.</p> <p>Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.</p> <p>Design and implement training and technical assistance system that will increase and enhance skills of providers to administer effective prevention services.</p> <p>Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.</p> <p>Establish County Prevention Taskforces.</p>	<p>Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.</p> <p>Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.</p> <p>Develop/identify training curriculums and conduct TOTs.</p>	<p>Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.</p> <p>Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.</p> <p>Conduct training curriculums and conduct TOTs.</p>	<p>Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.</p> <p>Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.</p> <p>Conduct training curriculums and conduct TOTs.</p>	<p>Collaborate with Arkansas Prevention Certification Board to increase the number of certified preventionists in the state.</p> <p>Encourage blending and braiding of funding streams to implement prevention strategies among prevention stakeholders.</p> <p>Conduct training curriculums and conduct TOTs.</p>



**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	SFY 2023
<p>Ensure increased statewide participation in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey by recruiting more schools.</p> <p>Increase collaboration among partner agencies to share data.</p> <p>Create marketing plan to promote available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p>	<p>Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE Survey.</p> <p>Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p>	<p>Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), Arkansas Collegiate Substance Abuse Survey.</p> <p>Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p>	<p>Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), Arkansas Collegiate Substance Abuse Survey.</p> <p>Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p>	<p>Recruit more schools to participate in the Arkansas Prevention Needs Assessment Student Survey (APNA), Arkansas Collegiate Substance Abuse Survey.</p> <p>Disseminate available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p> <p>Increase collaboration among partner agencies to share data.</p> <p>Create marketing plan to promote available data to behavioral health workforce, schools, policy makers, law enforcement and other prevention stakeholders.</p>

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

## STRATEGIES

1. DAABHS/MidSOUTH will continue to 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 continue to partner with Criminal Justice Institute to provide training on Naloxone to all first responders, school resource officers, and other community stakeholders.

## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
<p>Conduct assessments to determine training needs.</p> <p>Provide year round prevention trainings and annual statewide prevention conference.</p> <p>Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.</p> <p>Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders</p> <p>Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.</p> <p>Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.</p>	<p>Conduct assessments to determine training needs.</p> <p>Provide year round prevention trainings and annual statewide prevention conference.</p> <p>Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.</p> <p>Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders</p> <p>Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.</p> <p>Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.</p>	<p>Conduct assessments to determine training needs.</p> <p>Provide year round prevention trainings and annual statewide prevention conference.</p> <p>Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.</p> <p>Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders</p> <p>Provide training and technical assistance to enhance workforce knowledge and capacity to implement evidence based programs and environmental prevention strategies.</p> <p>Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.</p>	<p>Conduct assessments to determine training needs.</p> <p>Provide year round prevention trainings and annual statewide prevention conference.</p> <p>Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.</p> <p>Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders</p> <p>Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.</p> <p>Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.</p>	<p>Conduct assessments to determine training needs.</p> <p>Provide year round prevention trainings and annual statewide prevention conference.</p> <p>Collaborate with Arkansas Prevention Certification Board to provide workforce development trainings for prevention providers and other behavioral health workers.</p> <p>Provide trainings to increase the capacity and competency of Arkansas' substance abuse prevention workforce and other stakeholders</p> <p>Provide training and technical assistance to enhance workforce knowledge of and capacity to implement evidence based programs and environmental prevention strategies.</p> <p>Provide periodic trainings on SPF and SAPST to new providers and other behavioral healthcare providers.</p>

## 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 State Epidemiological Outcome Workgroup (SEOW) and Wyoming Survey and Analysis Center (WYSAC), the plan will be continuously monitored and evaluated periodically to determine if forecasted benchmarks are being met. The plan outcomes will be measured 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.
  - Opioid and All Drug Overdose Death Rates
2. Process data will continue to 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. Collaborate with partner agencies to leverage resources.
4. Continue to fund and maintain the SEOW to provide state and county-level data to support substance abuse prevention planning and evaluation for the prevention system.

## ACTION TIMEFRAME

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Continuously measure process and outcome data to determine if forecasted benchmarks are met.  Measure outcomes by reviewing the usage rates for selected substances.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.  Measure outcomes by reviewing the usage rates for selected substances.	Continuously measure process and outcome data to determine if forecasted benchmarks are met. Measure outcomes by reviewing the usage rates for selected substances.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.  Measure outcomes by reviewing the usage rates for selected substances.	Continuously measure process and outcome data to determine if forecasted benchmarks are met.  Measure 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 policymakers with a comprehensive picture of substance abuse challenges faced in Arkansas. Substance abuse data is compiled from various national and state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, etc.) to integrate information regarding the causes and consequences of the use of alcohol, tobacco, and other drugs in both adult and child populations. The profile includes a general population profile, information about factors that may contribute to substance abuse, and in an effort to determine the effect of substance abuse in Arkansas, health and economic consequences. Specific county level data is included for each of the 75 counties as a resource for community leaders throughout Arkansas. This report is posted online at <http://www.preventionworksar.org/>.



## Arkansas Prevention Needs Assessment

The Arkansas Prevention Needs Assessment (APNA) student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted 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 10<sup>th</sup> 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/>.

## AFMC

AFMC is a nonprofit organization engaged with beneficiaries and health care providers in all settings to improve overall health and consumers' experience of care, while reducing health care costs. We accomplish this through education, outreach, data analysis, information technology, medical case review and marketing/communications services. <https://afmc.org/>.

## APPENDIX i.

## 2023 Arkansas Prevention Strategic Plans Outcomes

Goal	Outcome Measured	Outcomes/Forecasts
1. Lower the reported 30-day alcohol usage rate according to the Arkansas Prevention Needs Assessment from 11% in 2016 to 10% in 2019.	30-day alcohol usage rate according to the APNA by 2019 was reported at 9.7%	This represents a 1.3 percentage point decrease.  Goal Surpassed by 0.3%  Forecast for 2023 is 8.8%
2. Lower the reported 30-day smokeless tobacco usage rate according to the Arkansas Prevention Needs Assessment from 4.3% in 2016 to 3.9% in 2019 and the cigarette usage rate from 5.6% in 2016 to 5% in 2019	30-day smokeless tobacco usage rate according to the APNA by 2019 was reported at 3.1%	This represents a 1.2 percentage point decrease.  Goal Surpassed by 0.8%  Forecast for 2023 is 3.0%
	30-day cigarette usage rate according to the APNA by 2019 was reported at 3.3%	This represents a 2.3 percentage point decrease.  Goal Surpassed by 1.7%  Forecast for 2023 is 3.1%
3. Lower the reported 30-day usage rate for prescription drugs according to the Arkansas Prevention Needs Assessment from 3% in 2016 to 2.9% by 2019.	30 day prescription drugs usage rate according to the APNA by 2019 was reported at 2.3%.	This represents a 0.7 percentage point decrease.  Goal Surpassed by 0.6%  Forecast for 2023 is 2.1%

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.

### 2019 Arkansas Prevention Strategic Plans Outcomes of Infrastructure Needs Identified

Infrastructure Needs Identified	Outcome
Need to source more funding from the state government and braiding of funds with other agencies.	<p>Prevention services did not receive funds from the state government. However, there has been increased coordination of services and braiding of funds, especially through trainings, with other agencies.</p> <p>Prevention services was able to secure the following discretionary funds from the Substance Abuse and Mental Health Services Administration (SAMHSA):</p> <ul style="list-style-type: none"> <li>• Substance Abuse Block Grant (SABG)</li> <li>• Strategic Prevention Framework Partnership for Success grant (PFS)</li> <li>• Prescription Drug Overdose Grant (PDO)</li> <li>• State Opioid Response grant (SOR)</li> <li>• First Responders-Comprehensive Addiction and Recovery Act Grants (FR-CARA)</li> </ul>
Increase collaboration among behavioral health organizations	DAABHS and MidSOUTH have increased collaborations with other behavioral health agencies.
Restructuring of the technical assistance system at the regional/community level	<p>DAABHS remains the Single State Agency (SSA) with authority to oversee the Substance Abuse Block Grant (SABG).</p> <p>DAABHS has contracted the University of Arkansas Little Rock, MidSOUTH Center for Prevention and Training to manage the state's prevention program.</p> <p>The regions of service were restructured from 8 regions to 13 regions.</p> <p>MidSOUTH is also in contract with Arkansas Collegiate Network (ACN).</p>

Comprehensive data management system	<p>The following data reporting systems are being used:</p> <ul style="list-style-type: none"> <li>• WITS data management system</li> <li>• REDCap</li> <li>• SAMHSA's Performance Accountability and Reporting System (SPARS)</li> <li>• PFS monthly report</li> </ul>
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.

### APPENDIX iii.

#### Original Arkansas Strategic Planning Committee

Name	Agency	Title
Chuks Odor	UA Little Rock/MidSOUTH Center for Prevention and Training	Prevention Program Manager
Tenesha Barnes	Arkansas Department of Human Services	Early Intervention and Prevention Director
Nelda Barnard	Arkansas Department of Human Services	Program Coordinator
Steven Blackwood		Consultant
Gloria Gordon	Private Citizen	Consultant
Megan Greenwood	Pulaski Technical College	ACDEC Representative
Darla Kelsay	UA Little Rock/MidSOUTH Center for Prevention and Training	Substance Abuse Prevention Coordinator
Kirk Lane	Arkansas Department of Human Services	State Drug Director
Jan Littleton-Caldwell	UA Little Rock/MidSOUTH Center for Prevention and Training	Assistant Director, MidSOUTH

Hayse Miller	Family Service Agency, Inc.	Region 9 Regional Prevention Representative
Sharron Mims	Arkansas Department of Human Services	Program Manager
Lisa Perry	Crowley's Ridge Development Council, Inc.	Region 4 Regional Prevention Representative
Gigi Peters	UA Little Rock/MidSOUTH Center for Prevention and Training	Executive Director, MidSOUTH
Joycelyn Pettus	Arkansas Department of Human Services	Grants Analyst
Gina Redford	Arkansas Foundation for Medical Care	Manager, Analytical Services
Laurie Reh	Preferred Family Health Decision Point	Region 1 Regional Prevention Representative
Johnny Riley	Bridging the Gaps	Executive Director
Rosalie Shahan	UA Little Rock/MidSOUTH Center for Prevention and Training	Prevention Admin and Data Specialist
Kent Thompson	Arkansas Foundation for Medical Care	Supervisor, Program Evaluation
Jill Weinischke	T.O.U.C.H Coalition	T.O.U.C.H. Project Coordinator

#### Current Arkansas Strategic Planning Committee

Name	Agency	Title	Email
Chuks Odor	UA Little Rock/MidSOUTH Center for Prevention and Training; LEAD: Strategic Planning Committee	Prevention Program Manager	<a href="mailto:CCOdor@midsouth.ualr.edu">CCOdor@midsouth.ualr.edu</a>
Tenesha Barnes	Arkansas Department of Human Services	Early Intervention and Prevention Director	<a href="mailto:Tenesha.Barnes@dhs.arkansas.gov">Tenesha.Barnes@dhs.arkansas.gov</a>



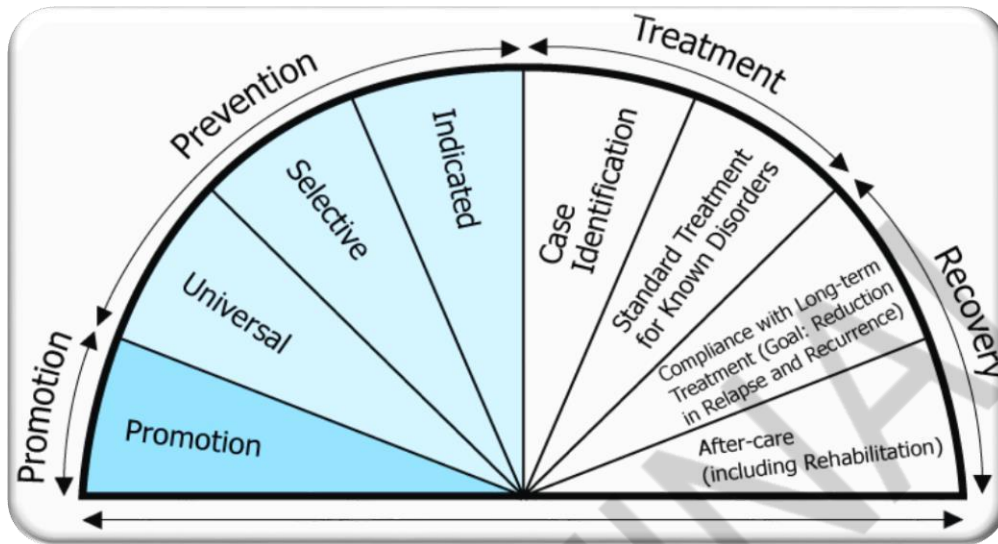
Gloria Gordon	Private Citizen	Consultant	<a href="mailto:gloria_gordon@sbcglobal.net">gloria_gordon@sbcglobal.net</a>
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Sharron Mims	Arkansas Department of Human Services	Program Manager	<a href="mailto:Sharron.Mims@asp.arkansas.gov">Sharron.Mims@asp.arkansas.gov</a>
Lisa Perry	Crowley's Ridge Development Council, Inc.	Region 4 Regional Prevention Representative	<a href="mailto:LPerry@crdcnea.com">LPerry@crdcnea.com</a>
Gigi Peters	UA Little Rock/MidSOUTH Center for Prevention and Training	Executive Director, MidSOUTH	<a href="mailto:GAPeters@midsouth.ualr.edu">GAPeters@midsouth.ualr.edu</a>
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Gina Redford	Arkansas Foundation for Medical Care	Manager, Analytical Services	<a href="mailto:Gina.Redford@afmc.org">Gina.Redford@afmc.org</a>
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Rosalie Shahan	UA Little Rock/MidSOUTH Center for Prevention and Training	Prevention Admin and Data Specialist	<a href="mailto:rsshahan@midsouth.ualr.edu">rsshahan@midsouth.ualr.edu</a>
Rodney Wambeam	Wyoming Survey & Analysis Center (WYSAC)	Senior Research Scientist	<a href="mailto:Rodney@uwyo.edu">Rodney@uwyo.edu</a>
Kent Thompson	Arkansas Foundation for Medical Care	Supervisor, Program Evaluation	<a href="mailto:KThompson@afmc.org">KThompson@afmc.org</a>
Lynetta Dickerson	Arkansas Department of Human Service	Substance Abuse Block Grant Program Coordinator	<a href="mailto:Lynetta.Dickerson@dhs.arkansas.gov">Lynetta.Dickerson@dhs.arkansas.gov</a>
Kymala Calloway	Arkansas Department of Human Service	PREVENTION SERVICES GRANT ANALYST	<a href="mailto:Kymala.Calloway@dhs.arkansas.gov">Kymala.Calloway@dhs.arkansas.gov</a>
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Jamal Williams	Arkansas Department of Human Service	First Responders Comprehensive Addiction and Recovery Act (FR CARA) - Project Director	<a href="mailto:Jamal.Williams.DHS@dhs.arkansas.gov">Jamal.Williams.DHS@dhs.arkansas.gov</a>
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Gregory Myles	Arkansas Department of Human Service	Research & Statistics Manager	<a href="mailto:Gregory.Myles@dhs.arkansas.gov">Gregory.Myles@dhs.arkansas.gov</a>
Amanda Hubbard	Arkansas Department of Human Service	State Opioid Response Coordinator	<a href="mailto:Amanda.Hubbard@dhs.arkansas.gov">Amanda.Hubbard@dhs.arkansas.gov</a>
Jill Weinischke	T.O.U.C.H Coalition	T.O.U.C.H. Project Coordinator	<a href="mailto:Jill.Touch@gmail.com">Jill.Touch@gmail.com</a>

NOT FINAL

## APPENDIX iv.

## Continuum of Care

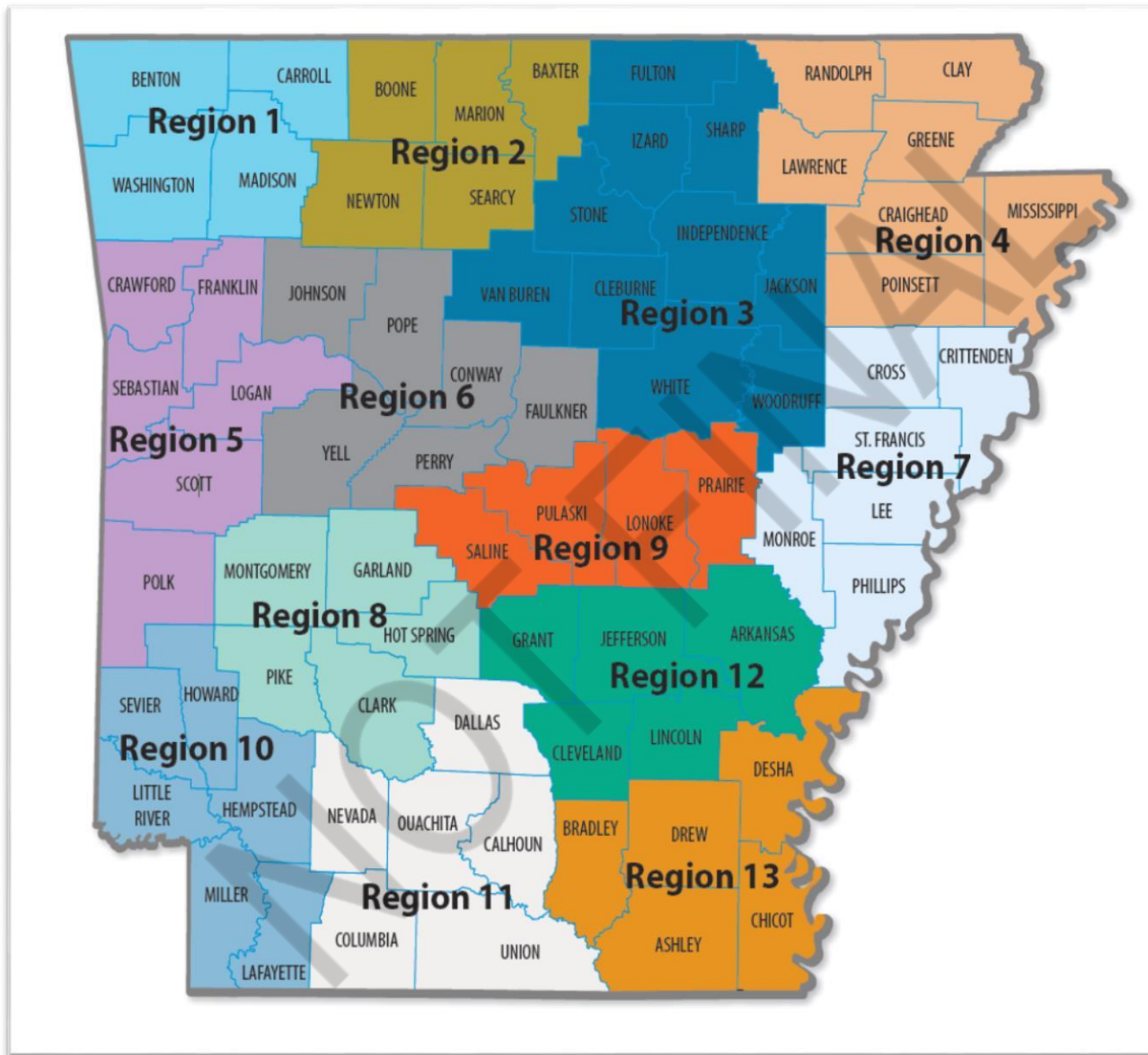


A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, 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





## Sources

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





NOT FINAL





## Environmental Factors and Plan

### 9. Statutory Criterion for MHBG - Required for MHBG

#### Narrative Question

##### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

#### Please respond to the following items

##### Criterion 1

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

DAABHS ensures mental health and behavioral health care is available to children, youth, and adults throughout the state. Outpatient mental health 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. PASSE members, but also those without insurance or a payor source for needed services can access a broader scope of rehabilitative services, which 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. Many of the mentioned services are now available by telehealth. 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. 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 31 in 2017 to over 541 as of June 2021 and the number of BHA site has risen from 253 in 2017 to 357 in June 2021.
2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
  - a) Physical Health ☒ Yes ☐ No
  - b) Mental Health ☒ Yes ☐ No
  - c) Rehabilitation services ☒ Yes ☐ No
  - d) Employment services ☒ Yes ☐ No
  - e) Housing services ☒ Yes ☐ No
  - f) Educational Services ☒ Yes ☐ No
  - g) Substance misuse prevention and SUD treatment services ☒ Yes ☐ No
  - h) Medical and dental services ☒ Yes ☐ No
  - i) Support services ☒ Yes ☐ No
  - j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) ☒ Yes ☐ No
  - k) Services for persons with co-occurring M/SUDs ☒ Yes ☐ No

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

3. Describe your state's case management services

Care Coordination from the assigned PASSE replaces case management in the previous CASSP program. This Care Coordinator assists the individual in obtaining the best array of services to meet their needs and is available for children and adults.

Additionally, case management is now a reimbursable service for persons accessing Counseling Level services. One of the primary tasks for case management is to ensure the individual gets access to available and appropriate healthcare insurance, but also other resources which positively impact the social determinants of health. As a part of the "Rural Life360 HOME" in the Arkansas Medicaid expansion program, a care coordinator will be assigned to all persons who have a social determinant of health need and a behavioral health need. These Rural Life360 HOMEs will operate out of a rural hospital which also offers acute crisis unit care for individuals in mental health/substance use disorder crisis.

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 4.2 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. The development of a robust Peer Recovery Support workforce is also seen as a way to decrease unnecessary hospitalizations and increase connection to services prior to crisis situations.

NOT FINAL

## 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	124000	24116
2.Children with SED	35790	12563

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 statewide prevalence of Adults with SMI was compiled by NRI in 2019 using the official SAMHSA estimation methodology. According to this data, prevalence estimates for adults in Arkansas in the SMI category amount to 124,000.

Children (17 and under)The statewide prevalence of Children with SED was compiled by NRI in 2019 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 35,790 for ages 9 to 17.

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 2020 according to submitted URS tables, specifically tables 14A & B.

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

**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?

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

NOT FINAL

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

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

**Criterion 4****a.** Describe your state's targeted services to rural population.

CMHC contracts have been revised to require agencies to have at least one physical location in every county of their Region, and all are compliant at the time of this application. Additionally, to combat the challenges with transportation, and limited mental health professionals in our more rural areas, CMHCs are required to provide telemedicine services which have now been expanded to include most outpatient services. FQHCs and rural health clinics can provide behavioral health services, including telehealth services. As noted previously, the AR HOME Medicaid expansion program targets rural health to include acute crisis units, crisis training and telehealth equipment including access through first responder personnel.

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

Arkansas annually receives approximately \$303,000 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 2019 Annual Report (2020 reporting has not been released by SAMHSA yet), 396 persons were contacted by PATH staff and 272 persons were enrolled in PATH services, including 8 veterans. The funds were used to assist 173 individuals in obtaining temporary or permanent housing (from Services Provided section ). 163 persons received a screening or mental health evaluation and case management services. Of these, 38 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. Nursing homes have been added as a place of allowable services for Medicaid. DAABHS has worked with the Senior Centers and AAA centers through agency nurses to assure information regarding accessing services and emergency service numbers are distributed to the older adult population.

NOT FINAL

## Criterion 5: Management Systems

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

**Criterion 5**

Describe your state's management systems.

DAABHS contracts with 12 Community Mental Health Centers to fulfill all of the service requirements of the MHBG. Each provider is contracted to provide all MHBG services, training of staff and financial accountability of grant funds. 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. SFY2021 contracts also include outreach for churches/youth pastors, intramural organizations, community centers, and summer youth programs. 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 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.

In FY2021, AFMC reported a total of 2,819 calls with 2,253 requesting information on substance use disorder providers, and 1,138 for mental health providers. Some of the callers were seeking both kinds of services, so adding up the requests for provider types and comparing to number of actual calls will not equal.

NOT FINAL



**Footnotes:**

NOT FINAL

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

b) Services for special populations:

- |                                      |   |
|--------------------------------------|---|
| Targeted services for veterans?      | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Adolescents?                         | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Other Adults?                        | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Medication-Assisted Treatment (MAT)? | <input checked="" type="radio"/> Yes <input type="radio"/> No |

## Criterion 2

NOT FINAL

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ Yes ☐ No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling ☒ Yes ☐ No
  - b) Establishment of an electronic system to identify available treatment slots ☒ Yes ☐ No
  - c) Expanded community network for supportive services and healthcare ☒ Yes ☐ No
  - d) Inclusion of recovery support services ☒ Yes ☐ No
  - e) Health navigators to assist clients with community linkages ☒ Yes ☐ No
  - f) Expanded capability for family services, relationship restoration, and custody issues? ☒ Yes ☐ No
  - g) Providing employment assistance ☒ Yes ☐ No
  - h) Providing transportation to and from services ☒ Yes ☐ No
  - i) Educational assistance ☒ Yes ☐ No
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

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, if applicable ☐ Yes ☒ No
  - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation ☐ Yes ☐ No
2. Has your state identified a need for any of the following:
  - a) Electronic system with alert when 90 percent capacity is reached ☐ Yes ☒ No
  - b) Automatic reminder system associated with 14-120 day performance requirement ☐ Yes ☒ No
  - c) Use of peer recovery supports to maintain contact and support ☒ Yes ☐ No
  - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? ☒ Yes ☐ No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.  
 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.C.Â§ 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, please provide a brief description of the elements and the arrangement

NOT FINAL



**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access ☒ Yes ☐ No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services ☒ Yes ☐ No
  - c) Establish a peer recovery support network to assist in filling the gaps ☒ Yes ☐ No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) ☒ Yes ☐ No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations ☒ Yes ☐ No
  - f) Explore expansion of services for:
    - i) 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 including the exceptions for disclosure: ☒ Yes ☐ No

### Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

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) ☒ Commission on the Accreditation of Rehabilitation Facilities
- ii) ☒ The Joint Commission
- iii) ☒ Other (please specify)

**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☐ Yes ☒ No
2. Has your state identified a need for any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ☐ Yes ☒ No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ☐ Yes ☒ No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state ☒ Yes ☐ No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ☒ Yes ☐ No
  - c) Performance-based accountability: ☒ Yes ☐ No
  - d) Data collection and reporting requirements ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs ☒ Yes ☐ No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services ☒ Yes ☐ No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ☒ Yes ☐ No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ☒ Yes ☐ No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
  - a) Prevention TTC? ☒ Yes ☐ No
  - b) Mental Health TTC? ☐ Yes ☒ No
  - c) Addiction TTC? ☒ Yes ☐ No
  - d) State Targeted Response TTC? ☒ Yes ☐ No

**Waivers**

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

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women ☐ Yes ☒ No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis ☐ Yes ☒ No
  - b) Early Intervention Services Regarding HIV ☐ Yes ☒ No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment ☐ Yes ☒ No
  - b) Professional Development ☐ Yes ☒ No

c) Coordination of Various Activities and Services

☐ Yes ☒ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

<https://humanservices.arkansas.gov/divisions-shared-services/aging-adult-behavioral-health-services/reports-publications/>

NOT FINAL

**Footnotes:**

NOT FINAL

## 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 2020-FFY 2021? ☐ Yes ☒ No

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

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#### Footnotes:

NOT FINAL



## Environmental Factors and Plan

### 12. Trauma - Requested

#### Narrative Question

**Trauma**<sup>57</sup> 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<sup>58</sup> paper.

<sup>57</sup> 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.*

<sup>58</sup> 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.

Arkansas Foundation for Medical Care (AFMC) 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 the University of Arkansas for Medical Science (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. Additionally, UAMS' ARBest (Arkansas Building Effective Services for Trauma) branch regularly offers comprehensive training and certification in Trauma-focused Cognitive Behavioral Therapy (TFCBT). DAABHS intends to use COVID and/or ARPA grant funds to request

additional training courses in TFCBT which will be offered to any clinician in the state.

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 UAMS, University of Arkansas at Little Rock, and ZERO TO THREE, developed curriculum for training in infant mental health as well as certification process. This certification process requires training in an evidenced-based dyadic treatment (e.g. Parent-Child Interaction Therapy, Theraplay®, and Child parent Relationship Therapy) or TFCBT and the DC:0-5 curriculum.

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

None at this time.

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**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### 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.<sup>59</sup>

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.<sup>60</sup>

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.

<sup>59</sup> 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, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <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:

Juvenile Justice: The Juvenile system has been transformed by The Division of Youth Services (DYS). There is currently more intensive monitoring of Assessment and Treatment for the youth that are committed into the DHS system through a multi-disciplinary team approach. The team works on the front end to identify the individual needs of the youth regarding their mental health, substance misuse, education, and health matters. The youth are then monitored at least every 90 days by the team who work in collaboration with the providers to assist the youth with meeting their treatment goals.

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 competitive bid process. Juveniles admitted to the Juvenile Drug Court program are provided a number of services including outpatient therapy, case management, and periodic drug tests. 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). 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 indicating such is presented to the court and the individual can then be ordered to proceed in 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 out on bond in the community 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 any of the latter cases 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-patient services. If the timeline 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 either: 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, Arkansas 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. 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 need for behavioral health treatment; and ensure he/she has access to treatment. The panel works 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 cycle.

According to an Arkansas Community Correction report, there are over 65,000 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 explore all efforts to make treatment available in order to keep felons from ending up back behind bars.

#### Specialty Courts:

Act 895 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 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 strives to 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 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 is evaluated under the following schedule. (1) A specialty court program application submitted on or after the effective date of the act requires 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 as of fiscal year 2019 shall be evaluated under the requirements of this section prior to expending resources budgeted for the next fiscal year; 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.

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 upon their release date.

The overhaul of Medicaid Expansion, known as ARHome (Arkansas Health & Opportunity for Me) does include a targeted focus for persons aged 19-24 who were formerly in the custody of the Division of Youth Services or were formerly incarcerated.

According to our data, a large percentage of these two populations were enrolled in a Medicaid expansion plan but health, behavioral health, and general social determinant categories scored quite low, indicating poor outcomes.

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

None at this time

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**Footnotes:**

As part of the current contract with our community mental health centers, these contractors must deliver services to indigent individuals who are incarcerated, including crisis services.

NOT FINAL

## Environmental Factors and Plan

### 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], 49[4], and 63[5].

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.

**TIP 40 - <https://www.ncbi.nlm.nih.gov/books/NBK64245/> [ncbi.nlm.nih.gov]**

**TIP 43 - <https://www.ncbi.nlm.nih.gov/books/NBK64164/> [ncbi.nlm.nih.gov]**

**TIP 45 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf> [store.samhsa.gov]**

**TIP 49 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf> [store.samhsa.gov]**

**TIP 63 - [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/PEP20-02-01-006\\_508.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf) [store.samhsa.gov]**

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☒ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ☒ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds? ☐ Yes ☐ No
  - a) ☐ Methadone
  - b) ☐ Buprenorphine, Buprenorphine/naloxone
  - c) ☐ Disulfiram
  - d) ☐ Acamprosate
  - e) ☐ 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.*

**Footnotes:**

NOT FINAL



## Environmental Factors and Plan

### 15. Crisis Services - Required for MHBG

#### 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.<sup>61</sup> 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](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"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.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>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?

\*With Arkansas' focus on significantly increasing the behavioral health Peer workforce, we are hopeful that Peer warm lines will be established within the next two years.

\*We acknowledge that we still have gaps in implementing true mobile crisis outreach and services and want to clearly indicate that a significant portion of our 5% Crisis Set Aside, COVID funds, and ARPA funds are being directed specifically to closing the existing gaps, and enhancing overall services. Our goal is to develop a robust system which can mirror the anyone, anywhere, any time concept.

\* We acknowledge gaps in these areas, too. With the renewed focus on building our Peer workforce, our plans for the 5% Crisis Set Aside, COVID, and ARPA funds all incorporate plans to increase the number of well-trained peers employed in areas where they will have opportunities to engage persons in crisis in a meaningful and therapeutic relationship. We hope that this immediate connection to a Peer, be it in an emergency room, a crisis unit, a court room, or when interacting with first responders, will lead to a solid connection which will ensure adequate and appropriate response to the immediate crisis, connection with mental health professionals when needed, and to make certain connections with needed resources are enabled.

+ In previous years Arkansas had a more intense focus on the development of Family Support Partners. Unfortunately, the workforce has waned. Once again, with our renewed focus on Peer Support, we are hopeful that Family Support Partners can be a renewed focus as one of our specialty Peer areas.

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 October 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, but these services are still being underutilized by providers. 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 home in on ensuring appropriate aftercare services are implemented for each individual.

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

None at this time

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**Footnotes:**

## Environmental Factors and Plan

### 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.

We are in the process of aligning training for our SUD Peers and our Mental Health Peers to ensure a consistently trained workforce is developed initially. Overtime, we will add specialty areas, such as criminal justice, Youth Support Specialists, or crisis services. Arkansas is one of the few states which has a tiered model of Peer Services, including a Core level, Advanced Level, and Peer Supervisor Level. As we are specifically focusing on increasing our Peers with lived experience in mental health, we are educating providers and peers about the importance of Peer Supervision, and not limiting supervision to a clinical focus.

SUD Recovery Support services are 100% non-clinical and provided by the recovery communities and peer workers. Currently Arkansas has 360 trained peer support specialists who provide support and service in multiple settings such as Emergency Departments, Jail Recovery Programs, Drug Courts, Criminal Courts, Recovery Residences. Additionally, we have an overdose response team where a law enforcement officer and a peer worker response to the scenes as a team.

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, including clinical/professional services. The SUD providers are actually surging far ahead of mental health providers with embracing Peer Services. Collectively, we are working to break down barriers, identify reasons for resistance/fear, and to ensure education is made available such that Arkansans will soon be readily able to access this crucial service in the continuum of care.

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

Arkansas is the only state that has created a career ladder for the peer recovery work force.

#### THE ARKANSAS MODEL

The Arkansas Model has three levels allowing peer specialists to advance in their profession:

- o Arkansas Core Peer Recovery Specialist (PR)
- o Arkansas Advanced Peer Recovery Specialist (APR)
- o Arkansas Peer Recovery Peer Supervisor (PRPS)

Ensuring that peer specialist are only supervised by seasoned peer workers. The Arkansas Peer Specialist Program (APSP) is an innovative three-tiered credentialing process that allows an individual the opportunity to progress through the core, advanced and supervision levels of The Arkansas Model. This process is designed to produce highly trained and knowledgeable peer specialists. The APSP is a collaborative effort between NAADAC, the Association for Addiction Professionals, and the State of Arkansas. This organized system will streamline each step of the credentialing process and allow users access to a one-stop shop for all their peer credentialing needs.

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

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#### Footnotes:

#2 MH is not measuring anything currently, but plan to do some pre and post measurement regarding crisis services to determine adequacy and appropriateness of the continuum of resources as we make improvements to our Crisis System, especially with the addition of Peer Services and a true Mobile Crisis approach.

## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

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

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

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

#### 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

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

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 services/standards became effective which allowed for additional community supports and that workforce is in development. It has been slow to take off in some areas. Arkansas continues to make updates to our policies and services to ensure home and community-based services are expanded and available to all who need them. For instance, we recently developed a new provider type, Community Support System Provider (CSSP) which only provides the home and community-based services.

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#### Footnotes:

While the state does not have a plan to transition individuals from a hospital to a community setting, Arkansas does strive to ensure the least restrictive placement option.

## Environmental Factors and Plan

### 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.<sup>63</sup> 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.<sup>64</sup> 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.<sup>65</sup>

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.<sup>66</sup> 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.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> 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).

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

<sup>64</sup>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.

<sup>65</sup>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](http://www.cdc.gov/injury/wisqars/index.html).

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

<sup>67</sup>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>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

### Please respond to the following items:

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED? ☒ Yes ☐ No
  - The recovery and resilience of children and youth with SUD? ☒ Yes ☐ No
- 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:
  - Child welfare? ☒ Yes ☐ No
  - Juvenile justice? ☒ Yes ☐ No
  - Education? ☒ Yes ☐ No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization? ☒ Yes ☐ No
  - Costs? ☒ Yes ☐ No
  - Outcomes for children and youth services? ☒ Yes ☐ No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
  - Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system? ☒ Yes ☐ No
  - for youth in foster care? ☒ Yes ☐ No

- 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 over 300 sites certified behavioral health agencies across the state and well over 500 Independently Licensed Clinicians (also Medicaid providers) who can provide outpatient treatment services for mental health or substance use disorders. 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.

The Division of Youth Services has undergone a two year overhaul to ensure that youth in their custody have access to appropriate mental health and substance use disorder screenings, assessments, and evidence-based treatment services.

Due to the loss of several providers, our residential treatment services for adolescents have suffered over the last 18 months. We are in the process of procuring new providers for this service.

- 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:**

NOT FINAL

## Environmental Factors and Plan

### 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.

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 in the state. A significant amount of information can be found on-line or by calling 501-683-0707. Below are some of their current programs:

- Introduction to Supporting Those at Risk – participants will receive information and resources on how to support those with lived experience with suicidal thoughts and/or a past attempt.
- Talk Saves Lives – Seniors Participants learn common risk factors for suicide in older adults, how to identify warning signs, and how to keep self, loved, ones, and our community safe.
- NWA Ride to Fight Suicide – a motorcycle ride to honor those lost to suicide or struggling with a mental illness
- A resource list is available: [https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide\\_Prevention\\_Helpful\\_Sites.pdf](https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Helpful_Sites.pdf)
- Special program and resources for veterans experiencing suicidal thoughts and behaviors, including treatment options and self-help tools.
- A listing of available educational programs:  
[https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide\\_Prevention\\_Programs\\_Promoted\\_by\\_ADH\\_2019\\_\(002\).pdf](https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Programs_Promoted_by_ADH_2019_(002).pdf)
- Broad promotion of availability of the National Suicide Prevention Lifeline at 1-800-273-TALK or [suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)
- NAMI sponsors events during Suicide Prevention Awareness Month, which includes a NAMIWalk event for fundraising.
- A listing of resources for Suicide Prevention – After a Suicide Toolkit:  
[https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide\\_Prevention\\_Programs\\_Promoted\\_by\\_ADH\\_2019\\_\(002\).pdf](https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Programs_Promoted_by_ADH_2019_(002).pdf)

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

Part of our plan to implement more effective Crisis Services includes working toward rapid connection with a Peer as a part of the discharge plan after an individual has experienced an acute hospital admission.

DAABHS Division Director and Assistant Director for Behavioral Health are involved in the VA/SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF) policy academy. Staff have been involved in pre-site visit meetings with various branches of state government, to include the Arkansas Dept. of Health, along with numerous veteran's organizations and community leaders. A three-day policy academy has been held and a post-visit meeting is scheduled for the end of July 2021. Efforts are focused on identifying needs/gaps and establishing a pilot program in two areas of the state to maximize resources in development of effective programs to reduce/end deaths by suicide and increase awareness and use of resources.

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

None at this time.

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#### Footnotes:

#1 Suicide Prevention efforts are largely overseen by the Arkansas Department of Health in our state.

#3 Crisis screenings completed by CMHCs are required to use an evidence-based screening tool as part of their assessment. Additionally, the development and implementation of safety plans are also required for crisis screenings, especially in cases where diversion is deemed appropriate.

NOT FINAL

## 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?

NA

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

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#### 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](https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf).<sup>69</sup>

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.

<sup>69</sup><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's (ABHPAC) Block Grant subcommittee began meetings in March of 2021. DAABHS has relied heavily on ABHPAC's request of several years to more fully embrace and develop a Peer Support Program. The ABHPAC Block Grant committee was provided with training and education about the Block Grant process, along with access to review the combined block grant application from previous years and drafts of the state's response to this application. Presentations have been made to this committee so that they have an understanding of different funding streams for behavioral health services and the variety of programs offered in the state for mental health and substance use disorder treatment services of different levels.

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 may attend 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, family members, providers, and representatives of state and private agencies. Though our consumer group has previously had a small handful of youth members, we have none currently. The council is federally mandated through PL 102-321 to review the state plans for the block grant and provide recommendations to the State,

and to serve as an advocate for adults with SMI, children with SED and others who might be experiencing mental health needs.

In the past year, the Council worked with Advocates for Human Potential to purchase and develop an environmental scan within Arkansas regarding access to crisis services. This data, and Council feedback, has helped to drive the development of several new goals for our Block Grant application, as well as plans for the use of Crisis Set Aside, COVID, and ARPA funding.

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

DAABHS leadership and ABHPAC are interested any technical assistance regarding leadership strategies for this group.

*Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>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.

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**Footnotes:**

#1b Arkansas currently has two different Councils—The ABHPAC group and the AADACC group. The ABHPAC group has been established with more of a focus on the block grant process and access to services. The AADACC group was legislatively developed and has input on the SABG portion of our combined application, but also oversees several other grants related to the reduction of opioid abuse, along with the planning and budgeting of education, prevention, treatment and law enforcement programs to efficiently and effectively combat the abuse of alcohol and drugs in the state of Arkansas.

NOT FINAL

## 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: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
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	bridget.atkins@dhs.arkansas.gov
Steven Blackwood	Family Members of Individuals in Recovery (to include family members of adults with SMI)		12618 Meadows Edge Little Rock AR, 72211 PH: 501-920-8110	srblackwood@gmail.com
Elizabeth Brooks	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			lizbrooks1907@gmail.com
Shawna Burns	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2844 Sand Flat Road Alpena AR, 72611 PH: 870-416-1253	shawnamartinburns@gmail.com
Linda Donovan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			Lindadonovan4945@msn.com
Kimberly Downie-Pierce	Parents of children with SED/SUD			
Rodney Farley	State Employees	Division of Developmental Disabilities		rodney.farley@dhs.arkansas.gov
Geoff Hamblen	Family Members of Individuals in Recovery (to include family members of adults with SMI)			HeyIhaveanewID@yahoo.com
Frank Hellmer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			Phrankdatank@gmail.com
Gaye Jones-Washington	State Employees	Arkansas Rehabilitation Services	525 West Capital Little Rock AR, 72201	gayejones-washington@arkansas.gov
Elizabeth Kindall	State Employees		OUR Educational Cooperative Valley Springs AR, 72682	elizabeth.kindall@arkansas.gov



Buster Lackey	Others (Advocates who are not State employees or providers)	NAMI Arkansas		buster.lackey@namiarkansas.org
Angie Lassiter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			arkansasbhpac@gmail.com
Christopher Lieux	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7800 Willaimsburg Road Fort Smith AR, 72903 PH: 479-420-0528	clieux@hotmail.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)		935 North Highland Avenue Fayetteville AR, 72701 PH: 479-601-6014	s.mashburn@sbcglobal.net
Linda Nelson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		17587 Clear Water Road Fayetteville AR, 72704 PH: 501-258-3989	lindanelson1006@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
Stephanie Pifer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		13805 Regina Lane Little Rock AR, 72206 PH: 501-486-8966	stephepifer@gmail.com
Stacie LeAnne Schulz	Family Members of Individuals in Recovery (to include family members of adults with SMI)			stacieschulz@gmail.com
William Shumaker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			williamshumaker@gmail.com
Rebecca Sparks	Providers	Crisis Intervention Center		beccas@fscic.org
Paula Stone	State Employees	University of Arkansas for Medical Sciences		PBStone@uams.edu
Deborah Swink	Providers	Public School Behavioral Health Provider		deborahswink@gmail.com
Rachel Tiffée	State Employees	AR Division of Children and Family Services	P.O. Box 1437, Little Rock AR, 72203	rachel.tiffée@dhs.arkansas.gov
Ben Udochi	State Employees	Arkansas Community Correction	105 West Capital Little Rock AR, 72201	ben.udochi@arkansas.gov
Kellie VanCuren	Parents of children with SED/SUD		1901 West Shady Grove Road Springdale AR, 72764 PH: 479-530-9254	kellievancuren@gmail.com
Pat Warner	Family Members of Individuals in Recovery (to include family members of adults with SMI)			patwarner1@yahoo.com
Janette Williams-Smith	Parents of children with SED/SUD		140 Stanton Road Cabot AR, 72023 PH: 501-920-6958	janette.williams@smith@yahoo.com

**Footnotes:**

State Education Agency - Elizabeth Kindall

State Vocational Rehabilitation Agency - Gaye Jones-Washington

State Criminal Justice Agency - Ben Udochi

State Housing Agency - Vacant

State Social Services Agency - Rachel Tiffiee

State Health (MH) Agency - Bridget Atkins

NOT FINAL

## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
<b>Total Membership</b>	<b>30</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	1	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>18</b>	<b>60.00%</b>
State Employees	8	
Providers	3	
Vacancies	1	
<b>Total State Employees &amp; Providers</b>	<b>12</b>	<b>40.00%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>12</b>	
Youth/adolescent representative (or member from an organization serving young people)	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

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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:  
The application will be posted for public comment August 1-15, 2021 on the DAABHS website:  
<https://humanservices.arkansas.gov/divisions-shared-services/aging-adult-behavioral-health-services/reports-publications/>
- c) Other (e.g. public service announcements, print media) ☐ Yes ☒ No

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#### Footnotes:

## Environmental Factors and Plan

### 23. Syringe Services (SSP)

#### Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction<sup>1,2</sup> on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018<sup>3</sup>.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers<sup>4</sup>. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs<sup>5</sup>: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>.

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf> ,
2. **Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf> ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

<sup>1</sup> Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

<sup>2</sup> Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

<sup>3</sup> Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

<sup>4</sup> Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

<sup>5</sup> ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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**Footnotes:**

NOT FINAL



## Environmental Factors and Plan

### Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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#### Footnotes:

NOT FINAL