State of Arizona

Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan

Prepared by Governors Office for Children, Youth and Families
Division for Substance Abuse Policy
April 21, 2006

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Introduction

While Arizona has continually sought to improve its substance abuse service delivery services, Governor Janet Napolitano established new high expectations for rapid systems improvement. Immediately after her election the Governor described her interest in a Substance Abuse Resource Management System. She asked that the system be data driven and support substance abuse prevention and treatment service delivery that is accountable in terms of availability, efficiency and effectiveness.

To support this, in 2004 Arizona was awarded the Strategic Prevention Framework State Incentive Grant (SPF SIG) and is taking full advantage of the opportunity this grant provides. This is the third State Incentive Grant awarded to Arizona. The Arizona SPF SIG will assist the state in creating, improving, and institutionalizing infrastructure change at both the state and local level.

The Arizona SPF SIG Strategic Plan describes the next step in the progression of system reform. It identifies target populations and geographic areas based on data that demonstrates rates and prevalence of local substance abuse issues. With that quantified Arizona can consider programs, policies, and practices that better address these issues in this state.

Contributions

The Division for Substance Abuse Policy in the Governor's Office for Children, Youth and Families, acknowledges the following agencies and individuals for their contribution to the development of this strategic plan and the successful implementation of this project.

SPF SIG Advisory Council

Advisory Council Members	**Agency/Department**
Steffie O'Neill (Chair)	Compass Health Care
Rob Evans, Project Director	Governor's Office for Children, Youth and Families-Division for Substance Abuse Policy
Lisa Shumaker	Arizona Department of Health Services/Division of Behavioral Health Services
Melissa McGee	Higher Education-University System
Jean Ajamie	Department of Education
Alida Montiel	Inter-Tribal Council of Arizona
Kevin Pollins	Arizona Parents Commission
Michael Hegarty	Governor's Office of Highway Safety
Karen Ziegler/Steve Ballance	Arizona Criminal Justice Commission
Steve Sparks/Judith Fritsch	Department of Economic Security
Bill Burnett	Community Partnership of Southern

	Arizona (CPSA)
Gail Chadwick	Arizona Prevention Resource Center
Dick Geasland	Tumbleweed Center for Youth Development
Gabrielle Guerra	ValueOptions: Prevention, Education and Outreach Office
Marcia Harmon	Mothers Against Drunk Driving
Robin Harris	University of Arizona, College of Public Health
Marnie Hodahkwen	Governor's Office-Tribal Liaison
Janet Garcia/Sheila Hoppe	Governor's Office for Children, Youth and Families-Division for Children (Juvenile Justice Commission and Governor's Portion of SFDS)
Tom Ivarie	Drug Enforcement Administration
Dick Yost/Cheryl Judd	Department of Liquor, Licenses and Control
Charles McCarty	Department of Emergency and Military Affairs
Patricia Tarango	Department of Health Services-Tobacco, Education & Prevention
Duce Minor	Parker Area Alliance for Community Empowerment, Inc. –PAACE
Jeanne Brandner	Administrative Office of the Courts (AOC), Juvenile Justice Services Division (JJSD)
Eve Nunez	Help4Kids, Help4Teenz
Petrice Post	Northern Arizona Regional Behavioral Health Authority (NARBHA)
Jessica Smith	Students Against Destructive Decisions (SADD)
Allen Ward	SAMHSA/CSAP
Gretchen Zimmerman	Arizona Department of Juvenile Corrections

Epidemiology Workgroup

Individual Name	**Agency/Department**
Michelle Anderson	Administrative Office of the Courts
Steve Ballance	Criminal Justice Commission
Jeanne Brandner	Administrative Office of the Courts
Leslie Carlson	Pima Prevention Partnership

Jenny Chong	University of Arizona, Mel and Enid Zuckerman Arizona College of Public Health
Wes Kortuem	Department of Health Services
Heather Dunn	Department of Health Services
Judith Fritsch	Department of Economic Security
Robin Harris	University of Arizona, Mel and Enid Zuckerman Arizona College of Public Health
Catherine Osborn	Department of Education
Richard Porter	Department of Health Services
Lisa Shumaker	Department of Health Services
Steve Sparks	Department of Economic Security
Wendy Wolfersteig	Arizona Prevention Resource Center, Arizona State University

Background

Arizona has long supported improving substance abuse prevention delivery through the state's previous SIG grants as well as state funding to implement evidence-based programs. Multiple state entities have produced and delivered the most current prevention information to communities, schools and to the public. However, expanded data analysis and collaborative strategic planning efforts are needed to effectively reduce the significant substance abuse issues that exist in Arizona.

In 1987, the Arizona Legislature created the Arizona Drug and Gang Policy Council. By definition, the Council was chaired by the Governor and included the heads of all relevant state agencies, community participants and a representative from one of the three major universities. The statutory requirements on the Council included many of the same goals as those in the SPF SIG. In February 2004, Arizona Governor Janet Napolitano directed the Arizona Drug and Gang Policy Council to create a statewide, data-driven strategic plan on substance abuse prevention needs and services. The Resource Management System Task Force was formed to carry out this directive. The goal of the directive was to ensure an accurate inventory of services, targeting resources to need and integrate data from large statewide data studies such as the Arizona Youth Survey (AYS), the Social Indicators Study and the Arizona Program Inventory and compare with national level surveys such as the Youth Risk Behavior Survey, the Monitoring the Future Survey, and the National Survey on Drug Use and Health.

Legislative changes in the Council created an opportunity to integrate the goals of the SPF SIG and move Council functions to the Arizona's SPF SIG Advisory Council. The council currently participates and makes recommendations in the development of Arizona's framework in which all substance abuse activities, planning, and policies will eventually participate.

Step 1: Needs Assessment

State Level Application-The first step in the State level needs assessment process was the development of a Statewide Epidemiological Workgroup (SEW). Members were invited from grant partner agencies, representatives of agencies with key data sets, public health experts, epidemiologists, community representatives, and the SPF SIG evaluator. The workgroup was convened and staffed by the Governor's Office and began to collect and analyze data related to substance abuse in Arizona. Initial efforts were made by staff to collect data related to the number of programs and amount of funds devoted to Underage Drinking prevention in Arizona. As part of the local needs assessment, the spreadsheet with this information will be compared to information gathered by local communities and then reevaluated for completeness, utility and availability. This information can be found in **Attachment A**.

Assessing the Problem (Epidemiological Profile)
From the beginning, it was understood that information eventually used must be reliable, regularly collected, and from readily accessible sources. The data must be of sufficient quality to provide some certainty for the conclusions drawn. It must also be regularly updated, at least annually or every other year, and have a good chance of being collected into the near future or at least over the five year life of the State Incentive Grant. Data should be available either in published reports, on agency web sites, or through a single communication with the data set manager. Data used by the Epidemiological Workgroup was archival or existed in surveys already completed; no primary research was done to inform the report. A complete list of the indicators considered is provided in **Attachment B**.

Early in the process, the decision was made to look only at those indicators of consumption or consequences directly related to substance use. The relationship between substance use and other health or social problems has been recognized in public health. Excessive drinking has been linked to liver cirrhosis, pancreatitis, and various cancers. Tobacco use has been associated with cancer and cardiovascular disease. Illicit drug use is also related to health problems such as heart disease and HIV/AIDS. Social problems such as criminal behavior and poor academic achievement are also affected by drug use. Although the literature suggests correlations between substance use and other health and social problems, the proportion of these problems *directly* attributable to substance abuse in Arizona were not readily quantifiable or available from existing sources. Two other concerns with the relationship between health and social problems and substance use influenced the decision to look solely at indicators with a direct relationship to substance use. First, it is difficult to measure the outcome of State Incentive Grant interventions since such effects may be delayed for many years or decades in those studies where the effect of substance abuse on chronic illness or social problems is measurable. Second,

Workgroup members who are public health experts and epidemiologists questioned the methods used to reliably calculate the proportion of a given problem that could be attributed to substance use.

The Epidemiological Workgroup considered consumption and consequence data from a variety of sources. Consumption data reported in the following sections comes from 2002 and 2003 average estimates for Arizona reported by the National Survey on Drug Use and Health (NSDUH). This data set was used because it provides state level estimates for youth and adults.

Consumption

In Arizona, it is estimated that 8.87 percent of the individuals ages 12 and older have used an illicit drug in the past month, of these 5.68 percent are estimated to have used marijuana. In this same age group, 50.2 percent were estimated to have used alcohol in the past 30 days and 24.32 percent were estimated to have had five or more alcoholic drinks at one sitting in the past 30 days. According to the survey, cigarettes have been used by 27.51 percent of the individuals ages 12 and older in the past month.

The highest estimated percentages of use for all reported substances were reported in the 18 to 25 year-olds. These substances include past month illicit drug use, past month marijuana use, past month alcohol use, past month binge alcohol use, and past month tobacco use. Among 18 to 25 year-olds, alcohol is the most frequently used substance. The percentage of 18 to 25 year-olds estimated to engage in past month binge drinking (41.43 percent) is six percent greater than the percentage reporting past month tobacco use (38.85 percent).

Alcohol is the most frequently used substance among 12 to 17 year-olds with an 18.69 percent past 30 day estimated usage. Past month binge drinking was reported by 11.94 percent, a rate that was fairly similar to tobacco usage at 12.84 percent and youth illicit drug use at 12.61 percent.

Consequences

Substance use including tobacco, alcohol, and illicit drug use accounts for a significant percentage of death and illness in Arizona. While less than three percent of Arizona deaths in 2003 were directly attributed to drugs or alcohol as a result of car crashes or drug and alcohol induced deaths, [1] the indirect effect of substance use on health problems leading to death or disease is much larger. The Centers for Disease Control and Prevention estimate that for Arizona in 2001, 20 percent of heart disease related deaths, 24 percent of cancer related deaths, and 85 percent of respiratory disease related deaths could be attributed to tobacco use.

For deaths that can be directly attributed to drugs and alcohol, 1,198 people in Arizona died as a result of overdoses and misuse of drugs and alcohol in 2003. Two hundred and ninety-eight people died in alcohol related car crashes and twenty-four people died in

[1] *Arizona Health Status and Vital Statistics*, 2003 data, Arizona Department of Health Services. Available online: http://www.azdhs.gov/plan/index.htm [cited September 13, 2005].

drug related car crashes.[2] Arizona reported 6,215 injuries for alcohol related car crashes in 2003.[3] It is estimated that 132,034 people reported having driven in the past 30 days when they think they had too much to drink. The number of arrests for driving under the influence (DUI) of alcohol or for 2003, was 39,536.[4]

In 2003, it was estimated that 488,000 people, ages 12 and older, abused illicit drugs or alcohol or had a clinical dependence on illicit drugs or alcohol.[5] In the same year, Arizona's publicly funded treatment system reported 15,879 admissions.[6]

According to the Arizona Department of Health Services (DHS), HIV infection as a direct result of substance use is relatively small as compared to other morbidity indicators. From 1998 to 2002, 500 cases of HIV infection were reported as a result of injection drug use (IDU) and there was a 51.8 percent increase to 759 cases when adding those cases that also fall under the risk category of men who have sex with men and are IDU.[7] Having unprotected sex while under the influence of alcohol or illicit drugs might also account for a portion of HIV infection cases; however, DHS does not quantify this aspect of substance abuse on the state's HIV incidence.

In the six-month period from July to December 2003, 30,298 emergency department visits were related to the non-dependent abuse of drugs.[8] In the same period, 5,321 emergency department visits were related to drug and alcohol dependence neuroses and 1,810 emergency department visits were related to drug or alcohol psychoses. In 2003, 19,507 hospital discharges were related to alcohol abuse and 19,102 hospital discharges were related to drug dependence or drug abuse.

Hospitals regularly test newborns for what are called noxious substances, i.e. narcotics, hallucinogens, and cocaine. In 2003, 517 newborns in Arizona tested positive for such substances.[9]

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[2] *2003 Arizona Crash Facts Summary*, 2004, Arizona Department of Transportation. Available on-line: http://www.azdot.gov/MVD/statistics/crash/index.asp. [cited September 13, 2005].

[3] *2003 Arizona Crash Facts Summary*, 2004.

[4] *Crime in Arizona 2003*, 2004. Arizona Department of Public Safety. Available on-line: http://www.azdps.gov/crimereport/default.asp. [cited September 13, 2005].

[5] *Source: National Survey on Drug Use and Health*, 2002 and 2003 averages. Substance Abuse and Mental Health Services Administration. Available on-line: http://oas.samhsa.gov/. [cited September 13, 2005].

[6] ***Treatment Episode Data Set,*** 2003 data. Substance Abuse and Mental Health Services Administration. Available online: http://wwwdasis.samhsa.gov/webt/quicklink/AZ03.htm. [cited September 13, 2005.

[7] *Arizona Statistics*, Office of HIV/AIDS, Department of Health Services. Available on-line: http://www.azdhs.gov/phs/hiv/pdf/arizona.pdf. [cited September 13, 2005].

[8] *Hospital Discharge Database*, 2003 data. Arizona Department of Health Services. Available online: http://www.azdhs.gov/plan/index.htm . [cited September 13, 2005].

[9] *Hospital Discharge Database*, 2003 data. Arizona Department of Health Services. Available online: http://www.azdhs.gov/plan/index.htm . [cited September 13, 2005].

Decision-making process

Over a ten-month period, eight Epidemiological Workgroup meetings were conducted in which members decided on the approach, selected indicators of substance abuse consequences and consumption, advised on data sets and analysis, reviewed findings, and decided on problem areas. The Governor's Office provided staff support, funding, set agendas and provided facilitation. Findings and reports were drafted by GOCYF Division for Substance Abuse Policy (DSAP) staff.

The work was conducted in two phases. First, an exhaustive list of potential indicators of substance use consequence and consumption patterns was developed **(Attachment B).** Consequence and consumption indicators were compiled from an indicator database developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), a list of indicators compiled from other State Incentive Grant awardees, and indicators suggested by Workgroup members. A search was conducted for data sets that could provide information on the indicators or data sets that were related to substance abuse and might provide additional indicators.

The second phase involved analyzing available indicator data that could be interpreted for the purposes of the State Incentive Grant. Specifically, there was a need to identify substance abuse consequence and consumption patterns and the populations implicated and establish priorities among the various consequences, consumption patterns and populations.

Data were presented in absolute numbers and rates when rates were available or when denominators were known for rate calculation. Absolute numbers provided a sense of the number of people affected and the magnitude of the problem. Rates suggest whether or not a particular population may be disproportionately affected by the problem and thus in need of more attention. Populations affected by a particular indicator were defined and analyzed by county or sub-county geography and by age when geographic or age data were available.

In analyzing and interpreting indicators, magnitude of the problem in terms of number of people or events and disproportional distribution of the problem in the population in terms of rates were the methods used. With the exception of death or illness, data on the severity of an indicator or problem or its effect on an individual or society such as economic costs or productivity losses were not included in the analysis.

Data from the first phase of the process were reviewed and a problem area identification exercise was conducted to specify those problem areas that the Epidemiological Workgroup considered most important. The exercise was disseminated to all members who were asked to rate consequence and consumption indicators on several criteria including prevalence or rate of the problem; severity of the problem in terms of economic, social or moral consequences; amenability of the problem to change; capacity of communities to change the problem; and ability to measure changes in the problem.

The exercise identified the following indicators that were of particular importance to the group:

1. Arrests for driving under the influence
2. Past month underage drinking
3. Past month underage binge drinking
4. Past month binge drinking for those 12 and older
5. Past year clinical dependence or abuse of illicit drugs and alcohol
6. Alcohol related crash injuries

Subsequent discussions in the group defined a problem construct called "problematic drinking" and included past month underage drinking, past month underage binge drinking, past month binge drinking for those twelve and older, and alcohol related car crashes.

Before the final problem areas were decided, workgroup members were polled for additional problem areas they felt should be considered. The results of the poll and subsequent workgroup discussions identified illicit drug use as another possible problem area. This problem area was proposed to address the perceived consequences of illicit drugs, particularly methamphetamine, on Arizona's population and to provide another potential target for intervention. Analysis of this indicator showed that indeed illicit drug use affected as many, if not more, youth than binge drinking. For adults, illicit drug use consumption ranked behind alcohol, binge alcohol and tobacco use. Based on this data the group identified another problem area, youth illicit drug use.

A geographic analysis was conducted for problematic drinking indicators and youth illict drug use to determine what geographic areas had the highest rates and occurrence of the particular indicator. This analysis provided the Advisory Council with additional information that assisted in the decision of how to allocate funding to local communities.

Data for underage drinking and underage binge drinking was provided for 8th, 10th, and 12th grade students in each of Arizona's fifteen counties. No county had the highest percentages for underage drinking and underage binge drinking across all three grades. Instead, data were analyzed to determine how many times a county had one of the five highest percentages of underage drinking or underage binge drinking for each grade. A single score for each county was obtained by adding the number of times each county was ranked in the top five counties in each grade category. Cochise, Gila, Mohave, and Santa Cruz counties had the most grades that ranked highest in underage drinking and underage binge drinking. Each county had two grades for underage drinking and two grades for underage binge drinking, for a total of four grades, that had one of the five highest percentages of students drinking or binge drinking.

Using this same method, the counties of Apache, Graham, Coconino, and Navajo had the most grades that ranked highest in illicit drug use. Apache, Graham, and Coconino counties' 8th, 10th, and 12th grades all reported the highest percentages of students using

illicit drugs. Navajo county's 10th and 12th grades reported high percentages of students using illicit drugs.

Data for underage drinking, underage binge drinking, and youth illicit drug use were also available at a sub-county level in geographic regions called community health analysis area. The community health analysis area is a geographic segment used by the Department of Health Services for public health surveillance. The community health analysis area is large enough to provide a population size meaningful for statistical analysis but small enough to capture geographic variations and maintain a sense of community or neighborhood. For this analysis, data were categorized by standard deviation from the state mean percentages of underage drinking and underage binge drinking. Data from 8th, 10th, and 12th grade samples were aggregated. These data were used to segment Maricopa and Pima county, the state's most populous counties,.

Within Maricopa and Pima counties, all community health analysis with underage drinking, underage binge drinking, or youth illicit drug use rates that were more than .5 standard deviations from the state's mean for each of the indicators were considered priority target geographies. In Pima county, these include Tucson SE, Tuscon W, Tucson SW, Marana, and Tanque Verde. In Maricopa county these include Gila River, Mesa S, Queen Creek, Laveen, Estrella, Paradise Valley Village, Paradise Valley, Camelback East, Peoria, Maryvale, and Chandler SE.

No sub-state level data exists for past month adult binge drinking so the whole state was selected for the target geographic area. However, a portion of this population falls under the age of 21 and is therefore included in the statewide underage drinking initiatives. The portion of this population that is over 21 will be addressed through improved sub-state data collection efforts and within local communities.

Alcohol related injury rates per 10,000 people in the specified county were compared across counties. Apache (19.9), La Paz (18.3), and Coconino (14.4) counties had the highest rates of alcohol related car crash injuries and were selected as target geographies.

Through the process of analysis and evaluation of the data the State has identified and decided to have SPF – SIG sub-recipient communities address one of two problem areas; problematic drinking among 12 – 25 year old and youth illicit drug use among 12 – 18 year olds.

Rationale for problem areas

For adults, problematic drinking refers to consumption patterns that lead to adverse health and social consequences. Because of associated impairment in physical and mental functioning, binge drinking in the past 30 days was taken as the best consumption indicator for problematic drinking. Given the percentage of 18 to 25 year-olds that are estimated to have engaged in binge drinking in the past 30 days, this age group was considered to be an important audience. The percentage of adults estimated to have engaged in binge drinking in the past 30 days is highest among 18 to 25 year-olds. Forty one percent of 18 to 25 year-olds are estimated to have engaged in binge drinking

compared to 23 percent of those 26 year-olds and older. The percentage of 18 to 25 year-olds estimated to have engaged in past 30-day binge drinking is also slightly higher than percentages of those 18 to 25 year-olds estimated to have used tobacco in the past 30 days (38.85 percent).

Health and social consequences associated with problematic drinking are also highest in the 18 to 25 year old age group. DUI arrest rates were highest in the 18-24 year old age category, 2112.8 per 100,000 18 to 24 year-olds. The next highest rate was 1695.2 per 100,000 25-29 year-olds. Both fatality and injury rates for alcohol related car crashes were highest among drivers in the 21 to 24 year old age category. For 21 to 24 year old drivers, fatality rates in alcohol related car crashes was 12.75 per 100,000 21 to 24 year-olds. The next highest fatality rate was 8.7 per 100,000 25 to 34 year-olds. For 21 to 24 year old drivers, the injury rate in alcohol related car crashes was 210 per 100,000 21 to 24 year-olds. The next highest rate was 129.16 per 100,000 25-34 year-olds.

For youth, problematic drinking was defined as alcohol consumption, because it is illegal to consume alcohol at this age, and binge drinking because of its risk for impairment. While the percentage of 12 to 17 year-olds estimated to have had alcohol in the past 30 days (18.69 percent) or to have engaged in binge drinking in the past 30 days (11.94 percent) is much smaller than the percentage of 18 to 25 year-olds estimated to consume alcohol, the younger age group is still an important target for two reasons. First, a substantial number of youth are estimated to engage in alcohol use and binge drinking, close to twenty percent of 12 to 17 year-olds. Second, even though health consequences related to alcohol use at this age are not as severe as older age groups, the work group hypothesized that it is at this age that behavior leading to high-risk alcohol consumption is being developed and can best be prevented.

For youth ages 12 to 17 the estimated percentages of those who have used an illicit drug in the past 30 days (12.61 percent) is larger than the estimated percentage of those who have engaged in binge drinking in the past 30 days (11.94). Alcohol consumption and possession of illicit drug are equally illegal for this age group suggesting that illicit drug use in this population should be a target for intervention. It should be pointed out that this age group is unique in that the estimated percentages using illicit drugs is similar to the estimated percentages engaging in binge alcohol use. The percentage of older age groups that engage in binge drinking is far greater than the estimated percentages of those that engage in illicit drug use. This places these older age groups at higher risk from binge alcohol consumption than illicit drug use.

In conclusion, two target populations were identified based on the consumption and consequence data available from the national, state, and county level; 18 to 25 year olds and 12 to 17 year olds. Eighteen to 25 year-olds are an important audience because they provide a target for both prevention and remediation intervention. A universal prevention strategy could focus on those individuals in this high-risk group who are not engaging in binge drinking. A selective or indicated remediation intervention could seek to reduce the amount of alcohol consumed by individuals in this high-risk group or to change behavior that leads to drinking and driving. Whereas the 12 to 17 year old population

critically needs primary prevention due to the link with long-term effects and damage to the development of the brain.

This table is based on the Arizona Youth Survey. As evidenced below, eleven (11) out of fifteen (15) counties in Arizona, averaged across all grades, exceed the state average for youth illicit drug. This combined with data documenting that youth illicit drug use in Arizona is equal to that of youth binge drinking, in terms of the percentage of youth reporting both activities, youth illicit drug use was determined to be a second problem area for the Arizona SPF SIG.

Table 1: Percentage of 8th, 10th, and 12th Grade Students Who Used Any Drug During the Past 30 Days, Arizona, 2004.

	8th Grade		10th Grade		12th Grade			
County	**%**	**Rank**	**%**	**Rank**	**%**	**Rank**	**Avg.**	**Rank**
State	**17.9**		**23.6**		**25.1**		**22.2**	
Apache	**24.3**	**3**	**34.1**	**1**	**36.4**	**1**	**31.6**	**1**
Cochise	**22.7**	**7**	**22.2**	**11**	**17.9**	**14**	**20.9**	**12**
Coconino	**27.1**	**2**	**28.1**	**3**	**28.2**	**5**	**27.8**	**3**
Gila	**23.5**	**5**	**22.1**	**12**	**25.6**	**7**	**23.7**	**7**
Graham	**27.4**	**1**	**27.8**	**5**	**29.6**	**2**	**28.3**	**2**
Greenlee	**18.5**	**10**	**26.8**	**6**	**25**	**9**	**23.4**	**9**
LaPaz	**18.8**	**9**	**22.3**	**10**	**10.7**	**15**	**17.3**	**15**
Maricopa	**16.1**	**13**	**22.2**	**11**	**25.2**	**8**	**21.2**	**11**
Mohave	**17.9**	**11**	**24.2**	**9**	**28.5**	**4**	**23.5**	**8**
Navajo	**23**	**6**	**28**	**4**	**29.4**	**3**	**26.8**	**4**
Pima	**21.2**	**8**	**24.4**	**8**	**23.7**	**12**	**23.1**	**10**
Pinal	**23.9**	**4**	**26.4**	**7**	**27**	**6**	**25.8**	**5**
Santa Cruz	**17.4**	**12**	**20.5**	**13**	**20.8**	**13**	**19.6**	**13**
Yavapai	**15.6**	**14**	**31.1**	**2**	**24.8**	**10**	**23.8**	**6**
Yuma	**14.3**	**15**	**17.7**	**14**	**23.8**	**11**	**18.6**	**14**

Source: ***Arizona Youth Survey: State Report, 2004*****. Arizona Criminal Justice Commission.**

Assessing the Systems (Capacity and Infrastructure)-The current prevention system in Arizona, as described in the Substance Abuse Prevention and Synar System Review Report for FY 2005, is based on a statewide network of tribal and regional behavioral health care organizations that provide and subcontract all prevention, treatment, and mental health services. The Arizona Department of Health Services (ADHS) is the Single State Authority (SSA) and as a result maintains oversight of the State Block Grant and Synar funds. The funds received by the SSA are then allocated to the tribal and regional health authorities (RHBAs) using a population-based model. These RHBAs then provide the services directly or subcontract with local non-profit agencies.

In addition to the SSA, the Governor's Office for Children, Youth and Families, Division for Substance Abuse Policy receives and allocates substance abuse dollars. The funding currently maintained by this office includes over twelve million dollars in alcohol tax that is legislatively set aside to be monitored by the Arizona Parents Commission, the COSIG that addresses co-occurring disorders out of SAMHSA, and the SPF SIG. Currently, the

majority of communication between the SSA and the Governor's Office are in regards to the SPF SIG. The staff at the Department of Health Services sit on the SPF SIG Advisory Council, Epidemiological Workgroup and all other subcommittees.

Significant gaps in the current state-level infrastructure include a lack of a united prevention framework between the SSA and the Governor's Office, which includes models for funding allocation, coordinated needs assessments, planning processes, training and evaluation. Historically, these two offices have worked together and even created training plans and cooperated in the development of the Prevention Framework out of DHS. However, the current population based funding allocation process through the RHBAs is not used by the Governor's Office, training plans are relatively independent, and data driven processes are just now being used through the development of the SEW and Epidemiological Profile. With the introduction of the data-driven planning process, as mentioned above, the SSA participates in all levels of the SPF SIG. Through shared data it is evident that there is high capacity to collect, analyze and report data for each step of the SPF at the state level. In addition, the two agencies are making every attempt to remedy these gaps through the SPF process as described in the implementation section of this plan.

Community infrastructure currently in place includes the tribal and regional health authorities who receive Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars, community coalitions funded through Drug Free Communities, Weed and Seed Programs, and additional coalitions and/or providers funded by the Governor's Office with Parents Commission dollars to provide prevention services.

Current gaps at the community level include a lack of communication between providers and coalitions in large counties. There are only 15 counties in Arizona, which makes them very large with very different populations. As a result, multiple coalitions and providers exist in the same geographic areas. There is some coordination of services as a result of the RHBAs, however coordination is needed to ensure that all coalitions are aware of another, avoid duplication of services and able to share information. Through the funding allocation process and associated technical assistance, a comprehensive list of all substance abuse related coalitions is being compiled and joint meetings/trainings are being hosted by both the Governor's Office and the Department of Health Services. Communities who receive funding will receive an extensive amount of technical assistance and training to improve their overall capacity to implement the SPF and to collect, analyze and report on data.

Problem Areas

The Epidemiological Workgroup identified five indicators that showed the worst rates of substance abuse problems in Arizona. These included four indicators related to alcohol and one indicator related to drugs. The Epidemiological Workgroup recommended grouping the four alcohol indicators under one problem area termed Problematic Drinking, and recommended a second problem area, Youth Illicit Drug Use.

1. Problematic Drinking among 12 – 25 year olds:
    a. Youth Binge Drinking (ages 12-18)
    b. Youth Alcohol Consumption (ages 12-18)
    c. Adult Binge Drinking (ages 18-25)
    d. Alcohol related crash injuries (ages 18-25)
2. Youth Illicit Drug Use among 12 – 18 year olds

In November 2005, this information was presented to the Advisory Council and the council unanimously approved the two problem areas recommended by the SEW as the priorities for the Arizona SPF SIG: Problematic Drinking and Youth Illicit Drug Use. Additionally, a statewide underage drinking initiative was included as a goal. The rationale for adopting these priorities areas included; one, that the SEW had completed a year long analysis of the data and had determined that the indicators listed above were the most severe consequences and substance abuse consumption patterns in the state; two, that infrastructure development at both the state and local level is critical in successfully impacting any of the identified problems; and third, that underage drinking impacts the state as a whole and therefore is a stand alone issue as well as specific to certain communities with even higher rates.

The state will address state level transformation, develop and coordinate a statewide underage drinking initiative and other substance abuse issues. Communities that are funded through this process will be expected to focus on improving community level capacity, participate in underage drinking activities and develop strategies to address one or both of the problem areas that have been identified in their community by the Epidemiological Workgroup.

Native American Tribal Governments- It is evident that populations within tribal boundaries are greatly impacted by substance abuse consumption and associated consequences. In an attempt to improve the quality and availability of tribal specific data, negotiations are currently in progress with the Inter-Tribal Council of Arizona (ITCA) to contract with their Epidemiology Center to investigate improving data collection and analysis methods for the 19 participating tribes. Additional agreements will be pursued with Arizona tribes that are not part of ITCA.

Local Level Application- Communities will be required to accurately assess their substance abuse-related problems using epidemiological data provided in the 2005

Arizona Statewide Epidemiological Profile, as well as additional local level data as part of their comprehensive needs assessments. Communities will not be expected to repeat the epidemiological process. They will, however, need to use it to understand which problem area has been identified in their community and then complete further analysis on how the problem (s) affects their community in terms of the following:

1) the magnitude of the problem to be addressed;
2) the specific populations affected; and
3) risk and protective factors associated with the problem.

The State of Arizona and all sub-recipients will be required to address one or both of the two (2) problem areas recommended by the Epidemiological Workgroup; this includes "Problematic drinking among 12 – 25 year olds" and "Youth Illicit Drug Use among 12 – 18 year olds" and participates in a statewide underage drinking initiative. Communities will be required to address the problem area (s) that they were found to have the most significant problem in comparison to the rest of the state. This is based on both prevalence of the problem and the rate of the problem. In addition, all communities will participate in the Statewide Underage Drinking Initiative.

SPF SIG sub-recipients will be funded to conduct in-depth needs assessment regarding Problematic Drinking among 12-25 year olds, build capacity to address this need, and plan, implement, and evaluate evidence-based programs, policies and practices designed to address the intervening variables related to the following:

-youth binge drinking among 12-18 year olds;
- youth alcohol consumption among 12-18 year olds;
-adult binge drinking among 18-25 year olds; and
-alcohol related crash injuries among 18-25 year olds.

SPF SIG sub-recipients will be funded to conduct in-depth needs assessment regarding Youth Illicit Drug Use among 12-18 year olds, build capacity to address this need, and plan, implement, and evaluate evidence-based programs, policies and practices designed to address the intervening variables related to the following:

-youth illicit drug use among 12-18, this includes all illicit drugs.

Community Profiles should take this data and add:

- Sub-population most affected locally
- Resources available
- Gaps in services targeted at the problem and/or population
- Additional sources of data related to the identified indicator
- Capacity and readiness to change

The community needs assessment, as demonstrated above, must provide a complete review of community assets and resources, gaps in services, capacity and readiness to change. Technical assistance will be provided to the funded communities, and to those identified as high risk, low capacity that do not receive funding, to complete the needs assessment. These communities have been identified by the Epidemiological Workgroup

as having high rates or prevalence of substance consumption/consequences and may not have agencies or individuals currently in place that can effectively apply for funding. This assistance will include instruction on how to access and utilize the profile as well as how to complete more in depth analysis.

Step 2: Capacity Building

State Level Application-The first step in improving the capacity of Arizona state government to address substance use was to assess the current level of capacity by reviewing Arizona Substance Abuse Prevention and Synar System Review Reports, historical documentation of the system and to create the SPF SIG Advisory Council, while convening the Statewide Epidemiological Workgroup. Through the council, the state partners were able to identify the multiple agencies that work with or impact substance abuse on a state, county or tribal level. The group then reviewed the current system and identified areas of need.

The second step was to develop the mission, vision and purpose of this project for the State of Arizona. The decision was made to keep the original goal of the project as the mission/vision for this project, which is to "Implement a comprehensive, integrated substance abuse prevention system across Arizona that results in improved outcomes for Arizona youth and families", specific objectives and activities will be described in Step 3.

The third step in building state level capacity to address substance use was to develop sub-committees. While the SEW is required as an independent body it is also considered a subcommittee of the Advisory Council. This is to ensure shared membership and continuous communication between the two groups. Two additional subcommittees have been formed; the Core Team, which functions similar to an executive body and the Underage Drinking Subcommittee, which focuses solely on underage drinking. Agency membership in either group must be maintained at the Advisory Council level; however, the individual agency representative may differ. New subcommittees will be formed and some may discontinue depending upon the needs of the Advisory Council and the State of Arizona. There has been some discussion regarding the need for subcommittees that focus on policy, cultural competency, sustainability and methamphetamines.

Areas Needing Strengthening-Building capacity, as with all the other steps, must be considered and treated as an ongoing process. In order to truly institutionalize change in state level infrastructure, the capacity of independent agencies and the overall system must be continuously evaluated and modified as needed. Current projects that address areas of need include; a collaborative social norms media campaign addressing underage drinking that will involve the Department of Liquor Control and Licensing, the Governor's Office of Highway Safety, Department of Education, Department of Health Services-Behavioral Health and the Division for Substance Abuse Policy in the Governor's Office for Children, Youth and Families; an assessment and alignment of all substance abuse prevention needed training and technical assistance involving the Department of Health Services-Behavioral Health, the Governor's Office, and all currently contracted technical assistance providers from both offices; identification of cross agency evaluation methods and data collection to align for compliance with the National Outcome Measures; adoption of a single method to assess cultural competency at the state level and to ensure cultural competency at the local level.

Role of the SEW- The Epidemiological Workgroup will continue to meet regularly throughout the grant period. Since the completion of the first Statewide Epidemiological Profile the SEW developed a list of activities that they would like to focus on in the coming years. In addition, the group will respond to any requests made by the Advisory Council and applicable subcommittees, such as the Underage Drinking Committee.

Long-term activities for the SEW will include the following:

- Publication and distribution of the Arizona Statewide Epidemiological Profile
- Annual updates, including continued collection and analysis of data to identify emerging priority areas and monitor changes in the substance abuse consequence and consumption patterns identified in the initial profile
- Detailed analysis and recommendations for addressing data infrastructure gaps identified in the original report
    - Methamphetamines
    - Sub-state adult data
    - Child welfare and substance abuse connection
- Conduct or participate in an adult prevalence/perception study regarding alcohol use
- Continue collection of data for a statewide comprehensive resource assessment
- Make recommendations to the SPF SIG Advisory Council regarding appropriate benchmark changes in substance use to guide state and local prevention efforts
- Develop tribal specific analysis of available data in partnership with the Inter-Tribal Council of Arizona (ITCA), which represents 19 of the 22 tribes in Arizona, and with the tribes that are not part of ITCA.

Local Level Application-Capacity building at the local level will be unique to each community that receives funding. Communities will be encouraged to articulate their current level of readiness in the original application as well as their strategic plan. This will allow the Governor's Office to provide appropriate technical assistance that will either improve existing infrastructure or help build the initial capacity. Each community will be given a guidebook that will contain community readiness tools such as logic models, community organization tools and instructions on how to evaluate the success of their particular approach.

Community coalitions will be expected to expand and diversify membership, partner with existing Drug-Free Community grantees, other prevention providers, local law enforcement, school districts, and local government entities. In addition, local coalitions will complete a sustainability plan within the first year of funding to ensure increased capacity through long-term planning and resource development. For the communities identified through the Statewide Epidemiological Profile as having a high need, but that do not currently have a coalition in place, technical assistance will be provided to assist the various organizations in mobilizing the community and developing a coalition.

Additional components to each community strategy will include a plan to address the various cultures within each geographic area in terms of age, ethnicity, gender, rural vs.

urban, and socio-economic status, and identify strategies to address substance abuse uniquely within each target population. Representation from each population will be maintained within the community coalition to ensure that accurate representation and culturally competent practices, programs and strategies are implemented.

Step 3: Planning

State Level Application- At the state level, the planning process will include the development of this strategic plan. This is a working document that will evolve throughout the course of the project and over time depend on the needs of Arizonans. Although the goal for SPF SIG remains constant, the objectives have been modified as a result of the work completed by the SEW and the Advisory Council.

Project Goal: Implement a comprehensive, integrated substance abuse prevention system across Arizona that results in improved outcomes for Arizona youth and families.

Objective 1. Develop an epidemiological framework allowing the Advisory Council to make data driven strategic recommendations concerning the statewide distribution of substance abuse education, prevention and treatment resources.

Objective 2. Develop and implement a comprehensive plan for improving efficiency and effectiveness of the substance abuse service delivery system.

Objective 3. Develop a plan to foster cooperation among all state entities to ensure optimal delivery of educational, treatment and prevention programs, as well as facilitate a state and community level partnership.

The strategic plan is a compilation of historical experiences and perspective, the story revealed by the data, the process of uniting state and local level partners, the development of a shared vision, the outline of a plan to achieve a shared vision and the methods and strategies that will be used to accomplish, monitor and evaluate the progress made toward each perspective.

State Planning Model

The State of Arizona will be using an open competitive application process for award of the SPF SIG funds. Communities will be required to address the indicator (s) that they were found to have the most significant problem in comparison to the rest of the state. These indicators are listed above, under Problem Areas on p. 14. There are two problem areas in Arizona, the first is Problematic Drinking (which includes youth alcohol consumption, youth binge drinking, adult binge drinking and alcohol related crash injuries) and the second is Youth Illicit Drug Use (which includes all illicit drug use indicators except tobacco).

Arizona used two approaches to identify communities to be funded. The first approach was to prioritize funding to counties that had the highest rates of the identified problems. The counties with the highest rates of either problematic drinking or youth illicit drug use were nine rural counties. Because these high-rate areas were relatively low in population,

Arizona also incorporated the highest-contributor approach and will also prioritize funding for each of the two counties containing the main population centers: Maricopa County (Phoenix) and Pima County (Tucson). Thus, the state-planning model is a hybrid of both the "Highest Need" communities and the "Highest Contributor" communities. Funding will be prioritized based on epidemiological data, meaning that counties with the highest rates of youth illicit drug use will be funded to address that problem area, and will also have to participate in the statewide underage drinking initiative. Counties with the highest rates of problematic drinking will be funded to address that problem area and will also need to participate in the statewide underage drinking initiative. This funding strategy is being used to follow State procurement laws; to allow for coalitions and tribes within the specific geographic areas the opportunity to apply; and to encourage multiple coalitions within the same area to collaborate in the application process.

Local Level Application/Funding Allocation Plan-The Arizona Governor's Office will issue a Request For Grant Application (RFGA) in 2006 for the SPF SIG community level five-step SPF process. Funding will be made available to coalitions and Tribal governments or organizations across the state for up to five (5) years of funding to develop a sustainable data-driven substance abuse prevention framework that serves both the individual community and the State as a whole. The funding is intended to focus state and community substance abuse prevention resources in two (2) statewide problem areas identified through epidemiological data collected at the state and local levels: Problematic Drinking among 12 – 25 year olds and Youth Illicit Drug Use among 12 – 18 year olds.

The funding will be awarded in two phases. Phase I will comprise the first three steps of the SPF, and the funding process for this phase will be open-competitive. Communities that have been identified through our hybrid state-planning model as either a "Highest Need" community or a "Highest Contributor" community in one or both of the problem areas in the Statewide Epidemiological Profile will be given priority during the application process. The method for prioritization will be to award additional points after the applications have been reviewed, evaluated and scored. Funding will be allocated in this method to allow tribes and communities in the same geographic region the opportunity to apply for funding. At this time the most reliable data is available at the county level, therefore collaboration is critical between tribes and communities to demonstrate change in consumption and consequence patterns.

The communities identified through the Epidemiological Profile include:
Rural Counties that will be prioritized based on county level data:

-Apache	-Santa Cruz	-Navajo
-Mohave	-Gila	-Coconino
-La Paz	-Cochise	-Graham

Urban Counties that will be prioritized based on county level data and sub-county (community health analysis) data that show the highest rates within these urban counties:

-Pima
  -Tucson SE
  -Tucson W
  -Tucson SW
  -Marana
  -Tanque Verde

-Maricopa
  -Gila River
  -Mesa S
  -Queen Creek
  -Laveen
  -Estrella
  -Paradise Valley Village
  -Paradise Valley
  -Camelback E
  -Peoria
  -Maryvale
  -Chandler SE

The Arizona Governor's Office for Children, Youth and Families anticipates allocating approximately 10-15 awards, ranging anywhere from $100,000 to $350,000. However, in the event that an insufficient number of applications are received from "High Need, Low Capacity" communities, funding may be reserved and re-competed within those geographic areas. Once awarded, each community will receive a resource guide with training and on-going technical assistance to assist in the needs assessment, capacity building, strategic planning, implementation and evaluation steps involved in the SPF SIG.

Sub-grantees who are awarded grants through the competitive process for Phase I will be funded to carry out the first three steps of the SPF in six (6) to twelve (12) months. The first step will be to apply the data from the Statewide Epidemiological Profile and complete a local level community needs assessment. This will include information on local data, assets and resources, identification of gaps in services, limitations of capacity and readiness to change. The second step, occurring concurrently, will entail building and/or improving capacity. Existing coalitions will evaluate their current membership to determine adequacy of community representation. Communities without established coalitions will receive technical assistance to support the development of a collaborative community entity that will foster improved substance abuse prevention efforts. The third step will be the completion of a local level comprehensive community strategic plan.

Upon completion of the strategic plan, communities will submit a non-competitive proposal for funding to complete Phase II, which will include SPF steps four and five. The funding level will remain stable for years two and three of the grant period. However, in year four funding will be reduced to 80 percent of the original award and in year five funding will be reduced to 60 percent of the original award.

Any remaining funds from the original competition and from the reduction in funds will be used:

A. *To support additional communities identified through the on-going epidemiological process*. It is anticipated that new communities may be identified over the project period as evidenced in the updated epidemiological profile. These communities will have the opportunity to receive limited dollars for capacity building activities.
B. *Tribal specific data analysis as a capacity building activity.* Current negotiations are underway to contract with ITCA to assess the feasibility of a statewide tribal specific epidemiological profile on behalf of the 19 participating tribes. Additional contracts will be pursued with tribes who are not represented by ITCA. These contracts are expected to continue through the contract period to enhance the capacity of tribes to collect, analyze, utilize and share data.
C. *To provide additional technical assistance and funding to communities identified as high-risk, but do not receive funding due to not submitting an application*. There is concern that some of the communities identified may not have the capacity to apply for funding. In the event that high-risk communities do not receive funding because they did not apply for funding, additional technical assistance will be provided and funding will be re-competed for these communities.

Implications of Allocation Approach-By using the Request for Grant Application (RFGA) approach for Phase I funding, Arizona remains in compliance with State procurement laws and ensures that communities have the opportunity to apply for funding through an open application process. The Epidemiological Profile determined the priorities of the state based on age and geography. By using an open competitive process, communities can then define themselves within a specific geographical region and under one or both problem areas. This allows for coalitions to collaborate and for tribes to obtain funding as part of a coalition or independently. In addition, the Governor's Office will be providing technical assistance to the rural and tribal areas identified in the profile before the release of the RFGA to address the high need/low capacity communities. If these communities still fail to apply, additional technical assistance will be provided and a second competitive process will take place.

In addition to the SPF SIG funding, the Arizona Parents Commission has awarded funding to coalitions around the state to address Methamphetamines in their communities. Funding was awarded to every county in the state and several tribes. Technical assistance is being coordinated to ensure that the SPF planning is implemented by these coalition and to avoid duplication when the SPF SIG funding is awarded. The Parents Commission has also set aside dollars to address underage drinking. This money is currently being used to complete a statewide adult perception study in preparation for a statewide social media campaign and currently funds a prom/graduation media campaign. All activities and planning is coordinated within the strategic prevention framework.

Step 4: Implementation

State Level Application-State level infrastructure change occurs in three phases. The first is to define our motivations for change. This occurs internally, within the Advisory Council at large, and with each partnering agency. The second phase is assessing the

readiness issues that influence change through identification of barriers to change, such as state, county or local policy or institutional policy barriers. The third phase is developing action steps based on the information that is found in the first two steps.

An example of how this has been achieved in Arizona is the Statewide Epidemiological Workgroup as it pertains to Native American data. :

A. **Motivation**: Members defined their motivation, both personally and on behalf of their agencies. All members found that they were committed to substance abuse data as it relates to their particular agency focus (courts, child welfare, health, criminal justice, etc.) and felt it was important to improve data sharing and collaborative analysis.
B. **Readiness**: This centered on the availability of data in terms of whether it was collected and if it could be shared. One challenge that was identified was lack of data from tribal lands. It is either not collected, not centralized and/or not available to any entities outside of the tribe.
C. **Action steps:**
    1. Consult with Inter-Tribal Council of Arizona (ITCA) to assess availability of data; does it exist, where is it, can it be analyzed, can it be shared?
    2. Develop a contract, if appropriate, with ITCA to complete an Epidemiological Profile on tribal lands.
    3. After the profile has been completed and permission obtained from the tribes to share the profile, the information will be integrated into the Statewide Epidemiological Profile.

The second example is the Underage Drinking Subcommittee:

A. **Motivation**: Agency partners attended the “National Meeting of the States” hosted by SAMHSA in October of 2005. At this meeting, all the attendees had the opportunity to share their motivation and passion around the prevention and reduction of underage drinking.
B. **Readiness**: These issues were dependent on specific agencies. For instance; the Department of Liquor Control and Licensing would like to do more compliance checks, however legislation prevents them from doing randomized checks. They are only legally allowed to complete compliance checks at locations that they have received a complaint about or have a history of violations.
C. **Action Steps**: Initially the following steps have been developed to enhance current collaborative relationships.
    1. Complete a resource assessment of the state and federal funds targeting underage drinking in Arizona.
    2. Describe the responsibilities of each partnering agency in addressing underage drinking; whether it is enforcement, education, prevention, or compliance.
    3. Reevaluate and reprioritize each agency’s responsibilities given what

is realistic to change.

4. Identify potential collaborative projects - the first being Underage Drinking Town Halls funded by SAMHSA.

Future activities to institutionalize infrastructure change will use the same three-phase approach. In the next year, the Advisory Council will do this with Cultural Competency, Methamphetamines and Other Illicit Drugs, and Sustainability.

Local Level Application-As described in the Funding Allocation Plan, funding will be awarded to coalitions and/or tribes across Arizona. Already established coalitions, such as the Drug-Free Community Programs and Methamphetamine funded coalitions will be encouraged to apply, however within the communities that have been identified as high need there is the opportunity to develop a coalition if one is not currently in place. Communities that receive funding will be expected to complete the five steps of the SPF just as the state is currently in the process of doing. The first phase will be to complete the first three steps. The end result of the first three steps will be the development of a strategic plan that articulates not only a vision for local prevention activities, but also strategies for organizing and implementing environmental prevention efforts. The strategic plan will:

- be based on documented needs,
- be developed from identified resources/strengths,
- set measurable objectives, and
- include the performance measures and baseline data against which progress will be monitored.

Plans will be adjusted as a result of ongoing needs assessment and monitoring activities at both the state and local levels. The issue of sustainability should be a constant throughout each step of planning and implementation and should lead to the creation of a long-term strategy to sustain policies, programs and practices.

The strategic plans will be data-driven, utilizing the Statewide Epidemiological Profile, and focused on addressing the most critical needs in the community. Funded communities will need to address the priorities set by the Advisory Council as part of their comprehensive strategic plan.

Step 5: Evaluation

The Arizona SPF SIG evaluation team will use a multilevel evaluation design to capture processes, outcomes, and impacts at the state and community levels of analysis. A mixed-methods approach will incorporate both qualitative and quantitative data elements

important for measuring changes over the course of the project. The design of the evaluation plan will be robust and remain flexible enough to (1) accommodate the varying levels of community capacity for engaging in data collection and evaluation activities; (2) be responsive to findings from the national cross-site evaluation; and (3) be sensitive to the evolution of the state's strategic plan over time.

1. **Given the SPF SIG allocations described in your plan, discuss the State-level surveillance, monitoring, and evaluation activities you anticipate implementing.**

   Based on the Arizona SPF SIG plan for community allocations, the evaluation will include the following:

   a. Collaboration with the State Epidemiological Workgroup to ensure collection and analysis of data available at sub-state levels that measure intervening variables, consumption, and consequences.
   b. Evaluation of community-level SPF processes and outcomes, including the following:
      - Community implementation of the steps of the SPF and resulting programs, policies and practices;
      - Improvements in local prevention capacity and prevention infrastructure changes;
      - Changes in community-level intervening variables; and
      - Changes in community-level outcomes.

2. **Describe what you hope to track and how you plan to accomplish this.**

   Data will be collected to track state-level and community-level changes, and to assess how the project applies cross-site evaluation findings to Arizona. Within each level of analysis, baseline and follow-up data will be collected to determine how the project uses the Strategic Prevention Framework to develop and implement programs, practices, and policies specific to the Arizona initiative.

   a. State-level tracking

      The evaluation will also collaborate with the Epidemiological Workgroup to track epidemiological indicators at the state level related to the substance abuse problem priorities. The evaluation will also track state infrastructure data elements that will include:
      - State organizational structure
      - Data systems
      - Cultural competency level
      - Additional requested information as identified in the national Cross Site Evaluation State Infrastructure Interview Protocol.

   b. Community-level tracking

Community-level implementation processes to be studied will include:

- Planning and needs assessment activities;
- Cultural competency;
- Selection of target groups and problem areas;
- Capacity improvements and prevention system changes.

The evaluation will also track indicators related to outcomes and intervening variables identified by funded communities. These will include:

- Variables such as risk and protective factors and local history effects related to economic, political, demographic, or other community characteristics;
- Changes in substance abuse consumption and consequences as a result of SPF SIG interventions;
- Outcome and impact data elements will include cost measures and substance abuse indicators such as:
  - 30-day use of alcohol and other drugs;
  - Age of first use;
  - Binge drinking;
  - Perceived risk of using drugs and alcohol;
  - Perceptions of harm; and
  - Drinking and driving.

c. Interface with Cross-site Evaluation

The state evaluation team will collaborate with the national cross-site evaluation team to assess how findings from the national cross-site evaluation may be used to inform and improve the Arizona SPF SIG. Cross-site state-level outcome data elements will include:

- NOM outcome data findings related to collective state action;
- NOM outcome data findings related to community implementation; and
- Impact of cross-site feedback on project implementation overall.

Baseline and follow-up data will be collected on both state- and community-level infrastructure and implementation. Data collection methods will include observation, key informant interviews, community-level surveys, and document review. If feasible, the community-level outcome and impact evaluations will include a matched-pairs comparison community design. Otherwise, a time-series design will be used to measure intervention community conditions at multiple time points before, during, and after the project period.

3. Discuss what changes you expect to measure.

The evaluation will measure changes in the state and community prevention system infrastructure, and changes in outcome indicators that are targeted by funded communities.

a. State-level change
The evaluation will measure changes in the state prevention system infrastructure, and will also measure processes and outcomes resulting from any statewide interventions that are implemented as part of SPF SIG. The evaluation will also assess how the project implements the steps of the Strategic Prevention Framework at the state level.

b. Community-level change
The evaluation will measure:
- Community implementation of the steps of the SPF and resulting programs, policies and practices;
- Capacity improvements and prevention system changes in communities;
- Changes in intervening variables; and
- Changes in community-level substance abuse consumption and consequences as a result of SPF SIG interventions.

c. Cross-site evaluation interface
The evaluation will assess how the project applies national cross-site evaluation results to the process of implementing the SPF SIG in Arizona.

4. Describe how you will ensure that sub-recipient communities will collect required NOMs data and how the data will then be submitted both to the state and to CSAP.

The evaluation team will rely on three methods to ensure that this requirement is met:
a. Funding agreements will require that sub-recipient communities collect and report NOMs and other required data and provide it to the state evaluators;
b. The evaluation team will provide opportunities for training and technical assistance to sub-recipient communities to achieve Arizona SPF SIG goals of capacity development and to ensure that communities collect and report all required evaluation data; and
a. The state evaluation team will compile NOMs and any other evaluation data required by CSAP.

Cultural Competency

State Level Application-
The SPF SIG Advisory Council is early in the process of addressing issues surrounding cultural competency issues in Arizona. It is the commitment of the council to ensure that prevention programs and strategies are implemented in a culturally sensitive and appropriate manner. It is equally important that services are made easily accessible and

meet the needs of the diverse communities across Arizona. The council will be examining the principles developed by the Arizona Council of Human Service Providers Diversity Committee in their Implementation Action Plan, "Achieving Culturally Competent and Linguistically Appropriate Human Service Delivery System," along with documents, frameworks, and strategies currently being adopted by the Arizona Behavioral Health Office, and the Center for Substance Abuse Prevention. The following principles, developed by the Arizona Council of Human Service Providers, offer direction for the SPF SIG in ensuring culturally competent planning, policy setting, and prevention implementation efforts regarding substance abuse issues in Arizona.

GUIDING PRINCIPLES

Taking Cultural Competency to a New Level—A Way of Life

These following principles reflect the beliefs and values that are critical in providing culturally and linguistically competent human services. The principles serve as the "guide posts" or parameters that must be met when recommending and implementing structural, policy, or funding changes.

The system of services must be:

Accountable: Gathering, analyzing and disseminating specific data to inform systems and agencies of disparities and successes, to develop, implement and monitor systems improvement efforts and to create systems and services that are results oriented.

Collaborative: Meaningful participation and decision making by consumers, policy makers, public, private and non-profit service providers and community leaders in planning, evaluating, educating, and implementing system change.

Community focused: Community institutions, traditions, ceremonies and community healers are respected and valued and are at the core of planning, designing and delivering services within the consumer's community.

Individual and Family Centered: Service planning and delivery in collaboration with individuals and families based on their strengths and identified needs, wants, goals and aspirations. Consumers are included in all decision-making processes.

Respectful: Affording respect and dignity to all who come in contact with the human service delivery system.

Empowering: Promoting and honoring cultural discovery, the individual orientation and opportunity it offers staff and consumers, and fostering independence, self-reliance, self efficacy, resilience and expression of self through the interdependence of family structures, clans, tribes, and community.

Responsive: Immediate access to services which are culturally and linguistically appropriate, open, inclusive and affirming at each point in the service process with no barriers to entry.

The system must have a foundation within each service agency that reflects:

Assurance: The human service delivery system builds trust and confidence with those served, across all agencies and with the community that the System will provide resources and services in a timely and culturally and linguistically appropriate manner.

Creativity: Standards for recruitment, retention, training and service delivery which encourage new ideas, methods and responses and are flexible and individualized to the agency and the community and their respective strengths.
Leadership and Commitment: Active support throughout the service delivery system (from administration to direct care), empowering staff, accepting responsibility and being accountable for the delivery of culturally competent and linguistically appropriate services.
Open Communication: Listening and responding while respecting differences as well as similarities.
Understanding Individual Family Values: Acknowledging and respecting individual and family beliefs, priorities and family composition and responding to the needs based on what families value most.
Wellness and Healthy Communities: Service planning and delivery which encompasses mind, body, spirit and environment, in the context of the individual, family, school, work and play; social and larger community aspects, honoring and promoting a holistic approach as vital to an individual's identity and healing.

Local Level Application-Communities will be expected to implement evidence-based practices that are accessible, culturally appropriate, and to evaluate organizational cultural competency using the method adopted by the SPF SIG Advisory Council. The principles listed above are to be used as an initial guide to evaluate the current level of cultural competency within a community and/or organization. Communities will be encouraged to adopt and specify the methods officially adopted by the SPF SIG Advisory Council to their needs. The Advisory Council may also choose to adopt the Agency Cultural Competency Assessment tool developed by Behavioral Health Services (BHS).

Sustainability

State Level Application-
Sustainability is an issue of ongoing concern for state level planning efforts in terms of relation to funding and the institutionalization of new policies and practices. A sub-committee of the SPF SIG Advisory Council will be formed to develop a long-term plan. The subcommittee may want to consider how to institutionalize outcome expectations across systems as a method to ensure sustainability of the overall infrastructure change. This will begin with discussions between the Governor's Office and the Department of Health Services, Division of Behavioral Health Services to assess the requirements regarding the National Outcome Measures. It is anticipated that the state level implementation three-step process will ensure sustainability by allowing for ownership of the change by partners, by open discussion of the barriers or realities involved with change, and by creating practical steps. By approaching infrastructure in a sequential, yet flexible manner Arizona is confident that this change in the approach to substance abuse prevention will be maintained and continued long after the grant period has ended.

Local Level Application-
Sustainability will be viewed in terms of financial support and institutionalization at the local level. The following will demonstrate the current efforts in place to encourage and

support sustainability efforts locally. Communities will be asked to develop a strategy for local level sustainability as part of their strategic plans.

1) Incremental reduction in funding to local communities will encourage long-term planning to sustain SPF SIG efforts. Coalitions will be awarded funding to complete steps one through three of the SPF. Once these steps have been completed an additional award may be made for steps four and five. Funding will remain stable for the first two years. In year four funding will be reduced to 80 percent of the original award and in year five reduced to 60 percent of the initial award. This move is in response to the challenge communities often face in continuing program implementation by obtaining financial support to sustain state funded strategies and activities.

2) The Governor's Office for Children, Youth and Families-Division for Children, the Division for Substance Abuse Policy, the Behavioral Health Services Division of the State Department of Health Services, and the WesternCAPT are collaborating to evaluate the training needs of local providers and to develop a training and technical assistance plan to address these needs and ensure that the materials and information provided are consistent across the various funding sources.

3) Technical assistance will be provided to grantees throughout the project period, to high-risk communities with low capacity that do not receive funding and to tribes throughout the project period with the intent to build capacity and the local level that will sustain their efforts long-term.

In addition, local communities will be asked to coordinate with Drug-Free Communities grantees and their local Regional Behavioral Health Authority, if there are any in their geographic region, to complete a comprehensive resource assessment that will effectively allow communities to more successfully obtain additional funding and solidify collaborative relationships.

Challenges

The challenge of utilizing a "need-based" allocation process is that many communities across the state feel that they have high need based on their own needs assessment processes. As a result, the Governor's Office will be providing "information exchanges" across the state to describe the SPF SIG and its unique expectations. This provides an opportunity to share the data that was collected and analyzed by the SEW and educate communities as to the definition of "need" for the purposes of this funding process and future funding processes as Arizona fully integrates the SPF SIG into its existing infrastructure.

The implementation of the SPF SIG Strategic Plan will be a continuous process over the grant period and beyond. The first phase was the development of the Advisory Council to oversee and participate in the development of the plan, the second was the completion of the Epidemiological Profile, the third was the completion of the plan itself to use as a

work plan and the fourth will be to award communities funding to complete the local level implementation. There are inherent challenges in allocating funding through a competitive process that will be addressed through training sessions prior to the release of the RFGA and through mandatory pre-proposal conferences following the release. Once funding has been allocated, technical assistance trainings will be scheduled with each community.

Timelines and milestones have been described in the quarterly reports and will continue to be updated as progress is made. The current timeline for release of the RFGA and funding is as follows:

SPF SIG RFGA Timeline

RFGA Notice of Availability	May 3, 2006
RFGA Release	May 10, 2006
Required Pre-Proposal Conferences	May 24-26, 2006
Applications Due	June 21, 2006
Reviewer Training	June 26, 2006
Joint Review Meeting	July 12-13, 2006
Recommendations to Director (Rob Evans) Clarifications sent out to applicants	July 14, 2006
Clarifications Due Back	July 19, 2006
Matrix sent Director	July 21, 2006
Award Letters Sent	July 24-28, 2006
Funding to effective by	August 1, 2006
Mandatory Regional Orientations	September 11-15, 2006