Arizona Statewide Prevention Needs Assessment

September 2018

LeCroy & Milligan
ASSOCIATES, INC.

Arizona Statewide Prevention Needs Assessment

September 2018

Submitted to:
AHCCCS
801 E. Jefferson St
Phoenix, AZ, 85034
Ph: (602) 417-4760
https://www.azahcccs.gov/

Submitted by:
LeCroy & Milligan Associates, Inc.
2002 N. Forbes Blvd. Suite 108
Tucson, AZ 85745
Ph: (520) 326-5154
Fax: (520) 326-5155
www.lecroymilligan.com

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

The evaluation team thanks The Arizona Health Care Cost Containment System (hereafter referenced as AHCCCS) Office of Grant and Project Management Team, Division of Health Care and Management, for their efforts and guidance with this evaluation.

About AHCCCS:

Founded in 1982, AHCCCS (pronounced 'access') is Arizona's Medicaid program. Medicaid is a federal healthcare program jointly funded by the federal and state governments for individuals and families who may qualify for acute or long-term services.

Built on a system of competition and choice, AHCCCS is a $12 billion program that operates under an integrated managed care model, through a Research and Demonstration 1115 Waiver. Contracted health plans coordinate and pay for medical services delivered by more than 70,000 health care providers for 1.9 million individuals and families in Arizona.

- **Mission:** Reaching across Arizona to provide comprehensive, quality health care to those in need.
- **Vision:** Shaping tomorrow's managed care...from today's experience, quality and innovation.
- **Values:** Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership
- **Credo:** Our first care is your health care.

About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. (hereafter referenced as LMA) is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

Suggested Citation:

LeCroy & Milligan Associates, Inc. (2018). Arizona Statewide Prevention Needs Assessment. Tucson, AZ.

Table of Contents

Acknowledgements 6
Data Limitations 8
Executive Summary 9
Introduction 12
    Needs Assessment Approach 12
    Substance Use Prevention 14
    Project Overview 16
Methodology 18
    Secondary Data Analysis 18
    Qualitative Data Analysis 22
    Community Prevention Inventory 24
    Workforce Survey 24
Geographic Areas and Demographics 26
Findings 33
  Substance Use 33
    Secondary Data Analysis 33
    Qualitative Findings: Substances 89
    Workforce Survey 98
  Prevention: Current Efforts 99
    Community Prevention Inventory 99
    Qualitative Findings: Current Prevention Efforts 102
    Workforce Survey 108
  Causal Factors 125
    Secondary Data Analysis 125
    Qualitative Findings: Causal Factors 142
  Prevention Needs 159
    Qualitative Findings 159
    Workforce Survey 175

Conclusion 184
Critical Findings 184
Strengths of Needs Assessment 186
Limitations 186
References 189
List of Figures 195
Appendix A: Key Informant Interview Protocol 200
Appendix B: Focus Group Protocol 202
Appendix C. Supplementary Demographic Data 204
Appendix D: Arizona Statewide Community Substance Use Prevention Inventory 205
Appendix E: Workforce Training Topics Available by County 231
Appendix F: Workforce Survey Content Analysis 236
Appendix G: Short Reports (Youth, Veterans, Older Adults, LGBTQ) 254

Acknowledgements

The Substance Abuse Block Grant (hereafter referenced as SABG) Program was authorized by US Congress to provide funds to States, Territories, and American Indian Tribes for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use and/or misuse and is the largest Federal program dedicated to improving publicly-funded substance use prevention and treatment systems. On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) the former designated State agency to administer the SABG Block Grant, merged with AHCCCS. This merger was passed by the legislature at the recommendation of the Governor and consolidated the administration of physical and behavioral health services under one agency. As a result, AHCCCS became the Single State Authority (SSA) in the administration for the SABG Blog Grant. This report represents the first AHCCCS Statewide Prevention Needs Assessment after this merging.

AHCCCS contracted with LMA to conduct a comprehensive statewide prevention needs assessment to better understand the current substance use prevention activities occurring in Arizona, as well as identify the totality of the State's prevention needs.
The Needs Assessment workplan included the following components (See Exhibit 1):

- Develop and Implementing the Needs Assessment Approach and Evaluation Plan
- Generate a Community Prevention Inventory
- Conduct Focus Groups throughout Arizona
- Conduct Key Informant Interviews throughout Arizona
- Conduct an Online Survey for the Substance Use Prevention Workforce
- Synthesize Secondary Data Analysis for a multitude of Data Sources

LMA engaged seven team members to complete this comprehensive Statewide Needs Assessment:

Katie Haverly, M.S. – Project Lead
Kate McDonald, PhD – Quantitative Analysis
Sonia Cota-Robles, PhD, JD – Qualitative Data Collection and Analysis
Steven Wind, PhD – Qualitative Data Collection and Analysis
Debby Urken, MSW - Qualitative Data Collection and Analysis
Pamela Hill, MPH - Qualitative Data Collection and Analysis
Frankie Valenzuela – Data Management

The State Needs Assessment process was successfully completed with the assistance and coordination of a Steering Committee which included AHCCCS and the AHCCCS' SABG Block Grant funded partners also known as the Regional Behavioral Health Authorities (hereafter referenced as RBHAs) including the Cenpatico Integrated Care (CIC) which serves Southern

Arizona, Mercy Maricopa Integrated Care (MMIC) which serves Central Arizona, and Health Choice Integrated Care (HCIC) which serves Northern Arizona; and the Tribal Regional Behavioral Health Authorities (TRBHA) including Pascua Yaqui and Gila River Health Care (which are unique and not synonymous with RBHAs); and the Governor's Office of Youth, Faith, and Family hereafter (GOYFF).

In addition, AHCCCS and LMA would like to thank the following organizations and community members for their support, data and/or resources to make the needs assessment process possible:

- The Administrative Office of the Courts/Arizona Supreme Court Juvenile Justice Services Division and Adult Probation Services Division
- The Arizona Alliance for Community Health Centers (AACHC)
- The Arizona Center for Rural Health (AzCRH)
- The Arizona Criminal Justice Commission
- The Arizona Department of Health Services (ADHS)
- The Arizona Suicide Prevention Coalition (AZSPC)
- The Arizona Prevention Workforce participants
- The Community Prevention Coalitions and other prevention programs for providing information for the Community Prevention Inventory.
- The Focus Groups' participants across the State
- The Inter-Tribal Council of Arizona (ITCA),
- The Key Informant Interviews' participants across the State
- The Prevention Specialists Workforce
- The Substance Abuse Coalition Leaders in Arizona (SACLA)
- The University of Arizona, Arizona State University and Northern Arizona University
- The LGBTQ/GSM (Gender and Sexual Minority) Statewide Advisory Committee
- The communities and other participants that supported and contributed with additional resources

Data Limitations

There were considerable data limitations in the development of this report. The time frame for the evaluation team to complete the Statewide Needs Assessment was limited to three months during the summer of 2018. Due to this short time frame, primary data collection for focus groups and interviews were conducted with those groups and individuals that responded quickly to requests from the evaluation team. Although an enormous amount of support and requests were made, due to scheduling concerns, travel coordination, resource availability, and willingness to participate, the reader should interpret qualitative findings as a sampling of perspectives in Arizona and should not consider the findings to be a statistically significant representation for the State. There may also be selection bias involved in the reporting on those groups and interviews because of the criteria mentioned above. In addition, it is important that the reflections of those members from the Pascua Yaqui Tribe and Gila River Indian Community focus groups and interviews not be generalized to each other or to other Tribes in Arizona. Of Arizona's 22 Federally recognized Tribes, these were the only two Tribes the evaluation team were able to connect with as part of this assessment. Finally, the inventory of prevention programs identified in this document do not reflect all of the prevention programs and activities currently being implemented in the State.

Executive Summary

The 2018 Statewide Prevention Needs Assessment was a systematic process to collect and analyze information to describe the prevention needs of Arizona. This assessment is a practical tool that will allow community planners, stakeholders and coalitions, in collaboration with local and State governments, to identify the levels of risk and protective factors operating in their communities that are predictive of substance use and/or misuse and related behaviors. This information can then be utilized by these groups to assist with reducing substance use and misuse risk factors, while enhancing protective factors to positively affect behavior(s). This information can be utilized to inform policy and program planning, allocation of funding, and guide the statewide strategic prevention plan. In addition, this assessment can provide clarity on current prevention programs across the State to better identify the gaps in available services and resources. The needs assessment included a four-pronged evaluation initiative divided in secondary data analyses, primary data collection and analyses, the collation of a community substance use prevention inventory, and the conduction of a statewide substance use prevention workforce survey. The overall purpose of the needs assessment was to explore the following four main questions:

1. *What are the current substance use issues in Arizona by region and subpopulation?*
2. *What substance use prevention programs are active in Arizona?*
3. *What are the causes for using and/or abusing substances in Arizona?*
4. *What are the recommendations for the future of substance use prevention in Arizona?*

The secondary data analyses included the gathering, review and summation of statewide and national data sources. Data for the secondary analysis originated from both statistical surveys and administrative sources. The primary data collection activities included conducting focus groups and interviews with key informants throughout Arizona. Nineteen focus groups comprised of 172 individuals were conducted throughout the three main regions of Arizona (north, central and south) with a mix of urban and rural communities. Four subpopulations of interest (Youth, Veterans, Elderly, and those that identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) guided the majority of the scheduling of these groups. In addition, one focus group was conducted with the Pascua Yaqui TRBHA, and one focus group was conducted with *Promotores* serving the Phoenix (Central) area. Participants of all focus groups included active members of the populations or individuals involved with the populations. Eighteen key informant interviews were conducted on a one-on-one basis with persons who could provide access to specific information about a population, and/or who understood the risk factors or substance use problem behaviors of that population. These included community leaders, coalition leaders, RBHA administrators, medical health

professionals, school principals, refugee prevention specialists, superintendents, related school staff, Tribal elders, Tribal council members and university prevention specialists.
A variety of sources were utilized to develop the Community Prevention Inventory. Many known programs and coalitions were invited to participate in a digital survey. Additional information about coalitions was obtained at Substance Abuse Coalition of Leaders in Arizona (SACLA) meetings and through phone contact. The project team also obtained information about prevention efforts at the State's three public universities directly from the university staff responsible for coordinating such efforts. Online research was also utilized to source information for the inventory. The Substance Use Prevention Workforce Survey was a digital survey shared with individuals affiliated with organizations and coalitions that focused on substance use prevention. LMA distributed survey invitations through primary agencies and key contacts, to complete the surveys and/or forward them to secondary contacts in the target populations. The survey was completed by 142 individuals who self-identified as working or volunteering in substance use and/or misuse prevention.

The analysis and summation across all evaluation components contributed to 10 major findings:

1) An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
2) LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.
3) Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
4) The Counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
5) A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
6) The normalization of marijuana and other substances may be leading to increased substance use.
7) Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
8) Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
9) Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.
10) If basic needs are not being met (e.g. shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.

For more information about the Arizona Statewide Prevention Needs Assessment, please contact Gabrielle Richard at Gabrielle.Richard@azahcccs.gov and/or Katie Haverly at katie@lecroymilligan.com.

Introduction

A Needs Assessment is a systematic process for collecting and analyzing information to describe the needs of a population. For substance use prevention, it allows community planners in collaboration with local and state governments to identify the levels of risk and protective factors operating in a given community that are predictive of substance use and related problem behaviors which can then inform policy and program planning. This process can also identify current prevention programs that are occurring across the State to better understand where gaps may exist, as well as what programming is most effective to help improve prevention activities statewide.

Needs Assessment Approach

This assessment was done utilizing the SAMHSA's Strategic Prevention Framework (SPF) (https://www.samhsa.gov/capt/applying-strategic-prevention-framework). The SPF is a planning process for preventing substance use and misuse. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive framework for addressing the substance misuse and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and engages community members in all stages of the planning process. The steps are as follow:

Step 1: Assess Needs

Step 2: Build Capacity

Step 3: Plan

Step 4: Implement

Step 5: Evaluate

The SPF also includes two guiding principles:

Cultural competence: The ability to interact effectively with members of a diverse population.

Sustainability: The process of achieving and maintaining long-term results.

Strategic Prevention Framework Diagram- Partnership for Success

The Arizona Statewide Prevention Needs Assessment is related to the critical first step of this process and will feed into and support each of the subsequent four steps.

The SPF planning process has five distinctive features according to SAMHSA. The SPF model is:

1. **Data-driven**: Quality decisions require quality data. The SPF is designed to help practitioners gather and use data to guide all prevention decisions—from ranking the community impact of each substance misuse issue, to choosing the most appropriate methods to address those problems. Data also helps practitioners determine whether communities are making progress in meeting their prevention needs.

2. **Dynamic**: Assessment is more than just a starting point. Practitioners will perform frequent ongoing assessments as the prevention needs of their communities change, and as community capacity to address these needs evolve. Communities may also simultaneously engage in activities categorized in different steps. For example, practitioners may need to find and mobilize additional capacity to support implementation once an intervention is underway. For these reasons, the SPF is a circular, rather than a linear, model.

3. **Focused on population-level change**: Earlier prevention models often measured success by evaluating individual program outcomes or changes among small groups. But effective prevention means implementing multiple strategies that address the constellation of risk and protective factors associated with substance misuse in a given community. This macro-oriented thinking is more likely to create an environment that helps people support healthy decision-making.

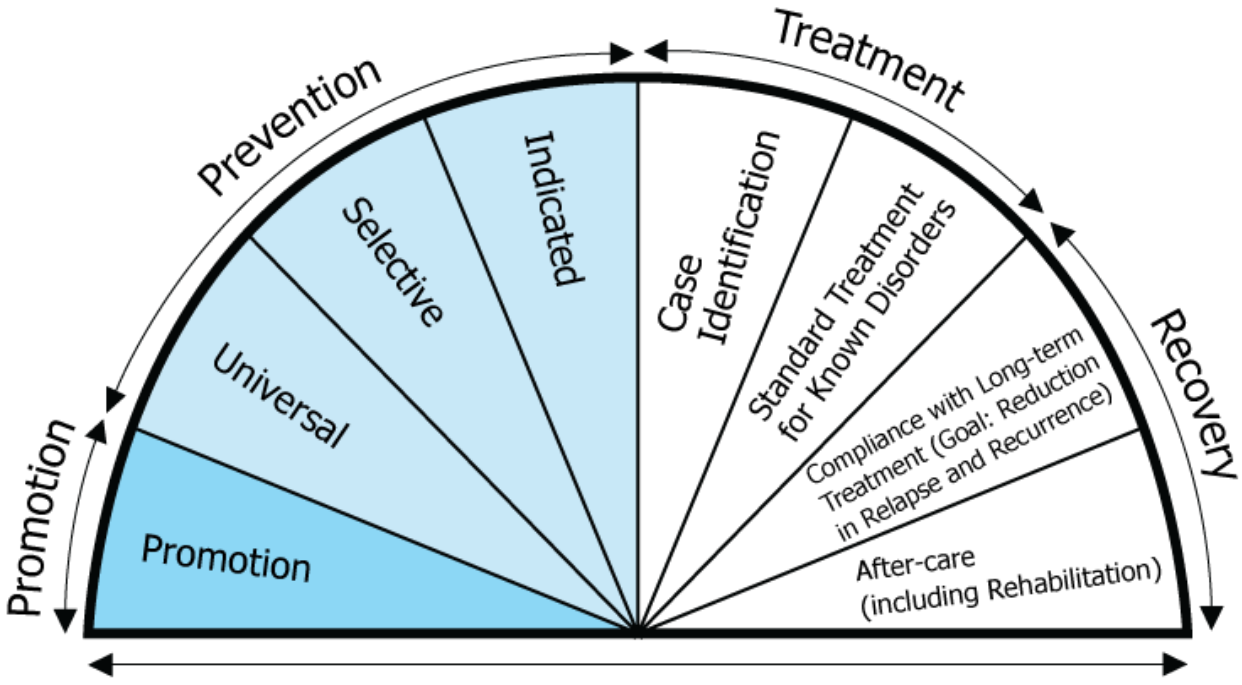
4. **Intended to guide prevention efforts for people of all ages:** The SPF challenges prevention professionals to look at substance misuse among populations that are often overlooked but at significant risk, such as young adults ages 18 to 25 and adults age 65 and older.

5. **Reliant on a team approach:** Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners.

To apply the SPF, a data-driven, outcomes-based approach is used to identify those substance misuse and behavioral outcomes that warrant the most immediate attention. This data is then used to identify risk and protective factors related to these outcomes and craft strategies to impact these factors. (https://www.samhsa.gov/capt/tools-learning-resources/data-prevention-planning-seow).

Substance Use Prevention

Prevention is part of a continuum of behavioral health programs and services that include treatment and recovery support.



Source: https://www.samhsa.gov/prevention

In 1994, The Institute of Medicine proposed a framework to classify prevention interventions according to their target population as Universal, Selective or Indicated (IOM, 1994). Universal interventions target the general population and are not directed at a specific risk group. Selective interventions target those at higher-than-average risk for substance abuse and Indicated interventions target those already using or engaged in higher risk behaviors.

Research national studies confirm the cost benefit of prevention programs. In a longitudinal, randomized control trial, Kuklinkski et al (2015) were able to calculate a benefit cost ratio of $8.22 for every dollar invested in the Communities That Care (CTC) prevention system; a community-based approach to prevent initiation of delinquency, alcohol use and tobacco use. Additionally, a longitudinal prevention trial conducted in Iowa (Spoth, Guyll & Day, 2002) explored the cost benefit/cost-effectiveness of a family centered program to strengthen families (ISFP) and delay or prevent onset of drug and alcohol use (Preparing for the Drug Free Years - PDFY). Conservative estimates for the ISFP intervention were a cost-effectiveness figure of $12,459 per case prevented, a benefit-cost ratio of S9.60 per $1 invested, and a net benefit of $5,923 per family. For PDFY, estimates were a cost effectiveness of $20,439 per case prevented, a benefit-cost ratio of $5.85 per $12 invested, and a net benefit of $2,697 per family.

In the most recent cost benefit analysis conducted by SAMHSA (Miller & Hendrie 2008), the total annual costs to society (including resource costs and productivity costs) for substance use and/or misuse were calculated to be **$510.8 billion**. This same report concluded that if effective school-based prevention programs were to be implemented nationwide, these programs could save an estimated **$18** per **$1** invested in prevention.

It is clear that the societal cost of substance use is staggering, and that the savings generated from effective prevention programs often are well worth the investment.

The objective of SABG funded AHCCCS Primary Prevention Services' is to help plan, implement, and evaluate activities that prevent and treat substance use and/or misuse at the state level. SAMHSA requires that grantees spend no less than 20% of their SABG allotment on substance use primary prevention strategies. These Primary Prevention Strategies are directed towards at-risk individuals not yet identified to be in need of treatment. The strategies include:

1. Information Dissemination
2. Education
3. Alternatives
4. Problem Identification and Referral
5. Community-Based Process
6. Environmental

Primary Prevention programs funded through AHCCCS SABG Block Grant are intended to decrease the prevalence and severity of substance use and misuse problems among populations

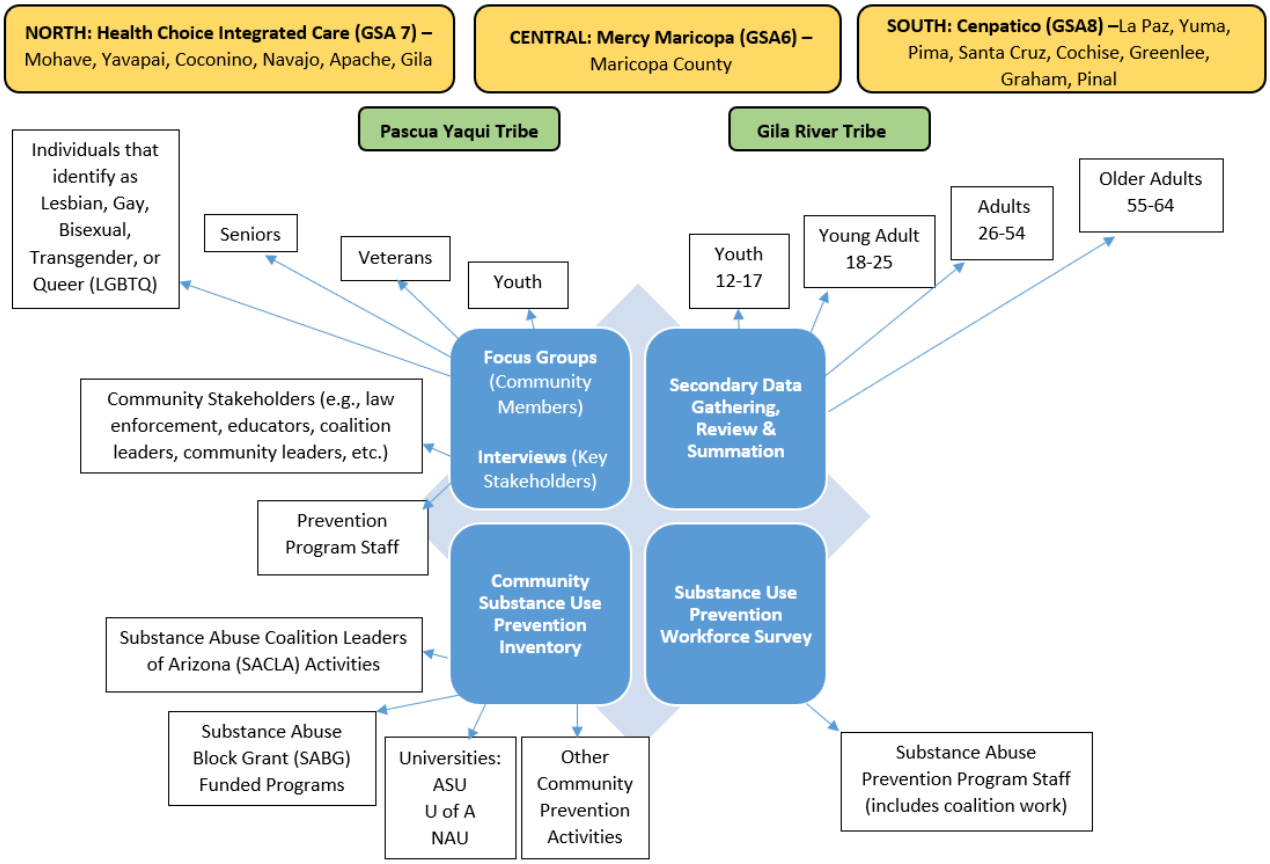
that do not have a diagnose of a mental or behavioral health disorder, including Substance Use Disorder (SUD). Prevention is accomplished by developing the system infrastructure and identify the strengths of individuals, families, and communities.

Project Overview

On June 6, 2018, the research team met with the Steering Committee for the Statewide Prevention Needs Assessment which included AHCCCS and other State government staff, representatives from the three RBHAs (Health Choice Integrated Care, Mercy Maricopa, and Cenpatico), The Governor's Office of Youth, Faith, and Family (GOYFF), and two TRBHAs (The Pascua Yaqui Tribe and Gila River Health Care). As part of this discussion, the committee agreed upon four subpopulations of interest for the needs assessment: (1) Youth, (2) Veterans, (3) Seniors, and (4) those that identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ). These subpopulations guided the scheduling and conduct of focus groups and interviews across the three regions of RBHAs (North, Central and South) as well as the two TRBHAs. Four short reports are also available that summarize the findings for each of these subpopulations. (See Appendices G, H, I, J)

In order to conduct a comprehensive prevention needs assessment for Arizona, four main areas of assessment were implemented: (1) conducting qualitative primary data collection including focus groups and interviews, (2) quantitative secondary data compilation, review and summation, (3) organizing a comprehensive Community Substance Use Prevention Inventory, and (4) conducting a statewide Prevention Workforce Survey (See Exhibit 1).

Exhibit 1. Overview of the Arizona Statewide Substance Use Prevention Needs Assessment



The structure of this needs assessment report will assist the reader in understanding:

1) Current substance use issues in Arizona by region and subpopulation.
2) Current prevention programs that are occurring in Arizona.
3) The causes and risk/protective factors for using and misusing substances in Arizona.
4) Data-driven recommendations, ideas and innovations for future prevention program development in Arizona.

Methodology

Secondary Data Analysis

The goals of the secondary data analysis for the Arizona Statewide Prevention Needs Assessment are to provide a comprehensive picture of:

- The prevalence of substance use in Arizona,
- The consequences of substance use, and
- The risk and protective factors associated with substance use.

Data for the secondary analysis was drawn from two general sources: statistical surveys and administrative sources. For some analyses, online data portals generated real time descriptive data summaries and cross-tabular analyses. Depending on variable and sample characteristics, other analyses included cross tabulation, chi square tests, means comparison and t-tests/ANOVAs. For all analyses, results were deemed significant if the p value is .05 or less, indicating that the possibility of the relationship occurring by chance is less than 5%. The specific data sources and their relative strengths and limitations are reviewed briefly below.

Statistical Surveys

In survey research, respondents are sampled from a target population, then data is collected and analyzed using statistical procedures. Because error is unavoidable in survey research, there is always some level of uncertainty with regard to survey estimates. Statisticians employ techniques to interpret survey data accurately given this uncertainty. Two techniques referenced in this report are 95% confidence intervals (95% CIs) and p-values.

- *A 95% confidence interval* is an upper and lower bound around a survey estimate. For example, the 2016 Behavioral Risk Factor Surveillance Survey (BRFSS) estimated that the prevalence of binge drinking among Arizona adults was 15.6%, with a 95% CI of 14.3% to 16.9%. This means there is a 95% chance that the true prevalence of binge drinking in Arizona falls between 14.3% and 16.9%. Larger confidence intervals suggest less-precision, or more uncertainty in the data. In this report, the 95%CI is indicated in the bar charts through the use of error lines.

- *P-values, or probability values,* are used in hypothesis testing to determine whether differences between estimates are statistically meaningful. For instance, the prevalence of binge drinking among adult males in Arizona according to the 2016 BRFSS was 21.3%, but only 10.1% for females. In order to test the hypothesis that the prevalence of binge drinking differs between males and females, the two estimates are statistically compared and a p-value is generated. If the p-value is less than .05, there is strong evidence that the two estimates are meaningfully different after accounting for the uncertainty in each estimate. The commonly accepted threshold is $p<.05$ for

determining statistical significance; p-values of <.10 are considered marginally significant. These thresholds are applied in this report.

The primary surveys referenced for the secondary data analysis include the:

- **National Survey on Drug Use and Health (NSDUH):** The NSDUH is an annual, national survey of the non-institutionalized population aged 12 or older directed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the NSDUH is to provide national and state level data on key substance use and mental health indicators in order to inform prevention and treatment efforts and monitor changes overtime. Because of sample size limitations, state level estimates are based on two or three years of combined data, with the most recent data drawn from the 2016 survey. Online analysis tools are still being developed for the NSDUH and are not currently functional. As a result, the secondary analysis relied on data already published in NSDUH reports. Data were not available to investigate disparities in indicators by key sociodemographic characteristics. Additionally, data were not available for finite age categories of adults over 25.

- **Behavioral Risk Factor Surveillance System (BRFSS):** The BRFSS is an annual state-based survey of non-institutionalized adults 18 or older coordinated by the Centers for Disease Control (CDC). The goal of the BRFSS is to monitor health risk behaviors and while it does not focus specifically on substance use, it does collect data on cigarette and alcohol use. Arizona sample sizes are larger for the BRFSS than the NSDUH, and there are online analysis tools available that permit statistical analyses of disparities, risks and more detailed age groupings than those allowed by the NSDUH. Data for this report were drawn from the 2016 BRFSS, which was the most recent year of data available at the time. Results from the 2017 BRFSS were released September 2018 and can be accessed online through the CDC maintained website: "BRFSS Prevalence Data and Data Analysis Tools."

- **Youth Risk Behavior Surveillance System (YRBSS):** The YRBSS is administered every two years to a representative sample of 9th through 12th grade students in the United States. The YRBSS is coordinated by the CDC with the goal of providing national, state and Tribal government estimates of youth risk behaviors, health conditions, and social problems. Data are available for a number of substance use indicators for 2017, and the online analysis tools permit statistical analyses of disparities and risks.

- **American Community Survey (ACS):** The ACS is an ongoing survey conducted by the U.S. Census Bureau to provide updated estimates of key socioeconomic and demographic indicators (e.g., educational attainment, income, veteran status, employment, etc.). Demographic data in this report are from five years of aggregated

ACS data (2012-2016). The 5-year aggregated data were used because the larger sample sizes enhance precision and enable functional estimates for small geographic areas, including small counties.

- **Arizona Youth Survey (AYS):** The AYS is conducted by the Arizona Criminal Justice Commission every two years among 8th, 10th and 12th graders in all 15 counties in Arizona. The AYS collects data about youth substance use and risk behaviors. Data are available at the state, county and zip-code level. Limitations of the AYS include that the survey does not randomly sample schools for inclusion in the study; rather all Arizona schools are invited to participate. In addition, the number and percentage of schools that participate in the survey can vary from year to year depending on the school's decision to participate in the survey.

Administrative Data Sources

Unlike survey data, which sample a subset of the population, administrative data aim to track every relevant case or event. These data are often collected for administrative purposes, such as tracking participants in a program, making decisions about funding, monitoring services, or tracking vital events (e.g., births, deaths, etc.). The secondary data analysis utilized numerous administrative data sources, including:

- **Arizona Vital Statistics Data:** The Bureau of Public Health Statistics in the Arizona Department of Health Services (ADHS) maintains Arizona's health and vital data. The secondary data analysis accessed mortality data in addition to hospital and emergency department discharge data related to drugs, alcohol and intentional self-harm (suicide).

- **The Treatment Episode Data Set (TEDS):** TEDS is maintained by the Center for Behavioral Health Statistics and Quality and SAMHSA. It tracks substance use and/or misuse admissions annually at the state and national level.

- **The Arizona Crime Report:** The Arizona Crime Report is compiled by the Arizona Department of Public Safety and includes annual data on arrests in the State, including arrests for drugs and alcohol.

- **The Arizona Motor Vehicle Crash Facts, 2017:** These data are compiled annually from Arizona's motor vehicle crashes for the Arizona Department of Transportation and provides data on drug and alcohol related crashes.

- **Fatality Analysis Reporting System (FARS):** FARS is a nationwide census maintained by the National Highway Traffic Safety Administration that tracks fatal injuries from motor vehicle traffic crashes, including fatal crashes involving drugs and alcohol.

- **U.S. 2010 Census Data:** The U.S. census is completed every ten years by the U.S. Census Bureau in order to enumerate the U.S. population and collect important demographic information.

Data Limitations and Challenges

There are a number of limitations to the secondary data analysis that are common when conducting comprehensive needs assessments with large surveillance datasets that should be considered when interpreting findings. LMA utilized the triangulation of multiple data sources where possible to mitigate some of these challenges.

Error, Chance and Bias

Survey samples may not be representative of the target population, either because of chance, low response rates, or some error in survey methodology. Survey respondents may answer survey questions inaccurately, either because they cannot recall the event correctly, did not understand the question, or because they want to provide a more socially desirable response. Social response bias can be especially problematic when survey questions ask about something illegal, like drug use. As a result, survey data may under-estimate the true prevalence of an event. Additionally, when sample sizes are small, it is more difficult to make accurate estimates or detect true differences between estimates. All data were also cross-sectional in nature, making it difficult to evaluate causality. Finally, administrative data sources are prone to error, especially due to mistakes or inconsistencies in mortality coding or disease classification. Errors in administrative data sources are difficult to identify and evaluate.

Data Inconsistencies

Most indicator data were compiled from multiple data sources. Users are cautioned not to directly compare prevalence estimates from different data sources. For instance, in 2016 the BRFSS estimated that the prevalence of adult binge drinking in Arizona was 15.6%, while the NSDUH estimated the prevalence was 24.5%. This significant difference was attributed to differences in survey administration techniques and other methodological inconsistences, including slight differences in question wording between the two surveys (Center for Behavioral Health Statistics and Quality, 2017).

Another limitation is that changes to survey methodology that occur overtime can compromise trend analyses. Two changes occurred in 2015 that impacted the secondary data analysis. First, the NSDUH sample and survey instrument were redesigned which limits the timeframe that can be utilized for trend analyses. Additionally, the Department of Health and Human Services mandated a coding transition from International Classification of Diseases 9th revision (ICD-9) to ICD-10 for many administrative data sources. The ICD codes are utilized for mortality coding and disease classification. Both the NSDUH revisions and ICD revisions impacted numerous indicators investigated in the secondary analysis. In these instances, data prior to 2015 were not

a practical comparison to future data; users are cautioned not to examine trends across the baseline established in 2015.

Limited Data for Priority Populations

Another challenge to providing a comprehensive secondary data analysis was the unavailability of statistically relevant samples for several key indicators and priority populations. Quantitative data were consistently limited for the following Arizona sub-populations:

- American Indian/Alaska Native populations, especially at the Tribal level.
- LGBTQ adults: Data on substance use risks among LGBTQ adults are limited for Arizona. However, results from a 2018 survey may help shed some light on the problem. The Shout Out survey was funded by the Maricopa County Department of Public Health and conducted by the Southwest Center for HIV/AIDS in partnership with the Health Management Associated Community Strategies and other groups. The goals of the survey were to learn more about the health needs of Arizona's LGBTQ populations in order to plan initiatives to better meet their needs. The survey asked specifically about substance use. The data are currently being analyzed and a public report is forthcoming.
- Veterans
- Older adults, especially substance use consumption patterns for finite categories of adults over 25.
- Specific geographic levels (e.g., communities, zip codes, TRBHAs, etc.)

To bolster information about these priority populations in Arizona, the majority of qualitative data collection was focused on these populations.

Additionally, the availability and utility of online analytical tools were limited in the statistical analyses they could perform making it difficult to completely assess disparities and test hypotheses. Finally, due to lags in data collection and processing, the most recent data for many indicators were from 2016. These data may not accurately reflect current substance use patterns, risks and consequences in Arizona. In the future, targeted data collection and analytical efforts could help improve information about substance use in Arizona.

Qualitative Data Analysis

Primary data collection is an important component of a comprehensive needs assessment. Real time insights about needs and issues can bolster quantitative data that may not be current, or that does not capture information about specific communities and populations. The statewide qualitative data collection plan sourced insights from one-on-one key informant interviews and focus groups comprised of qualifying individuals. Two evaluators were present at each focus group, one to facilitate the group and one to take detailed notes, with groups lasting on average for 90 minutes. Interviews were conducted in person or over the phone and lasted on average 30 minutes. Both focus groups and interviews were recorded in order to corroborate findings

after these sessions. Recordings, notes, and transcripts were then reviewed for emergent common key themes that arose by subgroup, and for the State as a whole. It is important to caution the reader that these focus groups and interviews should not be generalized to represent the viewpoints of entire regions or subpopulations. The insights gathered from these sessions are representative of the individuals who share them and need to be contextualized within the larger framework of further education regarding these communities and populations. In addition, some subpopulations had very few respondent perspectives and should be recognized as such. For example, two prevention specialists were interviewed to learn more about the refugee population in the Tucson area. One focus group was conducted with *Promotores* in the Phoenix area, and when discussing Tribal communities, only one focus group and one interview with a Tribal elder was conducted with the Pascua Yaqui Tribe, and one interview was conducted with a community key informant in Gila River Indian Community. When reading summaries of findings about these three groups, the reader should be cautioned that these perspectives are based on a handful of individuals.

18 Key informant interviews were conducted on a one-on-one basis with community leaders, coalition leaders, RBHA administrators, medical health professionals, school principals, superintendents and other school staff, Tribal elders and council members and University prevention specialists. Key informants were selected based on the following criteria: (1) Individuals who had key insights about a community and/or population, (2) Individuals who had key insights about a community and/or population where there was a dearth of quantitative data available to understand the issues and needs of that community, and /or (3) Individuals who had key insights about a community and/or population that were recommended to the research team by a variety of sources. The interview guide (Appendix A) was developed (with feedback from the Steering Committee) to ensure cultural competency, understandability, and relevance to the key questions of the needs assessment.

19 Focus groups were conducted with 172 individuals and were interactive, small group discussions conducted in a controlled environment, where a selected group of people discussed specific topics related to substance use prevention. The focus group protocol guide was developed (with feedback from the Steering Committee) to ensure cultural competency, clarity, and relevance to the key questions of the prevention needs assessment (Appendix B). Focus groups were convened for the four subpopulations of interest (youth and those serving youth, veterans, seniors and those that identify as LGBTQ) spread evenly over the three main regions of Arizona (North, Central, South) with a mix of urban and rural communities. Youth have traditionally been the focus of many primary prevention efforts due to the potential of delaying or preventing the onset of substance use and/or misuse. A series of focus groups were conducted with youth as well as individuals that serve or are connected to youth (educators, prevention specialists, teachers, law enforcement, parents, etc.) to generate a comprehensive understanding of the current substance use issues and prevention needs for Arizona. In addition, one focus group was conducted with Pascua Yaqui Tribe, and one focus group was

conducted with *promotores* serving the Phoenix (Central) area. A *Promotora* is a Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker. *Promotores* serve as liaisons between their community, health professionals, and human and social service organizations. Participants of all focus groups included active members of the population or persons involved with the populations. These conversations were led by a moderator whose role was to foster interaction, keep the group on task, and encourage participation.

Community Prevention Inventory

The project team used a variety of sources to develop the Community Prevention Inventory. To initially obtain data about community prevention coalitions, the team invited coalition leaders included on a list provided by the Substance Abuse Coalition Leaders of Arizona (SACLA) to complete a survey posted on SurveyMonkey. Additional information about coalitions was obtained at a SACLA meeting and through phone contact. The Governor's Office of Youth, Faith and Family also provided information about current prevention activities occurring throughout the State. The project team also obtained information about prevention efforts at the State's three public universities directly from university staff responsible for coordinating such efforts. Information on the AHCCCS SABG Block Grant funded programs were obtained from the RBHAs contacts, TRBHA programs were obtained via phone and e-mail, and online research also contributed information for the inventory. It is important to note that despite all of these efforts there are likely programs and efforts that were unable to be identified due to lack of response to surveys, little to no marketing or online information about programs, etc.

Workforce Survey

Instruments and Measures

The implemented survey was developed to collect information from statewide members of the substance use prevention workforce. The survey was anonymous to collect information about the types of substance use prevention efforts the respondents were engaged in, challenges on implementation, training access, training needs, efforts to evaluate impact, as well as demographics and information about the types of communities they serve. A screening question confirmed that respondents were working or volunteering in substance use prevention.

Data Collection

The Substance Use Prevention Workforce Survey was developed in an online format using Qualtrics and shared with individuals affiliated with organizations and coalitions that focus on substance use prevention. In collaboration with AHCCCS and to promote participation, it was determined that the invitation could reach the target populations in either of two ways: (1) agencies and key contacts could provide LMA with a list of staff and LMA team would be responsible for sending out an invitation to complete the survey that included the survey link, or (2) agencies and key contacts could forward the invitation and survey link to their own

contacts in the target population. This decision maximized participation, though it was not possible to track the response rate in the latter case because agencies and key contacts did not share the lists of those to whom they sent the invitation. The survey was completed by 142 individuals who self-identified as working or volunteering in substance use and/or misuse prevention. Not all respondents answered all questions; findings disseminated total response numbers to each question.

Geographic Areas and Demographics

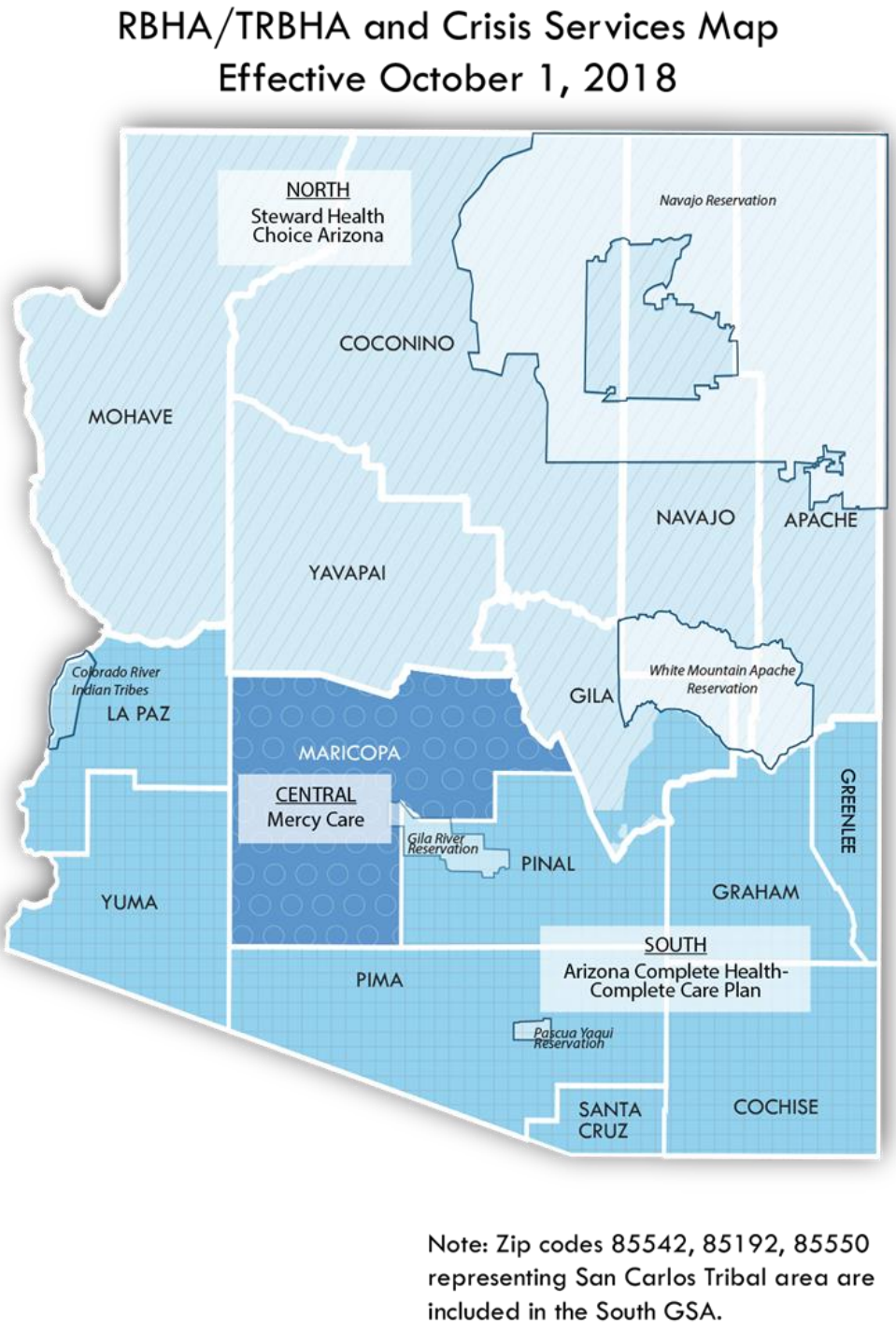
Tribal and Regional Behavioral Health Authorities (TRBHAs)

The Arizona Health Care Cost Containment System (AHCCCS) is the Single State Agency (SSA) that contracts with the Regional Behavioral Health Authorities (RBHAs), the Tribal Regional Behavioral Health Authorities (TRBHAs), and the Governor's Office of Youth, Faith and Families (GOYFF) to provide prevention and behavioral health services throughout Arizona. Eligible AHCCCS members are assigned to a TRBHA based on their zip code, geographic service area (GSA) or the Tribal community in which they reside. Exhibit 2 maps the location of each of Arizona's RBHAs and TRBHAs. It is important to note that AHCCCS has an Inter-Governmental Agreement (IGA) contract for Procurement requirements for the allocation of SABG Block Grant primary prevention funding with two TRBHAs to the Gila River Health Care and the Pascua Yaqui Tribe.

County and zip code designations for each RBHA at the time of the needs assessment are as follows:

- North RBHA (Health Choice Integrated Care) includes Apache, Coconino, Gila, Mohave, Navajo and Yavapai, counties with the exception of zip codes 85542, 85192, and 85550 representing the San Carlos Tribal area. These zip codes are served by the South RBHA.
- Central RBHA (Mercy Maricopa), includes Maricopa County and five zip codes in neighboring Pinal County: 85120, 85140, 85142, 85143, and 85220.
- South RBHA (Cenpatico Integrated Care) includes Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma, and zip codes 85542, 85192, and 85550. Zip codes covered by the Central region are excluded: 85120, 85140, 85142, 85143, and 85220.

Exhibit 2. Location of Arizona's Counties and Tribal and Regional Behavioral Health Authorities (TRBHAs)*



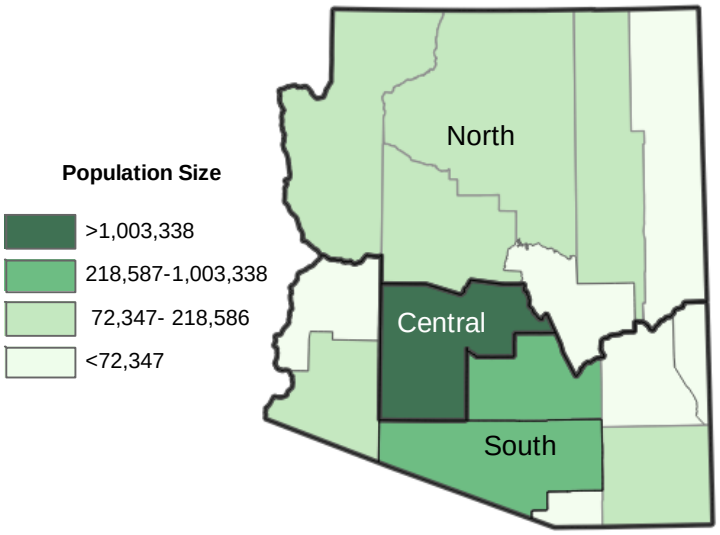
Source: Map provided by AHCCCS 02/22/19; Produced by AHCCCS October, 2018.

**This updated map is not reflective of the RBHA/TRBHAs that were providing services during the time of the needs assessment data collection. Since the assessment took place during a time of transition to AHCCCS Complete Care Plans, this map should be used going forward when determining RBHA/TRBHA designations and service areas.*

Population

Arizona is divided into 15 counties, with 22 sovereign American Indian Tribes and a population of over 6.7 million. Most of the population of Arizona is concentrated in Maricopa and Pima counties, specifically the urban areas in and around Phoenix and Tucson. Maricopa County is the largest county with a population of nearly 4.1 million, followed by Pima County (1.0 million; Exhibit 3)[1].

Exhibit 3. Population Estimates by Arizona County, 5-Year Estimates from 2012-2016[2]



Rank	County	Population
1	Maricopa	4,088,549
2	Pima	1,003,338
3	Pinal	397,604
4	Yavapai	218,586
5	Mohave	203,629
6	Yuma	203,292
7	Coconino	138,064
8	Cochise	128,177
9	Navajo	108,209
10	Apache	72,346
11	Gila	53,179
12	Santa Cruz	46,547
13	Graham	37,529
14	La Paz	20,304
15	Greenlee	9,224

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year

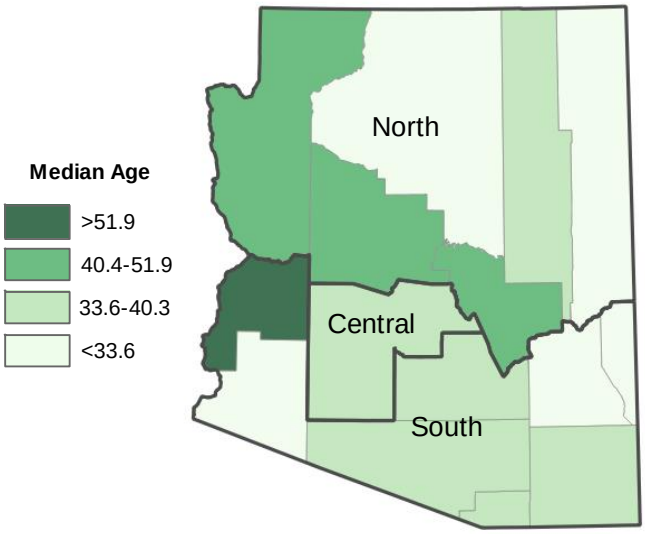
The seven least populated counties in Arizona are the rural counties of Navajo, Apache, Gila, Santa Cruz, Graham, La Paz and Greenlee (See Exhibit 3). Although Arizona's rural population comprises only 5% of the State's total population, nearly one-third of the rural population identify as American Indian/Alaska Native (Rural Health Quarterly, 2017).

Age

The median age in Arizona is 37.1 years, compared to 37.7 years nationally. The age profile differs by County (See Exhibit 4). La Paz, Yavapai and Mohave counties have the oldest populations. Over one-third of residents in La Paz (36.1%), and more than one-quarter of residents in Yavapai (28.3%) and Mohave (26.9%) are 65 and older. Coconino, Graham, Greenlee and Apache counties have among the youngest populations.

[1] Please note, except where indicated, demographic data are based on five years of aggregated data from the U.S. Census Bureau's American Community Survey, 2012-2016.
[2] Counts and rates for all maps are classified into four groups by the Jenks natural breaks classification.

Exhibit 4. Median Age by Arizona County, 5-Year Estimates from 2012-2016



Rank	County	Age
1	La Paz	55.1
2	Yavapai	51.9
3	Mohave	49.7
4	Gila	48.9
5	Cochise	40.3
6	Pinal	38.3
7	Pima	38.1
8	Santa Cruz	36.4
9	Maricopa	35.8
9	Navajo	35.8
12	Apache	33.5
12	Apache	33.5
13	Greenlee	33.3
14	Graham	32.4
15	Coconino	30.7

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Race/Ethnicity

In Arizona, the majority of residents identify as white only (56.1%; See Exhibit 5). Approximately 4.0% of the population identifies as black only, and another 4.0% identify as American Indian/Alaska Native only. Only 3.0% identify as Asian only, and fewer than 3% identify as multiracial or some other race. Nearly one-third of residents in Arizona identify as Hispanic/Latino of any race (30.5%; ACS, 2012-2016).

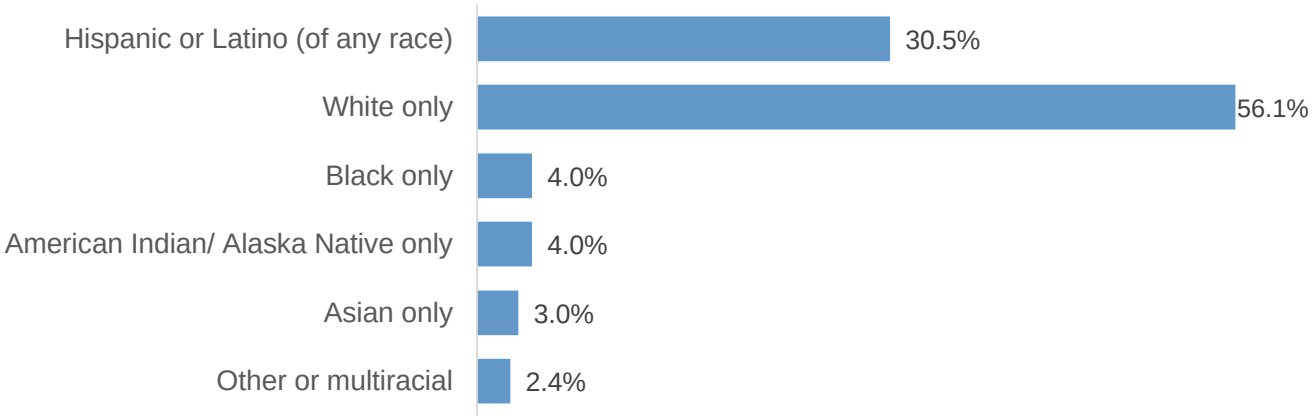
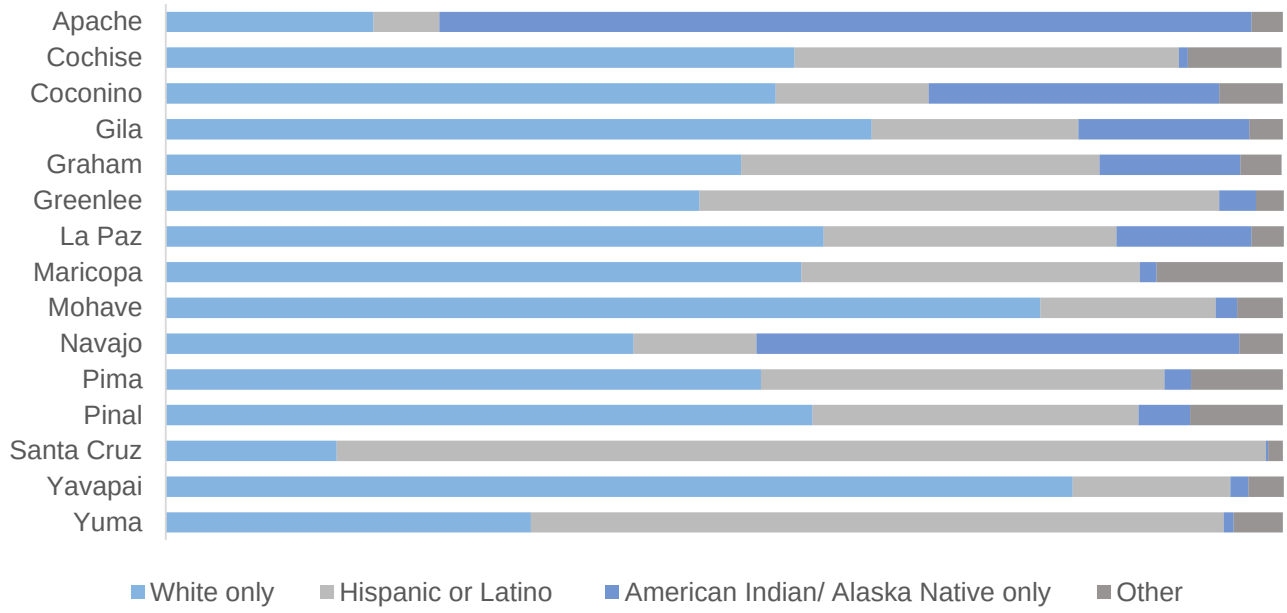


Exhibit 5. Race/Ethnicity in Arizona, 5-Year Estimates from 2012-2016
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Arizona's racial and ethnic profile differs significantly by county (See Exhibit 6). Approximately 81% of residents in Yavapai County identify as white only, while a minority of Santa Cruz County residents (15%) identify as white only. In Apache County nearly 73% of residents identify as American Indian/Alaska Native while fewer than 1% of residents in Cochise, Santa Cruz, and Yuma counties identify as American Indian/Alaska Native. Santa Cruz County has the highest proportion of residents identifying as Hispanic/Latino ethnicity (83%); Apache County has the smallest Hispanic/Latino population (6%). Detailed data on race and ethnicity by county are located in Appendix C.

Exhibit 6. Race/Ethnicity by Arizona County, 5-Year Estimates from 2012-2016

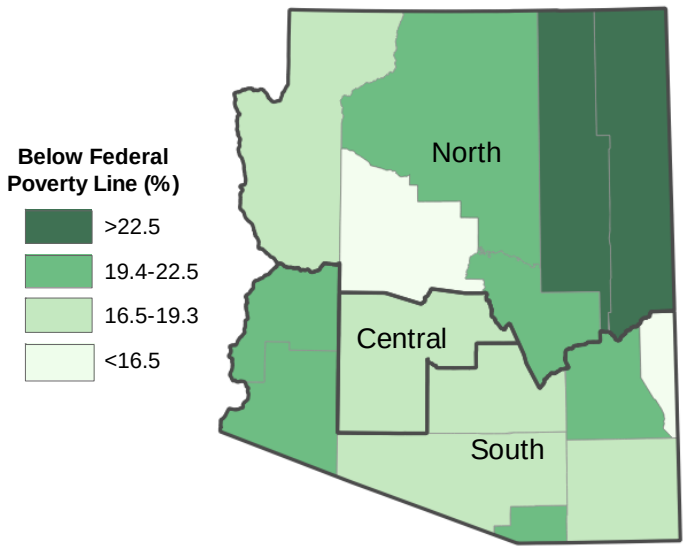


Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Poverty

In 2016, the poverty threshold for a family of four in Arizona was $24,300. Estimates from the 2012-2016 ACS indicate nearly 18% of Arizonans live below 100% of the federal poverty line, compared to 15% of the population nationally. The prevalence of poverty varies by Arizona county. Navajo and Apache counties report the highest percentage of residents living below 100% of the federal poverty line (36.2% and 29.9%, respectively). Greenlee and Yavapai counties have the fewest residents living below 100% of the federal poverty line (13.4% and 14.7%, respectively) (See Exhibit 7).

Exhibit 7. Percentage of Individuals Living Below 100% of the Federal Poverty Line by Arizona County, 5-Year Estimates from 2012-2016



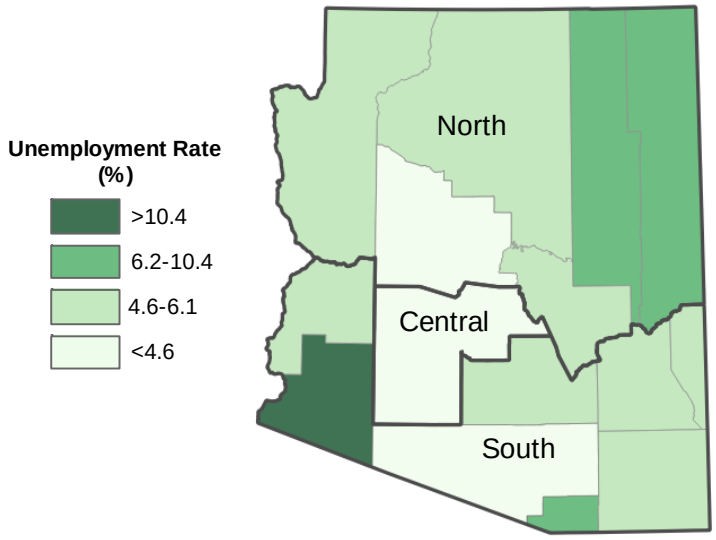
Rank	County	%
1	Apache	36.2
2	Navajo	29.9
3	Graham	22.5
4	Coconino	22.2
5	Santa Cruz	21.9
6	Gila	21.2
7	La Paz	21.1
8	Yuma	20.5
9	Mohave	19.3
10	Pima	19.1
11	Cochise	18.9
12	Maricopa	16.5
12	Pinal	16.5
14	Yavapai	14.7
15	Greenlee	13.4

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Unemployment

The Bureau of Labor Statistic's Community Population Survey (2018) estimated Arizona's seasonally adjusted unemployment rate to be 4.7 per 100 in May 2018, which is higher than the rate nationally (3.8). Annually, the highest unemployment rates in Arizona are reported in Yuma (17.0), Apache (10.4) and Santa Cruz (9.5) counties. The lowest unemployment rates are reported in Maricopa (4.2), Pima (4.5) and Yavapai (4.5) counties (See Exhibit 8).

Exhibit 8. Annual Average Unemployment Rate (%) by Arizona County, 2017



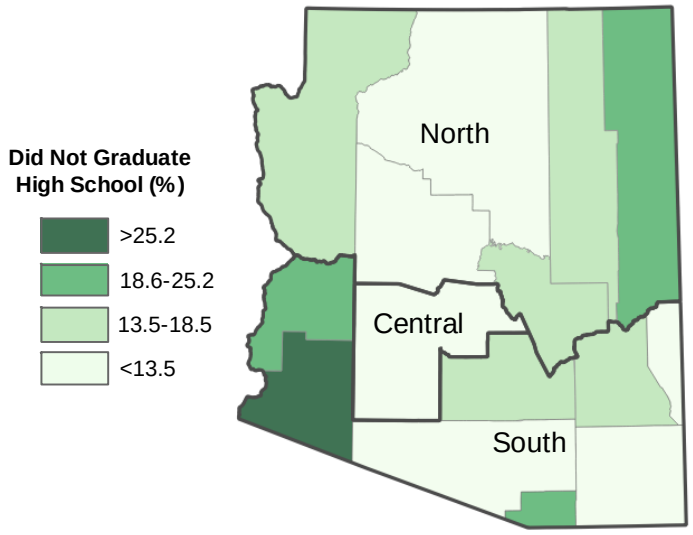
Rank	County	Rate
1	Yuma	17.0
2	Apache	10.4
3	Santa Cruz	9.5
4	Navajo	7.6
5	Gila	6.1
6	Mohave	5.9
7	Cochise	5.6
7	Coconino	5.6
9	Graham	5.4
9	La Paz	5.4
11	Greenlee	5.1
12	Pinal	5.0
13	Pima	4.5
13	Yavapai	4.5
15	Maricopa	4.2

Source: Bureau of Labor Statistics, Current Population Survey, 2017

High School Graduation Rate

High school graduation rates vary across Arizona Counties, with an estimated 13.8% of individuals 25 and older not graduating statewide, compared to 13.0% nationally. In Yuma County, an estimated 28.3% of residents 25 and older did not graduate from high school, while only 9.8% of Yavapai County residents did not graduate from high school (See Exhibit 9).

Exhibit 9. Percentage of Individuals 25 and Older who Did Not Graduate From High School by Arizona County, 5-Year Estimate 2012-2016



Rank	County	%
1	Yuma	28.3
2	Santa Cruz	25.2
3	La Paz	24.8
4	Apache	21.8
5	Navajo	18.5
6	Mohave	16.1
7	Gila	15.7
8	Pinal	15.1
9	Graham	14.6
10	Cochise	13.4
11	Maricopa	13.1
12	Pima	12.3
13	Greenlee	12.1
14	Coconino	11.1
15	Yavapai	9.8

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

High Risk Counties: Summary

These data indicate that a subset of Arizona counties share a disproportionate amount of socioeconomic burden. Apache, Yuma, Santa Cruz, Navajo, La Paz, Graham and Coconino counties rank among the top five in the indicators of unemployment, poverty and low educational attainment. These counties also have among the highest proportion of racial/ethnic minorities. Specifically, Navajo and Apache counties have the highest proportion of American Indian/Alaska Native residents and Santa Cruz County has the highest proportion of Hispanic/Latino residents.

Findings

Substance Use

Secondary Data Analysis

Prevalence estimates of substance use in Arizona are based on pooled data from the National Survey of Drug Use and Health (NSDUH), with the most recent year of data sourced from 2016[3]. The NSDUH prevalence estimates are supplemented with data from the 2017 Youth Risk Behavior Survey (YRBS) and the 2016 Behavioral Risk Factor Surveillance System Survey (BRFSS). Specifically, YRBS data are used to investigate substance use patterns and disparities specific to high school youth and is stratified by race/ethnicity, sexual identity, gender and high school grade. BRFSS data are used to estimate adult disparities for alcohol and tobacco use.

Data permitting, the following estimates are presented for each indicator:

- prevalence by age group,
- prevalence overtime (e.g., annually since 2009),
- prevalence by RBHA or county, and
- disparities in prevalence by available sociodemographic indicators (e.g., gender, race/ethnicity, sexual identity, etc.)

Primary Substance Use Indicators:

The primary indicators of past month (i.e., current) substance use includes:

- any alcohol use,
- binge alcohol use (defined as drinking five or more drinks for males, or four or more drinks for females, on the same occasion on at least one day in the past 30 days),
- use of any tobacco products or cigarettes,
- marijuana use, and
- any illicit drug use (defined as use in the month before the survey for any of the following 10 drugs: marijuana, cocaine/crack, heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives.)

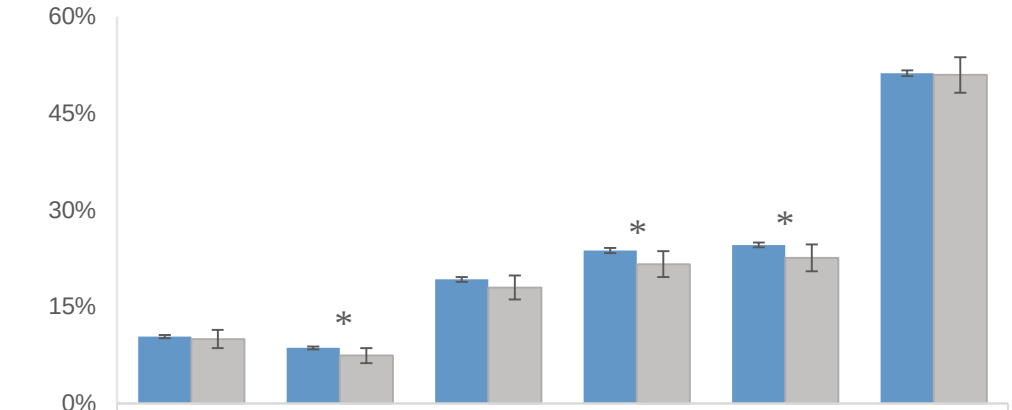
Exhibit 10 displays prevalence estimates of past month substance use in Arizona and the United States for the population aged 12 and older. The 95% Bayesian confidence interval for each estimate is indicated with error bars (SAMHSA, 2017). Data from the 2015-2016 NSDUH

[3] State-level prevalence estimates are based on two years of combined NSDUH data (2015,2016); estimates by RBHA are based on three years of combined NSDUH data (2014, 2015, 2016). NSDUH data are pooled in order to increase the precision of state and regional estimates, and to detect changes overtime more accurately given the small sample size (SAMHSA, 2017).

indicate that for the 12 and older population, alcohol was the most commonly used substance, both in Arizona and nationally.

Arizona's estimates were slightly lower than nationwide estimates for all indicators of past month use, but the differences were not statistically significant at p<.05. However, when the more lenient p-value threshold of p<.10 was used, prevalence estimates of past month marijuana, tobacco product, and binge alcohol use in Arizona were marginally lower than national estimate.

Exhibit 10. Prevalence of Past Month Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



	Any illicit drug use	Marijuana	Cigarette	Any Tobacco Product	Binge Alcohol Use	Any Alcohol Use
U.S.	10.4%	8.6%	19.2%	23.7%	24.6%	51.2%
Arizona	10.0%	7.4%	18.0%	21.6%	22.6%	50.9%

* Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Past Year Substance Use

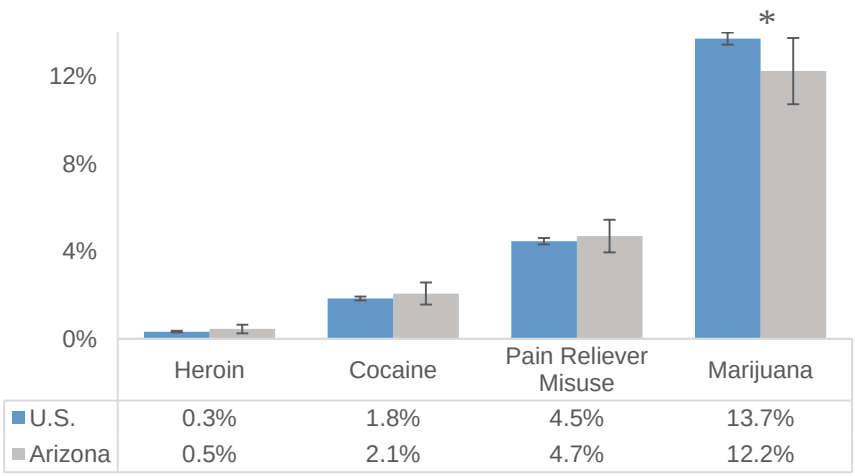
The NSDUH also collects data on past year substance use including:

- marijuana,
- heroin,
- cocaine, and
- pain reliever misuse, which includes misuse of opioid pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin® and Percocet®), and morphine. This misuse is defined as "use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor.

Misuse of over-the-counter drugs is not included" (SAMHSA, 2017)

Nearly one in eight, or 12.2% of Arizonans reported marijuana use in the past year, while 1 in 200 reported past year heroin use (0.5%). Arizonans reported marginally less past year marijuana use than the total U.S. population (12.2% vs 13.7%, p=0.07), however Arizonans reported slightly higher rates of past year heroin, cocaine and pain reliever misuse than national estimates. None of these differences were statistically significant (See Exhibit 11).

Exhibit 11. Prevalence of Past Year Drug Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



* Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

More detailed information about each indicator of substance use is presented in the remaining section of this report.

Alcohol Use

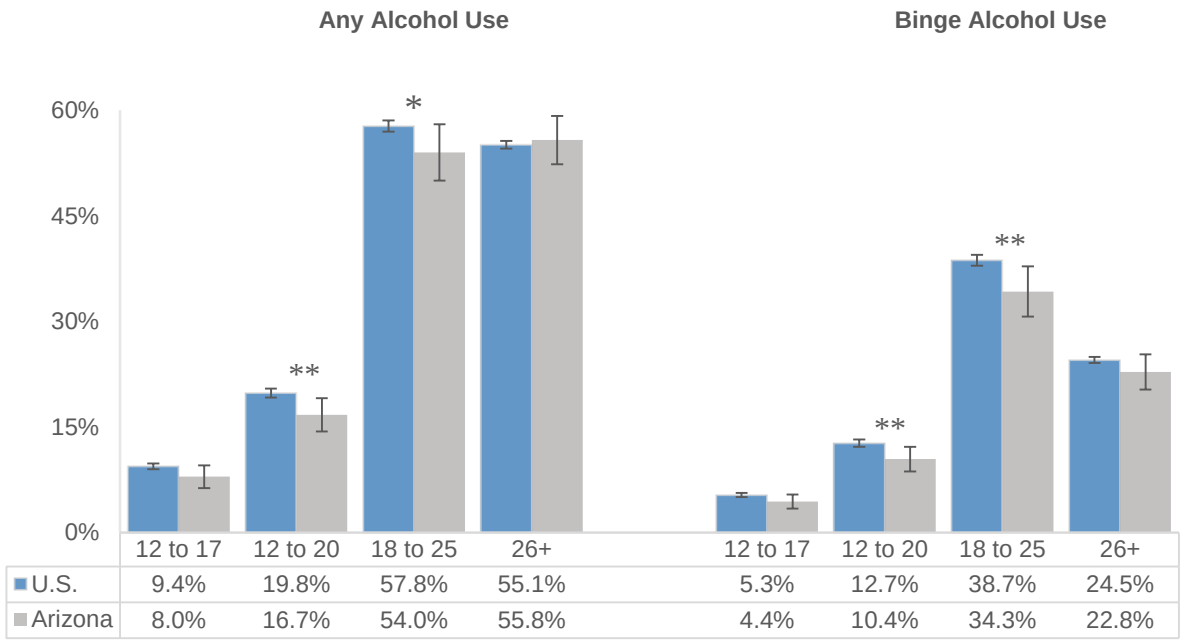
Alcohol is the most commonly used substance for youth and adults in Arizona. Data from the 2015-2016 NSDUH estimate that 2.90 million Arizonans, or 50.9% of the 12 or older population used any alcohol in the past month (i.e., qualified as current users). Nearly half of current alcohol users (44.3%) reported binge drinking, defined as drinking five or more drinks for males, or four or more drinks for females, on the same occasion on at least one day in the past 30 days (SAMHSA, 2017). This means that 1.29 million Arizonans, or 22.6% of the 12 or older population, met the criteria for current binge drinking. The prevalence of current alcohol use and binge drinking for Arizonans did not differ significantly from national estimates.

Youth Prevalence

NSDUH calculates underage drinking as alcohol use among those aged 12 to 20. Data from the 2015-2016 NSDUH indicate underage drinking was significantly lower in Arizona than nationally for both any alcohol use (16.7% vs 19.8%, p=0.021), and past month binge alcohol use (10.4% vs 12.7%, p=0.02; See Exhibit 12).

NSDUH data suggest youth 12 to 20 had lower rates of past month and binge alcohol use than youth nationally, though data from the 2017 YRBS indicates that the prevalence of binge drinking among high school students in Arizona was significantly *higher* than the national estimates (17.9% vs 13.2%, p=0.02). The estimate of any alcohol use was also higher for Arizona high school students based on YRBS data, although the difference was not significant as compared to national estimates at p<.05 (33.1% vs 29.8%, p=0.15).

Exhibit 12. Prevalence of Past Month Alcohol Use and Binge Alcohol Use by Age Group in the U.S. and Arizona, 2015-2016



	Any Alcohol Use				Binge Alcohol Use			
	12 to 17	12 to 20	18 to 25	26+	12 to 17	12 to 20	18 to 25	26+
U.S.	9.4%	19.8%	57.8%	55.1%	5.3%	12.7%	38.7%	24.5%
Arizona	8.0%	16.7%	54.0%	55.8%	4.4%	10.4%	34.3%	22.8%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10, or significant at p<.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Prevalence

Data from the 2015-2016 NSDUH estimates that approximately 2.86 million, or 55.5% of adults aged 18 or older in Arizona used any alcohol in the past month, and 1.26 million (24.5%)

reported past month binge drinking. Binge alcohol use peaked for those aged 18 to 25 (See Exhibit 12), tapering off for individuals over 25. Past month alcohol use in Arizona was marginally lower than national estimates for those 18 to 25 (54.0% vs 57.8, p=0.06). Binge alcohol use in Arizona was significantly lower than national estimates for those 18 to 25 (34.3% vs 38.7%, p=0.02).

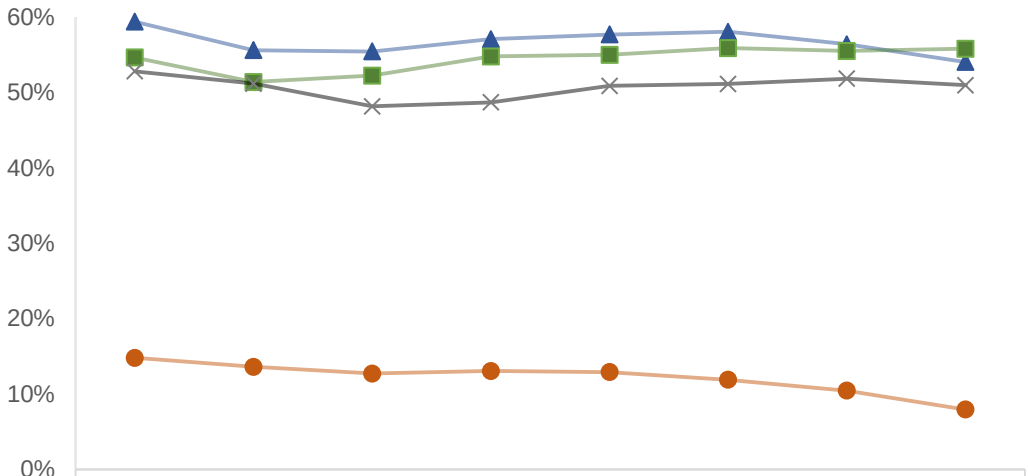
NSDUH data were not publicly available for finite age categories of adult alcohol use, however, the 2016 BRFSS showed that alcohol consumption for both binge drinking and current alcohol use peaked for those aged 25 to 44, and then declined with increasing age. Those 65 or older had the lowest prevalence of alcohol use. Please note, because of methodological differences between the two surveys, caution should be taken when directly comparing prevalence estimates from the NSDUH and BRFSS.

Youth Trends

Between 2008 and 2016, past month alcohol use in Arizona did not significantly change for the population overall (i.e., those aged 12 or older); however, there were significant decreases for youth. Arizona youth aged 12 to 17 reported substantial decreases in current alcohol use between 2008 and 2016, with the prevalence falling from 14.8% to 8.0% (p= <.001; See Exhibit 13). Drastic declines in current alcohol use were also reported between 2014 and 2016, falling from 10.5% to 8.0% (p=0.004). These data suggest current alcohol use among youth may have declined further in the last two years. National estimates of current alcohol use for youth 12 to 20 declined similarly over this time period.

Binge drinking data from the 2015-2016 NSDUH could not be compared with prior estimates because of a change in the definition of binge drinking for females from five to four drinks that occurred in 2015. However, data from 2008 to 2014 indicate the age trends for binge alcohol use mirrored the trends for past month alcohol use. Among those 12 to 17, past month binge alcohol use decreased from 8.8% in 2008 to 6.4% in 2014, although p-values were not available to assess statistical significance (See Exhibit 14).

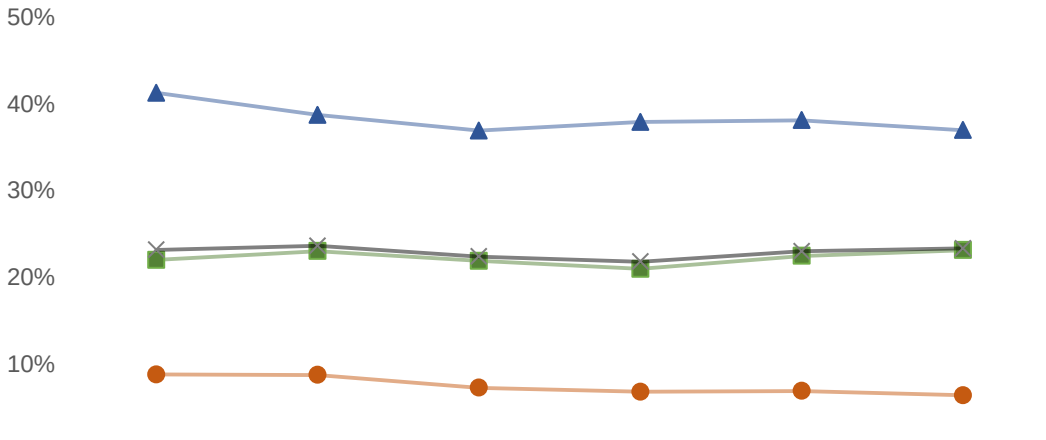
Exhibit 13. Trends in Prevalence of Past Month Alcohol Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	14.8%	13.6%	12.7%	13.1%	12.9%	11.9%	10.4%	8.0%
18 to 25	59.3%	55.6%	55.4%	57.1%	57.7%	58.0%	56.4%	54.0%
26 or older	54.6%	51.4%	52.2%	54.7%	55.0%	55.9%	55.5%	55.8%
12 or older	52.8%	51.2%	48.1%	48.7%	50.9%	51.1%	51.8%	50.9%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Exhibit 14. Trends in Prevalence of Past Month Binge Drinking in Arizona by Age Group, 2008-2014

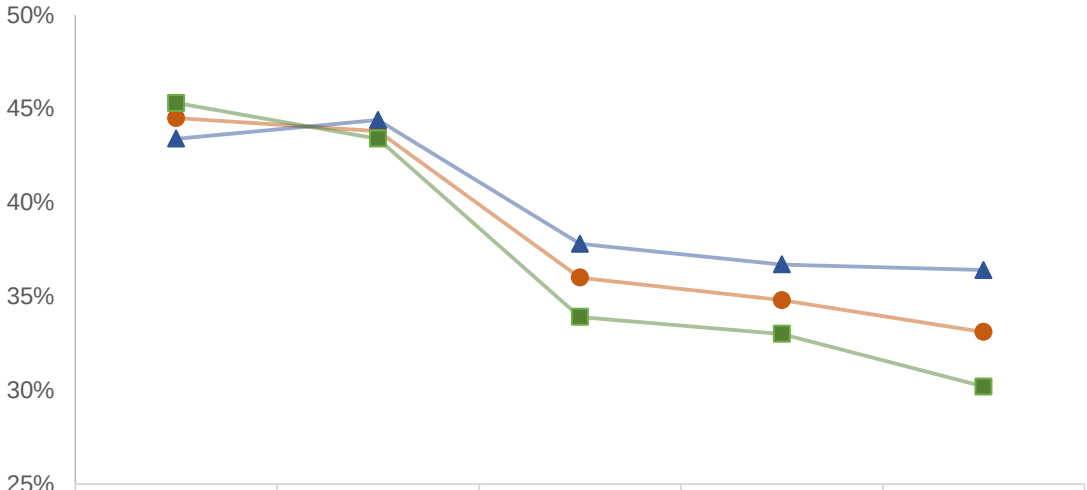


	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
12 to 17	8.8%	8.7%	7.2%	6.8%	6.9%	6.4%
18 to 25	41.3%	38.7%	36.9%	37.9%	38.1%	37.0%
26 and older	22.0%	23.0%	21.9%	21.0%	22.5%	23.1%
12 or older	23.2%	23.6%	22.4%	21.8%	23.0%	23.3%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Data from the YRBS also show significant declines in current alcohol use among Arizona high school students between 2009 and 2017 (44.5% versus 33.1%, p<.001) (Exhibit 15). Although declines were significant for both males and females, males experienced a greater decrease than females (males: 45.3% vs 30.2%; p=<.001 | females: 43.4% vs 36.4%; p<0.02). Again, because of the change in the definition, trends could not be assessed for binge drinking.

Exhibit 15. Trends in Prevalence of Past Month Alcohol Use Among Arizona High School Students by Gender, 2009-2017



	2009	2011	2013	2015	2017
Total	44.5%	43.8%	36.0%	34.8%	33.1%
Females	43.4%	44.4%	37.8%	36.7%	36.4%
Males	45.3%	43.4%	33.9%	33.0%	30.2%

Source: CDC, High School Youth Risk Behavior Survey (YRBS), 2017

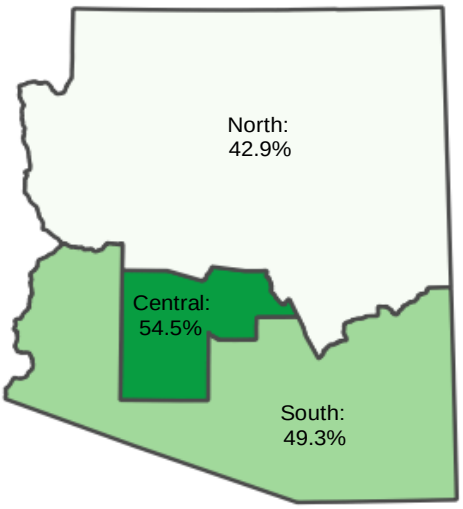
Adult Trends

There were also significant decreases in alcohol use for those aged 18 to 25, falling from 59.3% in 2008 to 54.0% in 2016 (p=0.045; See Exhibit 13). For those aged 18 to 25 binge alcohol use also decreased from 41.3% in 2008 to 37.0% in 2014, although p-values were not available to assess statistical significance (See Exhibit 14). There were no changes in the prevalence of past month alcohol use or binge alcohol use for those aged 26 or older.

Prevalence by RBHA

Exhibit 16. Prevalence of Any Alcohol Use in the Past Month Among those 12 and Older by Arizona's RBHA, 2014 - 2016

Combined NSDUH data from 2014, 2015 and 2016 demonstrate significant differences in alcohol use in the past month by Arizona's RBHA among those 12 and older (See Exhibit 16). The North Region had significantly less alcohol use than the Central (42.9% vs 54.5%; p<.001) or South Region (42.9% vs 49.3%, p=0.029). The South Region had moderate use, with significantly more alcohol use than the North Region and less alcohol use than the Central Region.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Data were not available for binge alcohol use in the past month because of changes to the definition of this measure that occurred in 2015, however, the data on alcohol use disorder indicated that there were no significant regional differences in alcohol use disorder in the past year by Arizona RBHAs. These findings could suggest that those who drank any alcohol in the North Region were more likely to engage in high risk drinking behaviors than those who drank alcohol in the Central and South regions. This is also supported by data presented later in the report, which indicate that some of the highest rates of alcohol related morbidity and mortality are in counties in Arizona's Northern Region.

Youth Disparities

The 2017 YRBS data revealed important disparities in alcohol use among sub-populations of Arizona's high school students (9th-12th grades).

- Gender: Female high school students in Arizona were significantly more likely than males to report any past month alcohol use (36.4% vs 30.2%, p=0.04), and marginally more likely to report binge alcohol use in the past month (20.7% vs 15.4%, p=0.06). At the national level, female high school students were also slightly more likely than males to report both past month alcohol use (31.8% vs 27.6%, p<.001), and binge alcohol use (14.1% vs 12.8%, p=0.10). It is noteworthy that the gender differences were not as pronounced nationally, and females in Arizona were significantly more likely to report binge drinking than females nationally (20.7% vs 14.1%, p=0.02). Differences between male students in Arizona and nationally were not statistically significant.

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a significant increased risk of any alcohol use in the past month (52.7% vs 30.8%, p<.001), and binge alcohol use in the past month (31.9% vs 16.5%, p<.001). Females identifying as gay, lesbian, or bisexual were

significantly more likely to report binge alcohol use than males (37.4% vs 21.6%, p=0.03).

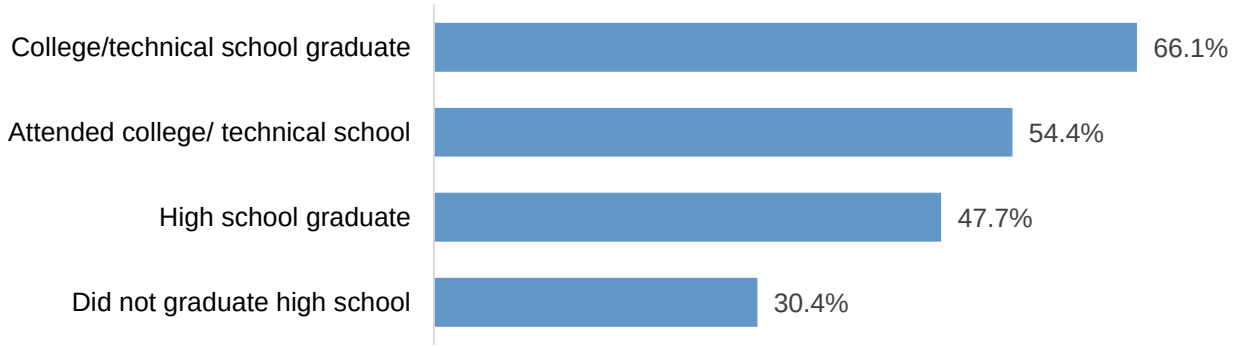
- Grade Level: Compared to 9th graders, 12th graders reported more alcohol use (21.3% vs 47.8%, p<.001), and binge alcohol use (11.6% vs. 25.7%, p=0.06).
- Race/Ethnicity: There were no significant differences in alcohol consumption indicators between non-Hispanic White and Hispanic high school students. Prevalence estimates for other racial and ethnic groups were not available for YRBS data.

Adult Disparities

The BRFSS 2016 highlights significant disparities in the prevalence of alcohol use among sub-populations of Arizona adults 18 or older.

- Gender: Although female high school students in Arizona reported significantly more alcohol use than their male peers, the gender risk profile for adults was reversed. Compared to female adults, male adults had a significantly higher prevalence of past month alcohol use (58.6% vs 45.7%, p<.001), and binge alcohol use (21.3% vs 10.1%, p<.001)
- Race/Ethnicity: Compared to other racial/ethnic groups, white non-Hispanics had the highest prevalence of past month alcohol use (58.1%), and Hispanics had amongst the lowest prevalence (42.4%, p<.001). There were no significant racial/ethnic differences in binge alcohol use.
- Educational Attainment: The prevalence of alcohol use differed significantly by educational attainment, with use increasing for each level of education (p<.001; See Exhibit 17). Those with a college or technical school degree had the highest prevalence of alcohol use (66.1%) and those who had not graduated high school had the lowest prevalence of alcohol use (30.4%). Binge alcohol use did not differ by educational attainment.
- Veterans: Veterans reported significantly more alcohol use in the past month than non-veterans (58.8% vs 51.0%, p=<.001), but did not have a significantly different prevalence of binge drinking (14.1% vs 15.8%, p=0.35)

Exhibit 17. Prevalence of Past Month Alcohol Use among Individuals 18 and Older by Educational Attainment, 2016



Source: The Centers for Disease Control, Behavior Risk Factor Surveillance System (BRFSS), 2016

Tobacco Use

According to data from the 2015-2016 NSDUH, 1.2 million Arizonans, or 21.6% of the population aged 12 or older reported using any tobacco product in the past month, and 1.0 million (18.0%) reported cigarette use. As such, the findings indicate that 83% of tobacco users in Arizona smoked cigarettes. The prevalence of tobacco product use in the past month in Arizona was marginally lower than the national prevalence (21.6% vs 23.7%, p=0.05). The estimate for cigarette use in Arizona was also slightly lower, but did not differ significantly from the national estimate (18.0% vs 19.2%, p=0.21).

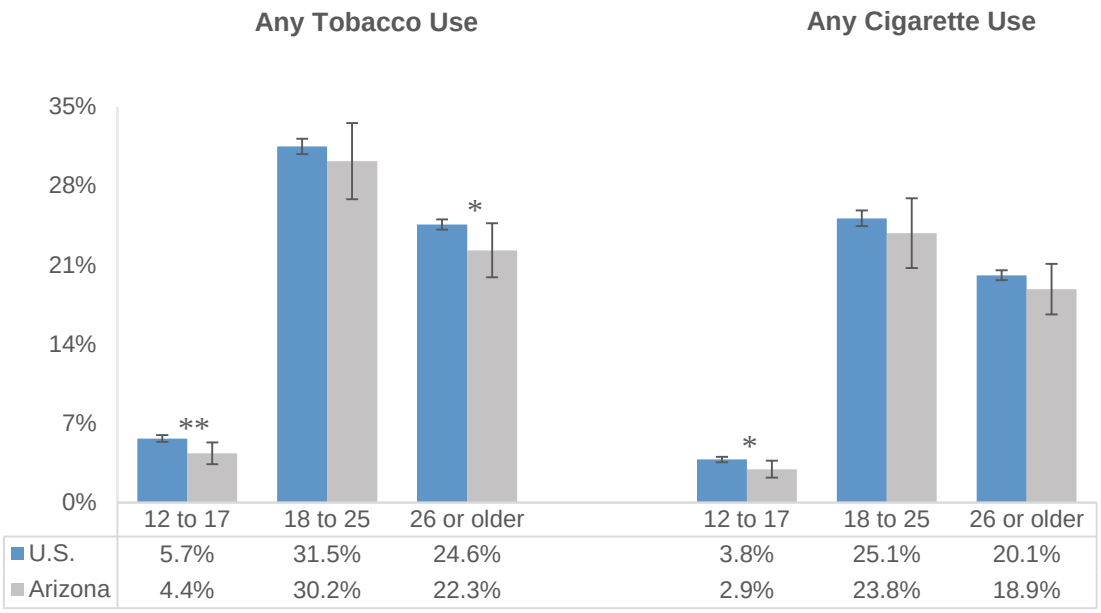
Youth Prevalence

Data from the 2015-2016 NSDUH estimated that 24,000 Arizona youth aged 12 to 17 actively used tobacco products, and 16,000 used cigarettes. Youth had the lowest prevalence of tobacco use of all age groups in Arizona (See Exhibit 18). Arizona youth reported significantly less tobacco use than youth nationally (4.4% vs 5.7%, p=0.026), and marginally less cigarette use than youth nationally (2.9% vs 3.8%, p=0.060). Only 69% of youth tobacco users in Arizona smoked cigarettes. YRBS data show no difference between Arizona high school students and national high school students use of cigarettes (AZ: 7.1% vs U.S.: 8.8%, p=0.21).

The NSDUH does not collect information on electronic vapor products, however, data from the 2017 YRBS indicated Arizona high school students were more likely to report that they had tried an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens) than youth nationally (51.0% vs 42.2%, p<.001). Current use of an electronic vapor product was also higher among Arizona's high school students than students nationally, but the differences were not significant (16.1% vs 13.2%, p=0.21). The full effects of e-cigarette use on adolescent health are still being researched, although the Office of the U.S. Surgeon General (2018) warns risks may include addiction, increased risk of other

tobacco use products, and negative effects on respiratory health and brain development.

Exhibit 18. Prevalence of Past Month Tobacco and Cigarette Use by Age Group in the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	5.7%	31.5%	24.6%	3.8%	25.1%	20.1%
Arizona	4.4%	30.2%	22.3%	2.9%	23.8%	18.9%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10, or significant at p<.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Prevalence

NSDUH data from 2015-2016 estimated that approximately 1.2 million (23.4%) of adults aged 18 or older used tobacco products in Arizona, and 1.0 million (19.6%) smoked cigarettes (See Exhibit 18). The prevalence of tobacco and cigarette use in Arizona did not differ significantly from national estimates for individuals aged 18 to 25, but those over 25 reported marginally less tobacco use in Arizona (22.3% vs 24.6%, p=0.074).

NSDUH data were not available for finite age categories of adult tobacco use, but these data were provided by the 2016 BRFSS. Those data estimated that the prevalence of current smoking among adults in Arizona was lowest for young adults aged 18 to 24 and adults older than 65, with usage peaking for middle aged adults. Because of methodological differences between the two surveys, caution should be taken when directly comparing prevalence estimates from the NSDUH and BRFSS, although general trends should be comparable.

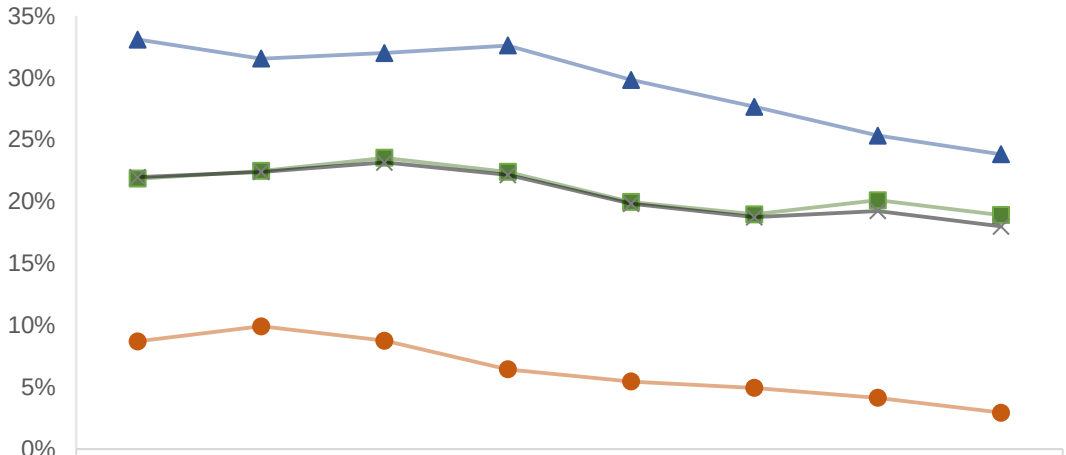
BRFSS 2016 data also show a significant inverse relationship between increasing age and active e-cigarette use, such that the prevalence of e-cigarette use decreased with each age group over 25. Most notably, the prevalence of e-cigarette use was 8.5% for those aged 18 to 24, but only

1.1% of those 65 or older (p<.001).

Youth Trends

NSDUH data indicate that past month tobacco use in Arizona for those 12 or older declined significantly between 2008 and 2016 (25.7% vs 21.6%, p=0.006), and past month cigarette use also declined (21.9% vs 18.0%, p=0.003; See Exhibit 19). Youth aged 12 to 17 had the most pronounced declines between 2008 and 2016 for tobacco use (10.2% vs 4.4%, p<.001) and past month cigarette use (8.7% vs 2.9%, p<.001). YRBS data also indicate significant declines in cigarette and tobacco use among Arizona high school students between 2009 and 2017 for the following survey questions: "ever tried cigarette smoking" (53.6% versus 29.9%, p<.001), and "currently smoked cigarettes" (19.7% versus 7.1%, p<.001).

Exhibit 19. Trends in the Prevalence of Past Month Cigarette Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	8.7%	9.9%	8.8%	6.4%	5.5%	4.9%	4.1%	2.9%
18 to 25	33.1%	31.5%	32.0%	32.6%	29.8%	27.6%	25.3%	23.8%
26 or older	21.8%	22.5%	23.5%	22.4%	20.0%	19.0%	20.1%	18.9%
12 or older	22.0%	22.4%	23.2%	22.1%	19.8%	18.7%	19.2%	18.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

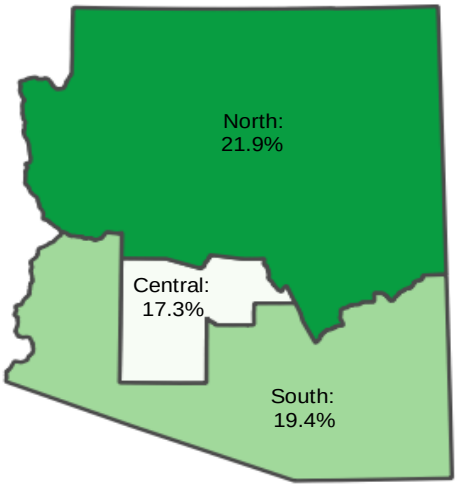
These declines in youth cigarette use should be contextualized by additional findings that approximately 16% of Arizona high school students reported that they currently used an electronic vapor product (YRBS, 2017). Data from the National Youth Tobacco Survey show the prevalence of e-cigarette use has increased significantly for adolescents across the U.S., and that e-cigarette use is higher among high school students than adults. Data on e-cigarette use in Arizona were first collected by the YRBS in 2015 making it difficult to assess trends, however preliminary indications suggest lifetime use of e-cigarettes did not change significantly from 2015 to 2017 among Arizona high school students (51.6% vs. 51.0%, p=0.84), but there were

significant declines in overall active e-cigarette use between 2015 and 2017 (27.5% versus 16.1%, p<.001). Trends in e-cigarette use should be assessed as more data are made available.

Adult Trends

NSDUH data also indicate significant decreases in tobacco use for those aged 18 to 25 from 2008 to 2016. Specifically, the prevalence of any tobacco use fell from 39.8% to 30.2%, (p<.001), and cigarette use fell from 21.8% to 18.9% (p=0.045; See Exhibit 19). There were only marginally significant changes in the prevalence of tobacco and cigarette use in the past month for those aged 26 or older.

Exhibit 20. Prevalence of Past Month Cigarette Use Among those 12 and Older by Arizona's RBHA, 2014 - 2016



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016

Prevalence by RBHA

Combined data from 2014, 2015 and 2016 NSDUH demonstrate substantial differences in tobacco and cigarette use in the past month by RBHA (See Exhibit 20). The North Region had significantly more past month tobacco use than the Central Region (26.5% vs 21.1%, p=0.011). The North Region also had significantly more past month cigarette use than the Central Region (21.9% vs 17.3%, p=0.027).

Youth Disparities

The 2017 YRBS data reveal important disparities in tobacco use among sub-populations of Arizona's high school students.

- Gender: Male high school students in Arizona were significantly more likely to use smokeless tobacco than females (6.9% vs 2.1%, p=<.001), and were more likely to report current use of an electronic vapor product (18.9% vs 13.1%, p=0.04). There were no other significant differences observed by gender.
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a significant increased risk of having ever tried a cigarette (50.4% vs 26.9%, p<.001), of smoking in the past 30 days (19.4% vs 5.4%, p<.001), of having ever tried an electronic vapor product (64.4% vs 49.6%, p<.001), and of currently using an electronic cigarette (30.8% vs 14.3%, p<.001).
- Grade Level: Compared to 9th graders, 12th graders reported more current cigarette use (5.1% vs 10.9%, p<.001). Current electronic vapor products use also increased but was not statistically significant (14.4% vs. 22.3%, p=0.25).
- Race/Ethnicity: There were no significant differences in cigarette or tobacco use between non-Hispanic White and Hispanic high school students. However, non-Hispanic white

students reported significantly more current electronic vapor product use (21.7% vs 13.2%, p=0.042). Estimates for other racial and ethnic groups were not available.

Adult Disparities

The BRFSS 2016 highlighted significant sociodemographic disparities in the prevalence of cigarette use in Arizona among those 18 or older.

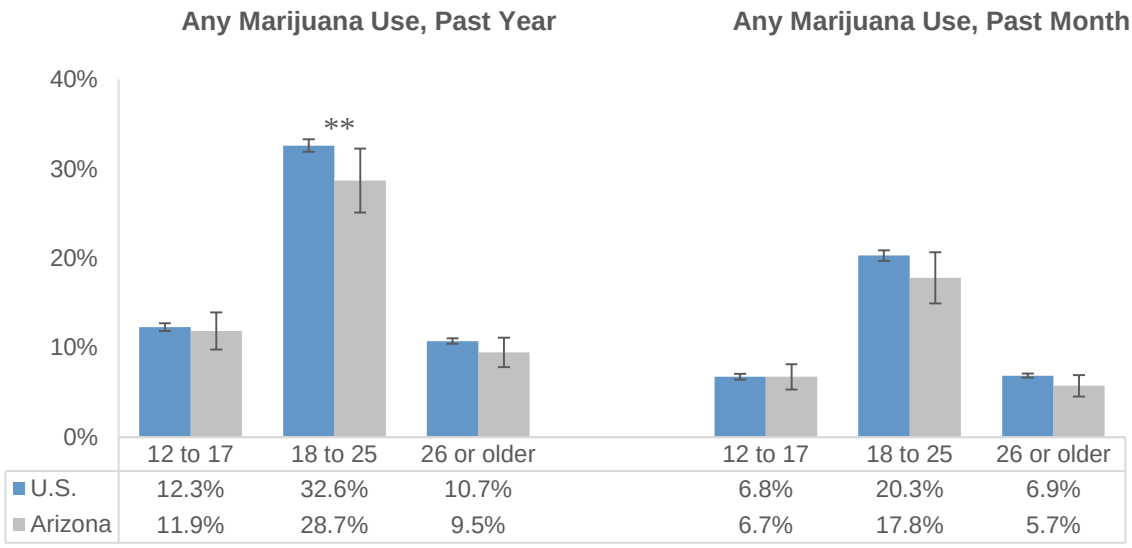
- Gender: Compared to female adults, male adults in Arizona had a significantly higher prevalence of current cigarette use (17.5% vs 12.1%, p<.001).
- Race/Ethnicity: Compared to other racial/ethnic groups, those identifying as multiracial had the highest prevalence of current cigarette use (29.8%), and Hispanics had the lowest prevalence of cigarette use (11.4%).
- Educational Attainment: Findings indicate the prevalence of cigarette use had a broadly inverse relationship with educational attainment. Those with a college or technical school degree had the lowest prevalence of cigarette use (6.7%). Those who had not graduated high school had the highest prevalence of cigarette use (20.2%).
- Veterans: Veterans reported significantly more current cigarette use in the past month than non-veterans (17.6% vs 14.2%, p=0.05).

Marijuana Use

According to data from the 2015-2016 NSDUH, 696,000 (12.2%) of Arizonans aged 12 or older used marijuana in the past year, and 422,000 (7.4%) reported past month marijuana use (See Exhibit 21). These estimates were marginally less than the national estimates of marijuana use (13.8% vs 12.2%, p=0.072).

Approximately 64,000 Arizonans 12 or older reported using marijuana for the first time in the 24 months leading up to the 2016 NSDUH. Of these 64,000 new users, approximately 39% were aged 12 to 17, 42% were aged 18 to 25, and 19% were older than 25. The percentage of recent marijuana initiates (overall and by age category) did not differ significantly between Arizona, the total U.S., or across Arizona's RBHAs. Although NSDUH collects initiation data for other drugs, these data were not included in the state level reports available from SAMHSA.

Exhibit 21. Prevalence of Past Year and Past Month Marijuana Use by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	12.3%	32.6%	10.7%	6.8%	20.3%	6.9%
Arizona	11.9%	28.7%	9.5%	6.7%	17.8%	5.7%

** Difference between the prevalence estimate for the total U.S. and Arizona is significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Youth Prevalence

Data from the 2015-2016 NSDUH estimated 65,000 (11.9%) of Arizona youth aged 12 to 17 used marijuana in the past year, and 37,000 (6.8%) used marijuana in the past month (See Exhibit 21). Data from the 2017 YRBS estimated that nearly one in five (19.5%) Arizona high school students used marijuana in the past month. None of the prevalence estimates for Arizona youth differed significantly from national estimates.

Adult Prevalence

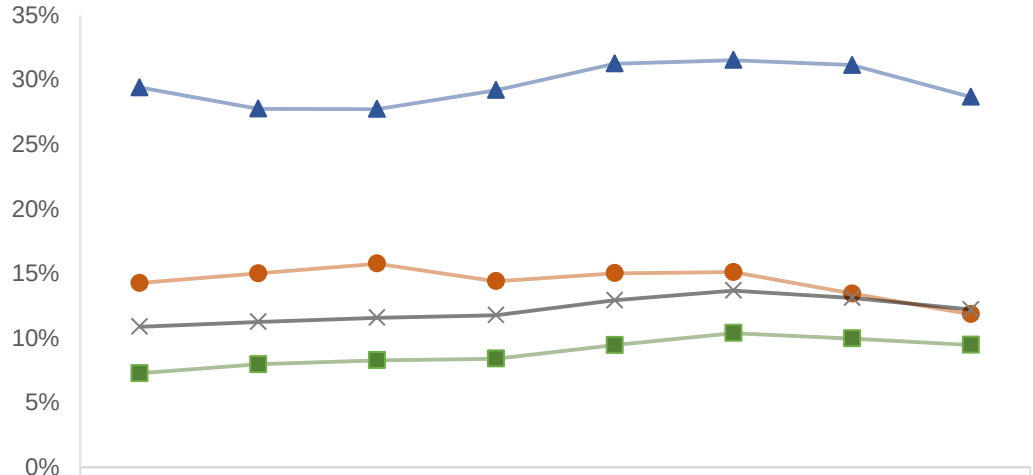
In Arizona, as nationally, the prevalence of past year and past month marijuana use peaked for those aged 18 to 25 (See Exhibit 21). Compared to young adults nationally, Arizonans aged 18 to 25 reported significantly less marijuana use in the past year (28.7% vs 32.6%, p=0.041), and less past month use (17.8% vs 20.3%, p=0.116), although past month use was not statistically significant. Estimates for older Arizonans 26 and over did not differ significantly from national estimates. Data were not available for more finite age categories.

Youth Trends

Data from the 2015-2016 NSDUH indicated marijuana use for those aged 12 or older increased slightly in the U.S. between 2008 and 2016 but the changes were not significant for either past year marijuana use (10.9% to 12.2%, p=0.147; See Exhibit 22), or past month marijuana use (6.7% to 7.4%, p=0.347). There were also no significant changes in past month or past year marijuana

use for youth aged 12 to 17 between 2008 and 2016. The YRBS similarly showed no significant changes in marijuana use for Arizona high school students between 2009 and 2017.

Exhibit 22. Trends in Prevalence of Past Year Marijuana Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	14.3%	15.0%	15.8%	14.4%	15.0%	15.1%	13.5%	11.9%
18 to 25	29.4%	27.8%	27.7%	29.2%	31.3%	31.5%	31.2%	28.7%
26 or older	7.3%	8.0%	8.3%	8.4%	9.5%	10.4%	10.0%	9.5%
12 or older	10.9%	11.3%	11.6%	11.8%	12.9%	13.7%	13.1%	12.2%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Trends

No significant changes in past month or past year marijuana use were detected for young adults aged 18 to 25 between 2008 and 2016 (See Exhibit 22). However, there were significant increases in prevalence of past year marijuana use between 2008 and 2016 for adults aged 26 or older (7.3% to 9.5%, p=0.035). Increases in past month marijuana use were not significant for this age group. Nationally, past year and past month marijuana use increased significantly for adults 18 to 25 and 26 or older.

Prevalence by RBHA

Data from 2014, 2015, and 2016 NSDUH indicated that there were no significant differences in marijuana use in the past year, or past month, by RBHA in Arizona.

Youth Disparities

Disparities in high school marijuana consumption in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected for estimates by sexual identify. Specifically, the prevalence of past month marijuana use among gay, lesbian or bisexual students in Arizona was more than

twice the prevalence for heterosexual students (37.7% vs 17.2%, p<.001).

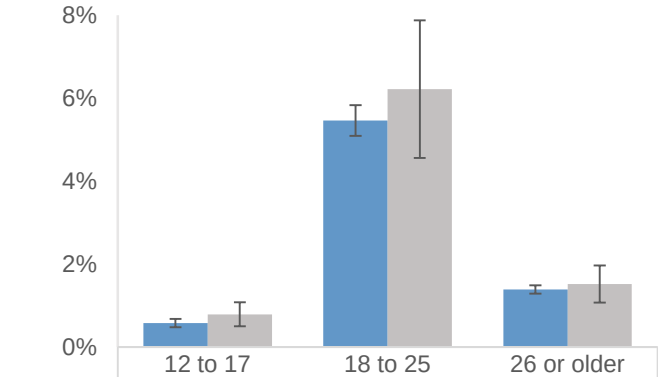
Adult Disparities:
No data were available to estimate disparities in marijuana use in Arizona for adult populations. Understanding what disparities may exist in adult marijuana usage should be considered as an important initiative moving forward to inform prevention priorities.

Cocaine Use

Data from 2015-2016 NSDUH estimated 118,000 (2.1%) of Arizonans 12 or older used cocaine, including crack cocaine, in the past year (See Exhibit 23). Although the estimate for past year cocaine use among those 12 or older was higher in Arizona than nationally, the difference was not statistically significant (2.1% versus 1.8%, p=0.454).

Youth Prevalence
Data from the 2015-2016 NSDUH estimated that fewer than 1% of Arizona youth aged 12 to 17 used cocaine in the past year (0.8%), which corresponds to approximately 4,000 youth across the State. Past year data were not collected by the YRBS, however, in 2017 a survey question was included pertaining to lifetime cocaine use. According to these data approximately 5.6% of Arizona high school youth reported ever using cocaine. None of the youth prevalence estimates differed significantly from national estimates.

Exhibit 23. Prevalence of Past Year Cocaine Use by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	0.6%	5.5%	1.4%
Arizona	0.8%	6.2%	1.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Adult Prevalence
Data from the 2015-2016 NSDUH estimated that 113,000 (2.2%) of Arizona adults 18 or older used cocaine in the past year. Prevalence of cocaine use is over four times higher for young adults aged 18 to 25 than adults 26 or older (6.2% versus 1.5%). Adult estimates in Arizona did not differ significantly from national estimates.

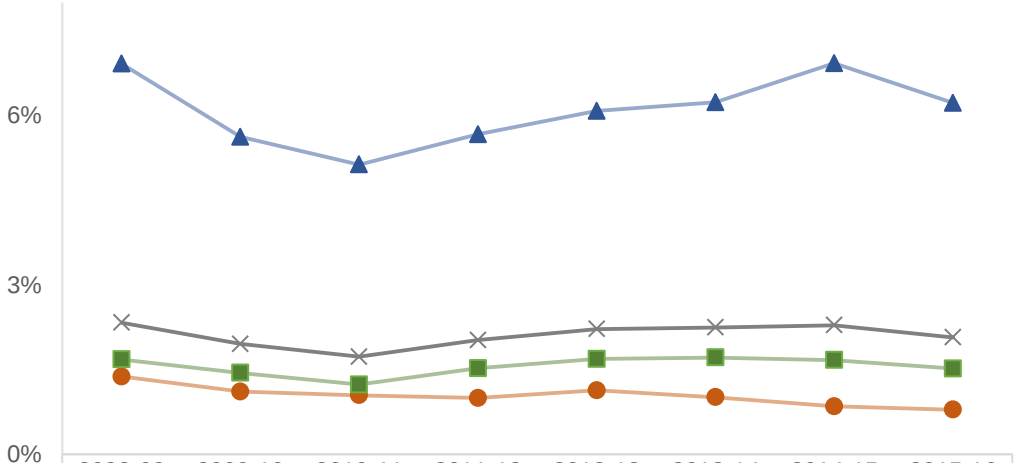
Youth Trends
Between 2008 and 2016, past year cocaine use for those aged 12 or older declined significantly in the U.S. (2.01% versus 1.84%, p=0.003), but did not change in Arizona (2.3% versus 2.1%, p=0.278) (See Exhibit 24). However, in Arizona there were significant declines in past year cocaine use for youth aged 12 to 17 between 2008 and 2016 (1.4% versus

0.8%, p=0.037). Data from the YRBS also indicated significant declines in "ever using cocaine" among Arizona high school students from 2009 to 2017 (11.5% versus 5.6%, p<0.001).

Adult Trends

There have been no significant declines in past year cocaine use among adults in Arizona. Nationally, prevalence rates remained unchanged among adults as well.

Exhibit 24. Trends in Prevalence of Past Year Cocaine Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	1.4%	1.1%	1.0%	1.0%	1.1%	1.0%	0.8%	0.8%
18 to 25	6.9%	5.6%	5.1%	5.7%	6.1%	6.2%	6.9%	6.2%
26 or older	1.7%	1.4%	1.2%	1.5%	1.7%	1.7%	1.7%	1.52%
12 or older	2.3%	2.0%	1.7%	2.0%	2.2%	2.2%	2.3%	2.1%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Prevalence by RBHA

Data from the 2014, 2015 and 2016 NSDUH found no significant differences in past year cocaine use between the State's RBHAs at the p<.05 level.

Youth Disparities

Disparities in "ever using cocaine" among high school students in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected by race/ethnicity. Specifically, the prevalence of lifetime cocaine use among Hispanic students in Arizona was higher than the prevalence for non-Hispanic white students (8.0% vs 3.8%, p=0.01). Estimates for other racial and ethnic groups were not available.

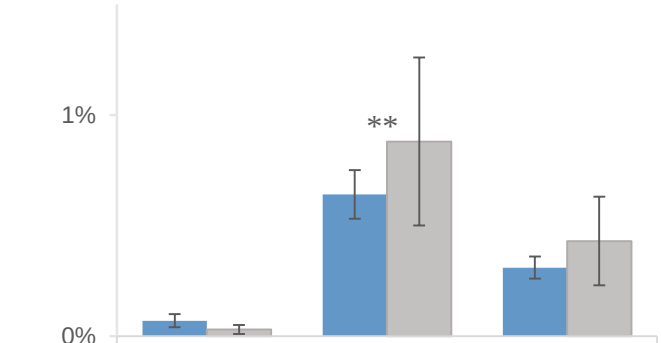
Adult Disparities

No data were available to estimate disparities in cocaine use in Arizona for adult populations. Understanding what disparities may exist in adult cocaine usage should be considered as an important initiative moving forward to inform prevention priorities.

Heroin Use

Data from the 2015-2016 NSDUH estimated 26,000 Arizonans 12 or older used heroin in the past year. This corresponds to a prevalence of less than half a percent (0.45%). Overall, the prevalence of heroin use in Arizona did not differ from national estimates.

Exhibit 25. Prevalence of Past Year Heroin Use by Age Group in the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	0.07%	0.64%	0.31%
Arizona	0.03%	0.88%	0.43%

U.S. and Arizona is marginally significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Youth Prevalence

Youth aged 12 to 17 in Arizona had significantly lower rates of heroin use than youth nationally (0.03% versus 0.07%, p=0.026) (See Exhibit 25). Data from the 2017 YRBS indicated that 1.9% of Arizona high school students ever used heroin, compared to 1.7% nationally (p=0.76).

Adult Prevalence

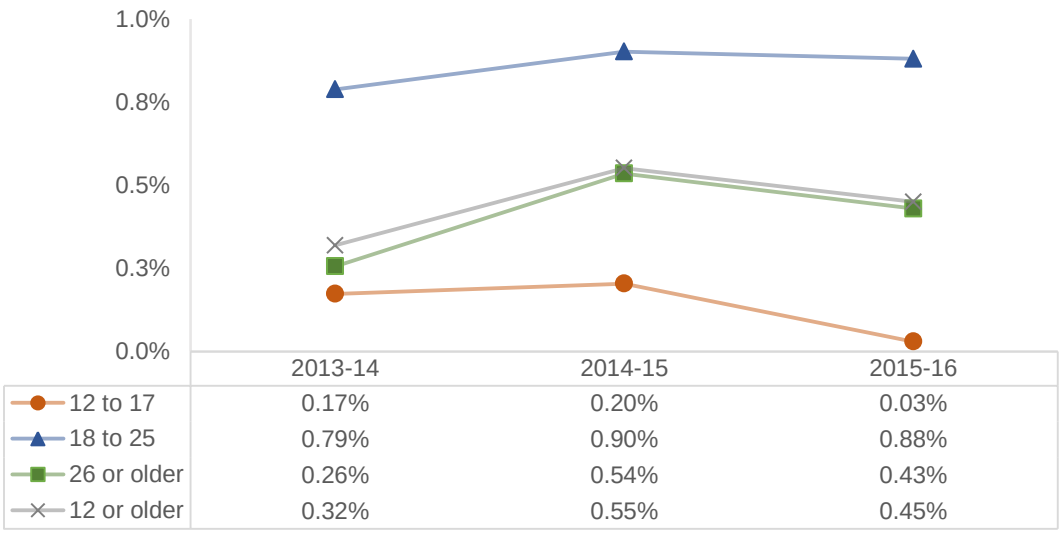
The prevalence of past year heroin use peaked for those 18 to 25 (0.88%), declining to 0.43% for those older than 25. The prevalence of heroin use among adults did not differ from national estimates.

Youth Trends

Data prior to 2013 were not available for heroin use in Arizona. Between 2014 and 2016 there were no significant changes in heroin use among those 12 and older, either nationally or in Arizona, but there were significant declines in the prevalence of heroin use for youth aged 12 to 17 (0.20% vs 0.03%, p=0.006) (See Exhibit 26). Data were not available to estimate the significance of changes between 2013 and 2016. Significant changes were not detected for youth nationally during this time.

Data from the YRBS comparing lifetime heroin use among Arizona high school students between 2009 and 2017 detected marginally significant declines (3.5% vs 1.9%, p=0.07).

Exhibit 26. Trends in the Prevalence of Past Year Heroin Use in Arizona by Age Group, 2013-2016



	2013-14	2014-15	2015-16
12 to 17	0.17%	0.20%	0.03%
18 to 25	0.79%	0.90%	0.88%
26 or older	0.26%	0.54%	0.43%
12 or older	0.32%	0.55%	0.45%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Trends

Between 2013 and 2016 there were no significant declines in heroin use among Arizona adults. This lack of substantial change was also observed at the national-level.

Prevalence by RBHA

Data from the 2014, 2015 and 2016 NSDUH found no significant differences in heroin use by RBHA.

Youth Disparities

Disparities in "ever using heroin" among high school students in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Differences were detected by gender and sexual identity.

- Gender: Male high school students in Arizona were marginally more likely to report that they ever used heroin than females (2.6% vs 1.2%, p=0.05).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as lesbian, gay or bisexual were more likely to report that they had ever used heroin, although the difference was only marginally significant (0.9 vs 6.9; p=0.06). Most of the difference is due to the much higher prevalence of lifetime heroin use among gay and bisexual males. In fact, more than one in six (17.8%) male high school students in Arizona identifying as gay or bisexual reported that they had tried heroin in their lifetime. Males identifying as gay or bisexual were significantly more likely to report that they had ever used heroin when compared to females identifying as

lesbian, gay or bisexual (1.7% vs 17.8%, p=0.01), or heterosexual males (1.2 vs 17.8%, p=0.02).

Adult Disparities

No data were available to estimate disparities in heroin use in Arizona for adult populations. Understanding what disparities may exist in adult heroin usage should be considered as an important initiative moving forward to inform prevention priorities.

Pain Reliever Misuse

NSDUH defines pain reliever misuse as "use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. Misuse of over-the-counter drugs is not included" (SAMHSA, 2017). NSDUH asks specifically about the misuse of opioid pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin® and Percocet®), and morphine, although respondents may specify that they misused other non-opioid pain relievers. Data reports from the 2015-2016 NSDUH estimated 267,000 (4.7%) of Arizonans 12 or older misused pain relievers in the past year. The prevalence estimates for Arizona, overall and by age group, did not differ from national estimates for pain reliever misuse.

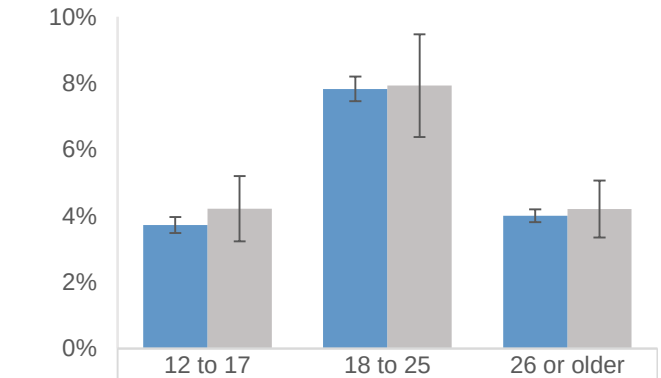
Youth Prevalence

The 2015-2016 NSDUH estimated that 23,000 (4.2%) youth aged 12 to 17 misused prescription pain relievers in the past year (See Exhibit 27). The 2017 YRBS also asked about prescription pain reliever misuse among high school students, however, the measure was slightly different from NSDUH's metric. YRBS measured if respondents ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin®, OxyContin®, hydrocodone, and Percocet®, one or more times during their life). Based on this measure, approximately 15.4% of Arizona high school students reported ever misusing pain relievers.

Adult Prevalence

According to data from the 2015-2016 NSDUH, an estimated 244,000 (4.7%) Arizonans 18 or older misused prescription pain relievers in the past year. The prevalence of prescription pain reliever misuse use in Arizona was greatest for young adults, aged 18 to 25 (7.9%; See Exhibit 27). Arizona's estimates did not differ from national estimates.

Exhibit 27. Prevalence of Past Year Pain Reliever Misuse by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	3.72%	7.82%	4.00%
Arizona	4.21%	7.92%	4.20%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Trends

NSDUH redesigned their questionnaire in 2015, creating a new baseline for pain reliever misuse. As a result, trend data are not presented for this outcome.

Prevalence by RBHA

Data were not available to estimate pain reliever misuse by RBHA.

Youth Disparities:

Disparities in high school pain reliever misuse in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected for estimates by sexual identify. Specifically, the prevalence of lifetime pain reliever misuse among gay, lesbian or bisexual students in Arizona was more than twice the prevalence for heterosexual students (30.7% vs 13.3%, $p<.001$).

Adult Disparities:

No data were available to estimate disparities in pain reliever use in Arizona for adult populations. Understanding what disparities may exist in adult pain reliever usage should be considered as an important initiative moving forward to inform prevention priorities.

Past Month Illicit Drug Use

The NSDUH defined current illicit drug use as drug use in the month before the survey for any of the following 10 drugs: marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives. An estimated one in 10 Arizonans aged 12 or older reported current use of illicit drugs. This corresponds to approximately 568,000 Arizonans. The majority of illicit

drug use was marijuana use, with only 4% of Arizonans 12 or older (223,000) reporting illicit drug use other than marijuana.

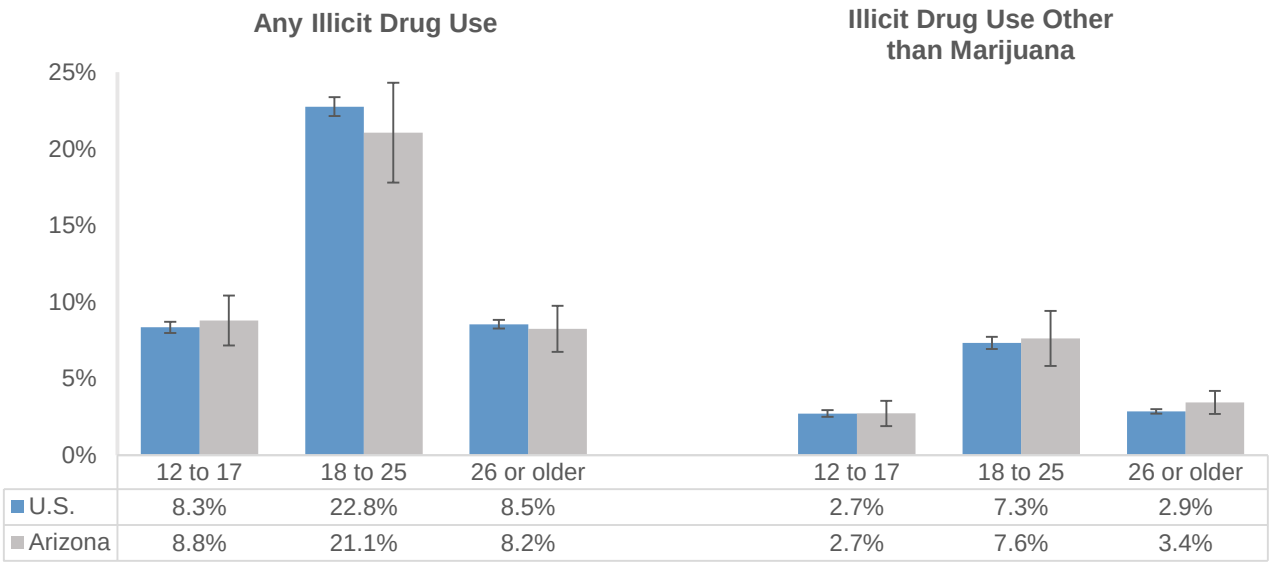
Youth Prevalence

In 2015-2016, an estimated 48,000 (8.8%) of Arizona youth aged 12 to 17 reported current illicit drug use, and 15,000 (2.7%) used illicit drugs other than marijuana (See Exhibit 28). Arizona prevalence estimates did not differ from national estimates.

Adult Prevalence

In 2015-2016, an estimated 520,000 (10.1%) of Arizona adults 18 or older were current illicit drug users, and 208,000 (4.1%) used illicit drugs other than marijuana. The prevalence of current illicit drug use peaked for those aged 18 to 25 (21.1%). Arizona's estimates of illicit drug use did not differ significantly from national estimates.

Exhibit 28. Prevalence of Past Month Illicit Drug Use and Illicit Drug Use Other than Marijuana by Age Group for the U.S. and Arizona, 2015-2016



	Any Illicit Drug Use			Illicit Drug Use Other than Marijuana		
	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	8.3%	22.8%	8.5%	2.7%	7.3%	2.9%
Arizona	8.8%	21.1%	8.2%	2.7%	7.6%	3.4%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Trends

NSDUH redesigned their questionnaire in 2015, creating a new baseline for past month illicit drug use. As a result, trend data are not presented for this outcome.

Prevalence by RBHA

Data were not available to estimate past month illicit drug use by RBHA.

Disparities

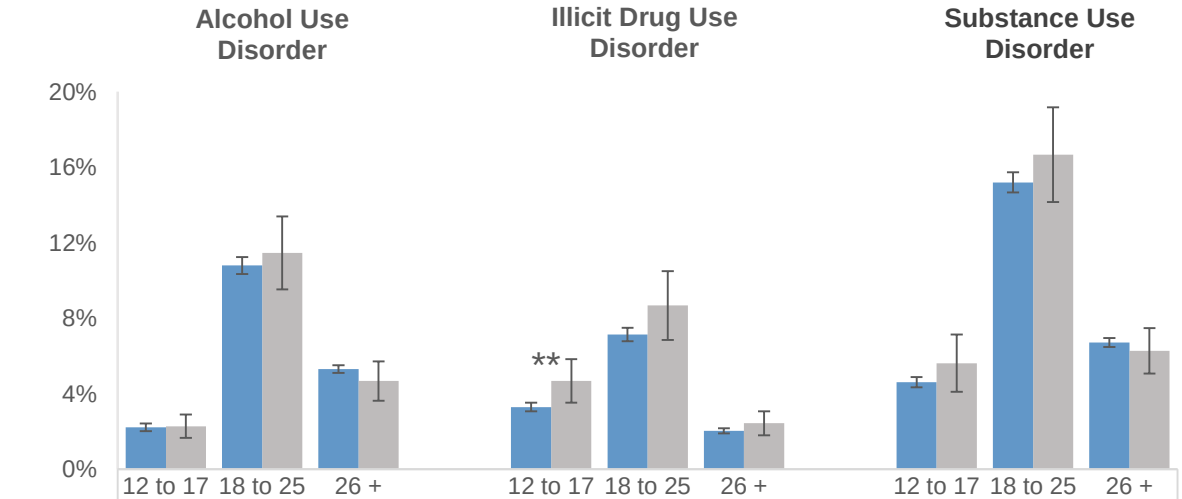
Data were not available to estimate disparities in past month illicit drug use for youth or adults.

Past Year Substance Use Disorders

Substance Use Disorders (SUDs) are defined as "clinically significant impairment due to recurrent use of alcohol or other drugs (or both), including health problems, disability, or failure to meet major responsibilities at work, school, home" (SAMHSA, 2017, p. 24). The 2015-2016 NSDUH estimated the prevalence of Substance Use Disorders (SUD) among respondents 12 or older using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria. The DSM 5 criteria were not included in this survey due to the time frame of the data collection. Respondents who reported alcohol or illicit drug use were screened for SUDs.

NSDUH estimated three categories of past year substance use disorder: alcohol use disorder, illicit drug use disorder, and substance use disorder (which was the combined estimate for those with either alcohol or illicit drug use disorder, or both conditions). Data on changes overtime and across RBHAs were only available for the measure of alcohol use disorder.

Exhibit 29. Prevalence of Past Year Alcohol, Illicit Drug Use and Substance Use Disorder by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 +	12 to 17	18 to 25	26 +	12 to 17	18 to 25	26 +
U.S.	2.2%	10.8%	5.3%	3.3%	7.1%	2.0%	4.6%	15.2%	6.7%
Arizona	2.3%	11.5%	4.7%	4.7%	8.7%	2.4%	5.6%	16.7%	6.3%

** Difference between the prevalence estimate for the total U.S. and Arizona is significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Alcohol Use Disorder

Youth and Adult Prevalence

Alcohol use disorder was defined as dependence or abuse of alcohol based on DSM-IV criteria. An estimated 304,000 (5.3%) of Arizonans aged 12 or older met the criteria for past year alcohol

use disorder based on data from the 2015-2016 NSDUH (See Exhibit 29). The prevalence of alcohol use peaked for those aged 18 to 25 (11.5%). None of estimates for Arizona differed significantly from national estimates.

Youth and Adult Trends

Estimates of alcohol use disorder in Arizona declined significantly between 2008-2009 and 2015-2016 for the Arizona's 12 or older population (7.7% vs 5.3%, p=0.001), and for each age group as follows: 12 to 17 (5.4% vs 2.3%, p<0.001), 18 to 25 (18.2% vs 11.5%, p<0.001), and 26 or older (6.3% vs 4.7%, p=0.05). Similar declines in prevalence were observed nationally.

Prevalence by RBHA

There were no significant differences in alcohol use disorder by RBHA. As noted earlier, this is meaningful in light of the significant regional differences observed in the indicator of any alcohol use in the past month (i.e., the North Region had significantly less current alcohol use than the South or Central regions). These data suggest that although fewer residents 12 or older drink alcohol in the North Region, those who do may be more likely to engage in risky drinking behaviors.

Disparities in Alcohol Use Disorder

No data were available to estimate disparities in Alcohol Use Disorder.

Past Year Illicit Drug Use Disorder

Youth and Adult Prevalence

An estimated 198,000 (3.5%) Arizonans 12 or older met the criteria for illicit drug use disorder in the past year based on data from the 2015-2016 NSDUH. Prevalence of illicit drug use disorder peaked for those aged 18 to 25 (8.7%). The prevalence of illicit drug use disorder was significantly higher for Arizona youth aged 12 to 17 than youth nationally (4.7% vs 3.3%, p=0.013; See Exhibit 29). No other significant differences were detected between Arizona and national estimates of illicit drug use, and no other data were available for past year illicit drug use.

Past Year Substance Use Disorder

Youth and Adult Prevalence

NSDUH defines substance use disorder as those who met the DSM-IV criteria for either dependence or abuse of alcohol or illicit drugs in the past year. An estimated 431,000 (7.6%) Arizonans 12 or older met the criteria for substance use disorder in the past year based on data from the 2015-2016 NSDUH. NSDUH did not estimate the proportion of people in Arizona suffering from both alcohol and illicit drug use disorders, but nationally 11.6% of those with SUDs had both alcohol and illicit drug use disorder. The prevalence of substance use disorder peaked for those aged 18 to 25 (16.7%; See Exhibit 29). No significant differences were detected

between Arizona and national estimates of substance use disorder. Exhibit 30 provides a summary of youth and adult substance use prevalence across all above reported measures.

Summary of Substance Use Data

Exhibit 30 summarizes the substance use data presented in this section of the report. Prevalence estimates are included for each of the substance use indicators as reported by the NSDUH, YRBS and BRFSS surveys. Again, users are cautioned not to directly compare prevalence estimates across different surveys because of methodological differences. For each survey, prevalence estimates are presented for the sample overall, and for sub-populations where available.

Exhibit 30. Prevalence of Substance Use Indicators Available in the NSDUH, YRBS, and BRFSS

	Past Month Prevalence							Past Year Prevalence				Lifetime Prevalence			
Indicator	Alcohol	Binge Alcohol	Tobacco Product	Ciga-rette	Electronic Vapor	Mari-juana	Any Illicit Drug	Mari-juana	Cocaine	Heroin	Pain Reliever Misuse	Cocaine	Heroin	Metham-phetamine	Pain Reliver Misuse
National Survey of Drug Use and Health (NSDUH), 2015-2016															
Overall Prevalence (12 and older)	50.9	22.6	21.6	18.0	--	7.4	10.0	12.2	2.1	0.5	4.7	--	--	--	--
Age Categories															
12 to 17	8.0	4.4	4.4	2.9	--	6.7	8.8	11.9	0.8	0.0	4.2	--	--	--	--
12 to 20	16.7	10.4	--	--	--	--	--	--	--	--	--	--	--	--	--
18 to 25	54.0	34.3	30.2	23.8	--	17.8	21.1	28.7	6.2	0.9	7.9	--	--	--	--
18 and older	55.5	24.5	23.4	19.6	--	7.5	10.1	12.3	2.2	0.5	4.7	--	--	--	--
25 and older	55.8	22.8	22.3	18.9	--	5.7	8.2	9.5	1.5	0.4	4.2	--	--	--	--
RBHA															
North	42.9	--	26.5	21.9	--	7.1	--	11.0	2.2	0.5	--	--	--	--	--
Central	54.5	--	21.1	17.4	--	8.0	--	13.0	2.1	0.5	--	--	--	--	--
South	49.3	--	22.5	19.4	--	7.5	--	12.1	2.3	0.5	--	--	--	--	--
Youth Risk Factor Behavioral Surveillance System (YRBS), 2017															
Overall Prevalence (9th- 12th grades)	33.1	17.9	12.3	7.1	16.1	19.5	--	--	--	--	--	5.6	1.9	2.3	15.4
Gender															
Female	36.4	20.7	8.5	6.2	13.1	20.2	--	--	--	--	--	5.0	1.2	1.9	15.8
Male	30.2	15.4	15.7	7.5	18.9	18.7	--	--	--	--	--	6.0	2.6	2.5	14.7
Hispanic vs White															
Hispanic	35.2	19.4	12.0	7.3	13.2	21.0	--	--	--	--	--	8.0	2.8	3.7	15.6
Non-Hispanic white	35.0	20.0	13.9	7.4	21.7	18.2	--	--	--	--	--	3.8	1.3	1.1	15.3
Sexual Identity															
Heterosexual (straight)	30.8	16.5	10.4	5.4	14.3	17.2	--	--	--	--	--	5.0	0.9	1.4	13.3
Gay, lesbian or bisexual	52.7	31.9	24.9	19.4	30.8	37.7	--	--	--	--	--	9.2	6.9	7.2	30.7
Behavioral Risk Factor Surveillance System (BRFSS), 2016															
Overall Prevalence (18 and older)	52.1	15.6	--	14.7	--	--	--	--	--	--	--	--	--	--	--
Age Categories															
Age 18 to 24	48.2	21.8	--	9.0	--	--	--	--	--	--	--	--	--	--	--
Age 25 to 44	55.7	22.7	--	18.6	--	--	--	--	--	--	--	--	--	--	--
Age 45 to 64	52.8	13.2	--	17.2	--	--	--	--	--	--	--	--	--	--	--
Age 65 or older	47.9	4.4	--	8.7	--	--	--	--	--	--	--	--	--	--	--
Race/Ethnicity															
Non-Hispanic white, only	58.1	15.6	--	15.5	--	--	--	--	--	--	--	--	--	--	--
Non-Hispanic black, only	49.4	14.7	--	22.0	--	--	--	--	--	--	--	--	--	--	--
Non-Hispanic other race, only	40.3	13.6	--	15.6	--	--	--	--	--	--	--	--	--	--	--
Non-Hispanic, multiracial	52.5	24.1	--	29.8	--	--	--	--	--	--	--	--	--	--	--
Hispanic	42.4	16.1	--	11.4	--	--	--	--	--	--	--	--	--	--	--
Gender															
Male	58.6	21.3	--	17.5	--	--	--	--	--	--	--	--	--	--	--
Female	45.7	10.1	--	12.1	--	--	--	--	--	--	--	--	--	--	--
Educational Attainment															
Did not graduate high school	30.4	12.5	--	20.2	--	--	--	--	--	--	--	--	--	--	--
High school graduate	47.7	16.0	--	19.6	--	--	--	--	--	--	--	--	--	--	--
Attended college/ technical school	54.4	15.6	--	14.5	--	--	--	--	--	--	--	--	--	--	--
College/technical school graduate	66.1	17.0	--	6.7	--	--	--	--	--	--	--	--	--	--	--
Veteran Status															
Veteran	58.8	14.1	--	17.6	--	--	--	--	--	--	--	--	--	--	--
Not Veteran	51.0	15.8	--	14.2	--	--	--	--	--	--	--	--	--	--	--

-- Not Available
Binge alcohol use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.
Electronic vapor product use includes using e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least one day during the 30 days.
Misuse of pain relievers is defined by NSDUH as use of prescription psychotherapeutics in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.
Misuse of pain relievers is defined by YRBSS as ever taking prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, Oxycontin, Hydrocodone, and Percocet, one or more times during their life).
Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Consequences of Substance Use

In addition to estimating the prevalence of substance use in Arizona, secondary data were also used to estimate the consequences of substance use. This section of the report presents data on the following consequences of substance use:

- discharge data on hospitalizations and emergency department visits for alcohol and drug use,
- drug and alcohol-induced mortality rates,
- treatment rates by substance use,
- suicides, and
- criminal activities related to impaired driving and drug possessions.

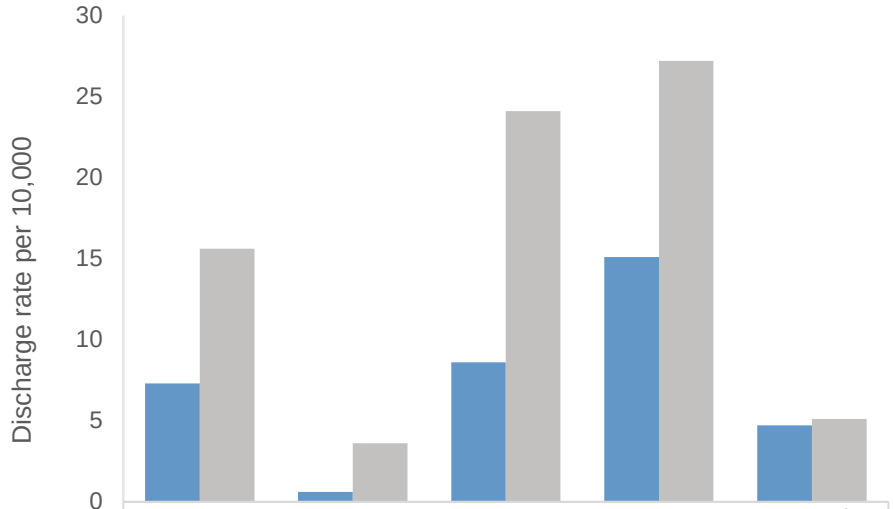
Hospitalizations and Emergency Department Discharges

The Arizona Department of Health Services publishes discharge data on alcohol and drug related hospitalizations and Emergency Department (ED) visits. For both inpatient and ED discharges, the unit of analysis is the discharge event (i.e., individuals with multiple discharges are enumerated more than once). Diagnostic categories for alcohol and drug conditions were based on ICD-10 codes beginning in 2016; prior years were coded from ICD-9 and are not directly comparable. Arizona data are only compared to national estimates when comparable sources could be located.

Discharge Rates for Alcohol Abuse

In 2016, in Arizona, the rate of ED discharges with alcohol abuse as the first-listed diagnosis was 15.6 per 10,000, and the rate of hospital discharges was 7.3 per 10,000. For both ED and hospital discharges the rates rose consistently with increasing age, peaking for those aged 45 to64, and then declining for those 65 and older (See Exhibit 31).

Exhibit 31. Hospital and ED Discharge Rates per 10,000 with Alcohol Abuse as First-Listed Diagnosis, by Age in Arizona, 2016



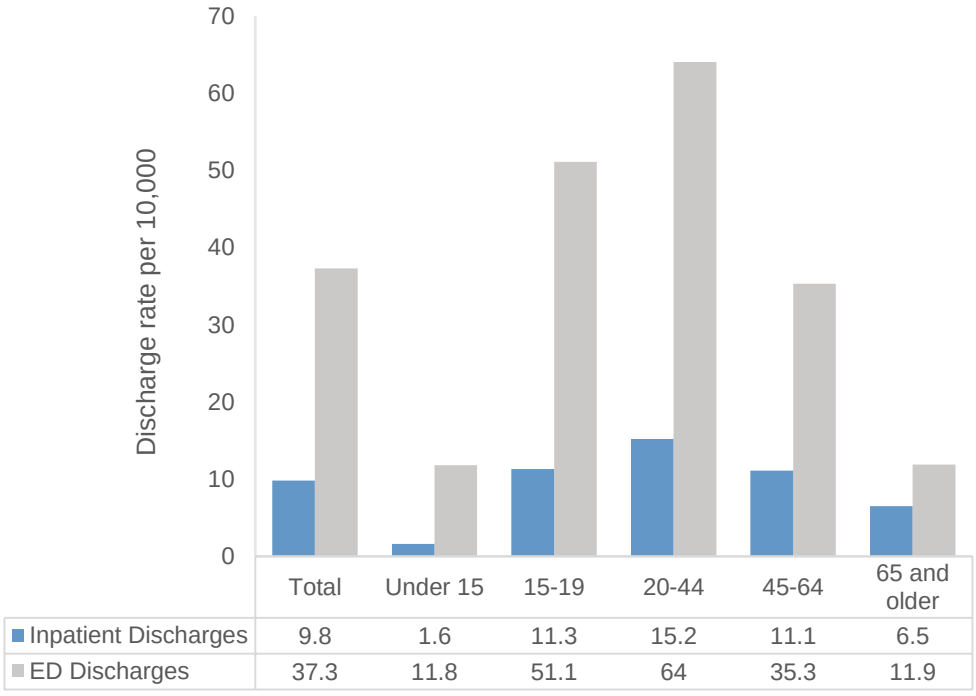
	Total	15-19	20-44	45-64	65 and older
Inpatient Discharges	7.30	0.60	8.60	15.10	4.70
ED Discharges	15.60	3.60	24.10	27.20	5.10

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Discharge Rates for Drug Dependence, Abuse or Misuse

In 2016, in Arizona, the rate of ED discharges with drug dependence, abuse or misuse as the first-listed diagnosis was 37.3 per 10,000, and the rate of hospital discharges was 9.8 per 10,000. Rates of ED visits and hospital discharges peaked for those aged 20-44, and then decreased with increasing age (See Exhibit 32).

Exhibit 32. Hospital and ED Discharge Rates per 10,000 with Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Age in Arizona, 2016



	Total	Under 15	15-19	20-44	45-64	65 and older
Inpatient Discharges	9.8	1.6	11.3	15.2	11.1	6.5
ED Discharges	37.3	11.8	51.1	64	35.3	11.9

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

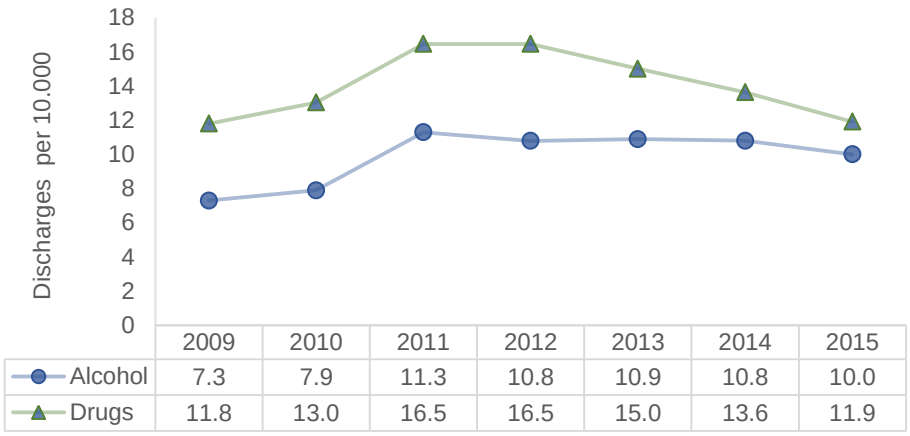
In 2016, there were 51,203 hospital discharges that included any mention of drug dependence or drug abuse. Counts and rates of hospital discharges were provided for three specific categories of drugs; for these data it is important to note that more than one type of drug could be identified on a discharge record.

- amphetamines and other psychostimulants: 18.5 per 10,000(12,627 discharges)
- cocaine: 4.0 per 10,000 (2,757 discharges); and,
- opioids, including heroin, morphine, methadone, opium; synthetics with morphine like effects: 27.0 per 10,000 (18,445 discharges). Opioid data are discussed in more detail in separate sections of this report.

Trends in Discharge Rates for Alcohol Abuse

The discharge rates of hospital inpatients with alcohol abuse as the first-listed diagnosis was 7.3 per 10,000 in 2009 (4,806 discharges). The rate peaked in 2011 at 11.3 per 10,000, decreasing to 10.0 by 2015 (See Exhibit 33).

Exhibit 33. Trends in Hospital Discharge Rates per 10,000 for Alcohol Abuse and Drug Dependence, Abuse and Misuse as First-Listed Diagnosis in Arizona, 2009-2015.



	2009	2010	2011	2012	2013	2014	2015
Alcohol	7.3	7.9	11.3	10.8	10.9	10.8	10.0
Drugs	11.8	13.0	16.5	16.5	15.0	13.6	11.9

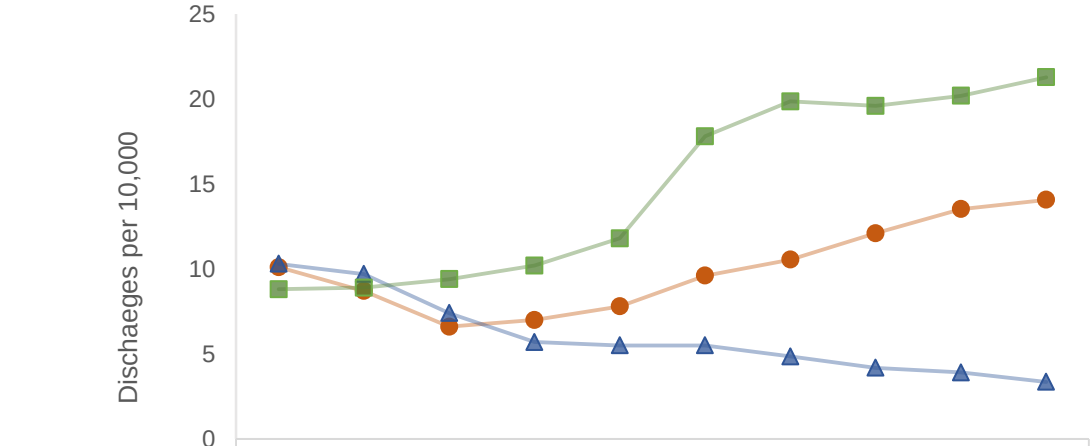
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Trends in Discharge Rates for Drug Dependence, Abuse or Misuse

The discharge rates of inpatients with drug dependence, abuse or misuse as the first-listed diagnosis increased from 11.8 per 10,000 (7,790 discharges) in 2009 to 16.5 per 10,000 in 2011 and 2012. The rate began decreasing in 2013 and was 11.9 per 10,000 by 2015 (See Exhibit 33 above).

Although the overall rate of drug related discharges decreased, there were substantial increases in discharges for specific categories of drugs. Specifically, discharges for opiates and amphetamines increased in Arizona, while discharges for cocaine decreased between 2009 and 2016 (See Exhibit 34).

Exhibit 34. Trends in Hospital Discharge Rates per 10,000 for Specific Categories of Drugs in Arizona, 2009-2015.



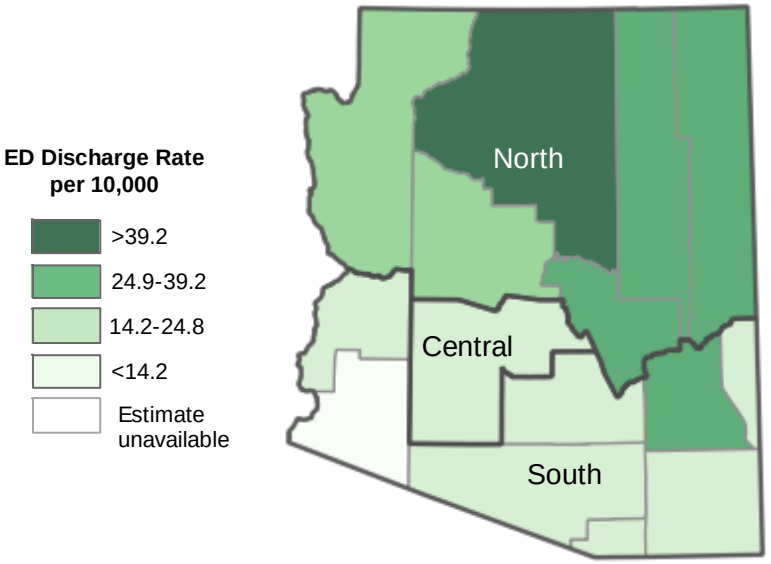
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amphetamines	10.1	8.7	6.6	7.0	7.8	9.6	10.5	12.1	13.5	14.1
Cocaine	10.3	9.7	7.4	5.7	5.5	5.5	4.9	4.2	3.9	3.4
Opiates	8.8	8.9	9.4	10.2	11.8	17.8	19.9	19.6	20.2	21.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) Hospital inpatient discharges and emergency room visits statistics.

Discharge Rates for Alcohol Abuse by Arizona County

Rates of Emergency Department (ED) discharges with alcohol abuse as the first-listed diagnosis differed by county across Arizona. Coconino County had the highest rate (58.6 per 10,000, 836 discharges), and La Paz County had the lowest rate (6.6 per 10,000, 14 discharges; data unavailable for Yuma) (See Exhibit 35). For hospitalizations, Navajo County had the highest rate (18.7 per 10,000, 206 discharges) and Santa Cruz County had the lowest rate (3.2 per 10,000, 16 discharges) (See Exhibit 36). It is noteworthy that many of the counties experiencing high rates of alcohol discharges are located in the North Region.

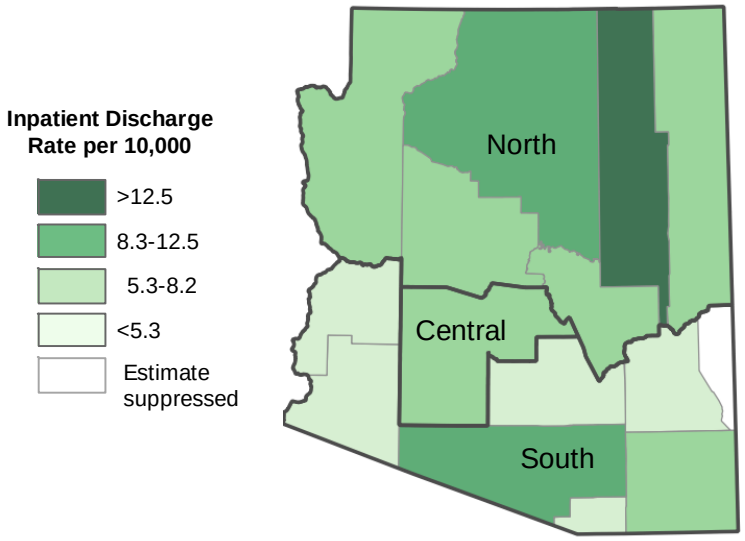
Exhibit 35. Emegency Department Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Coconino	58.6
2	Navajo	39.2
3	Apache	37.3
4	Graham	31.6
5	Gila	28.9
6	Mohave	24.8
7	Yavapai	20.0
8	Pima	14.1
9	Maricopa	13.6
10	Cochise	12.9
11	Greenlee	11.5
12	Pinal	11.0
13	Santa Cruz	10.9
14	La Paz	6.6
	Yuma	--

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

Exhibit 36. Hospital Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Navajo	18.7
2	Coconino	12.5
3	Pima	11.2
4	Apache	8.2
5	Gila	7.7
6	Yavapai	7.3
7	Cochise	7.2
8	Maricopa	6.4
9	Mohave	6.0
10	Graham	5.2
11	Pinal	5.0
12	Yuma	3.4
13	La Paz	3.3
14	Santa Cruz	3.2
N/A	Greenlee	N/A

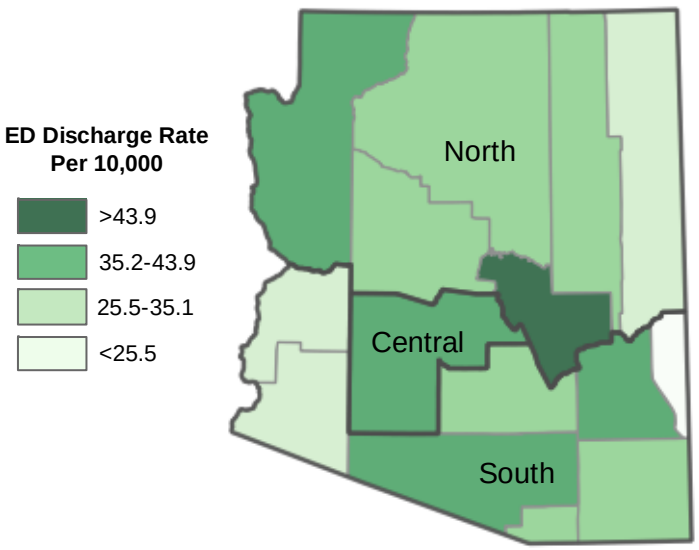
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

Discharge Rates for Drug Dependence, Abuse or Misuse by Arizona County

Rates of hospitalization and ED discharges for drugs differed by Arizona county. Gila County had the highest rate of ED discharges (49.9 per 10,000, 271 discharges) and Apache County had

the lowest rate (17.1 per 10,000, 123 discharges) (See Exhibit 37). For hospitalizations, Pima County had the highest rate of discharges (14.0 per 10,000, 1,414 discharges) and Santa Cruz County had the lowest rate (3.0 per 10,000, 15 discharges) (See Exhibit 38).

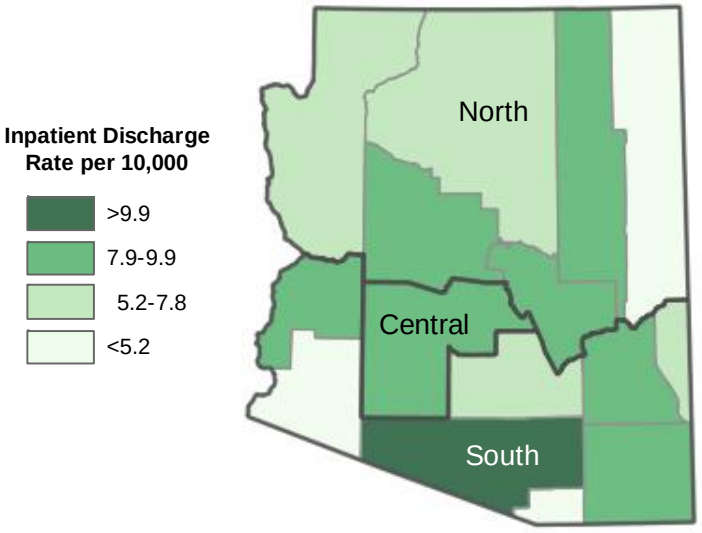
Exhibit 37. Emegency Department Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Gila	49.9
2	Graham	43.9
3	Mohave	43.0
4	Pima	39.5
5	Maricopa	38.7
6	Yavapai	35.1
7	Cochise	33.2
8	Navajo	31.9
9	Pinal	31.9
10	Coconino	28.8
11	Santa Cruz	28.5
12	La Paz	25.4
13	Yuma	24.8
14	Greenlee	21.1
15	Apache	17.1

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 38. Hospital Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Pima	14.0
2	Maricopa	9.9
3	Navajo	9.9
4	Yavapai	9.0
5	Gila	8.7
6	Cochise	8.6
7	La Paz	8.5
8	Graham	8.1
9	Coconino	7.8
10	Pinal	7.1
11	Mohave	6.9
12	Greenlee	6.7
13	Yuma	5.1
14	Apache	4.7
15	Santa Cruz	3.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

In interpreting data on hospitalizations and ED discharges across geographic areas, it is important to note that a higher discharge rate is not necessarily indicative of greater risk. For example, in some regions treatment services may be limited and/or inaccessible to many individuals in need of emergency department or hospital care. In these regions, the number of discharges may be low, while the number of deaths could be relatively high. The ratio of deaths to total hospital discharges is a useful indicator to identify areas where substance users may be less likely to have access to life-saving treatments and are most at risk for death. These data indicate La Paz, Mohave and Gila Counties have the highest ratio of deaths to hospital discharges in drug related instances (See Exhibit 39).

Exhibit 39. Ratio of the Count of Drug-Related Deaths to Inpatient Discharges for Drug Abuse, Misuse or Dependence as First-Listed Dianosis by Arizona County, 2016

County Rank for Ratio	County	# of inpatient discharges for drugs	# of drug-induced deaths	Ratio of deaths to hospital discharges for drugs
1	La Paz	18	10	0.56
2	Mohave	142	70	0.49
3	Gila	47	20	0.43
4	Yuma	110	40	0.36
5	Yavapai	199	70	0.35
6	Graham	31	10	0.32
7	Apache	34	10	0.29
8	Navajo	109	30	0.28
9	Cochise	111	30	0.27
10	Pinal	292	60	0.21
11	Maricopa	4,092	800	0.20
12	Coconino	111	20	0.18
12	Pima	1,414	250	0.18
14	Greenlee	7	0	0.00
14	Santa Cruz	15	0	0.00
TOTAL	**Arizona**	**6,732**	**1470**	**0.22**

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Disparities in Alcohol Abuse

Disparities in rates of alcohol abuse discharges were detected by gender and race/ethnicity. Males had higher rates of alcohol abuse discharges for both ED visits and hospitalizations than females (ED Visits: 22.5 vs 8.9 per 10,000; Hospitalizations: 10.4 vs 4.2 per 10,000). American Indian/Alaska Natives had higher rates of hospitalization discharges than all other race/ethnicities combined (Hospitalization visits: 21.2 per 10,000) (See Exhibit 40). This may correspond to the finding that there were higher rates of alcohol abuse discharges in counties with a higher proportion of American Indian/Alaska Natives. Data were not available to estimate disparities in ED discharge rates by race/ethnicity.

Exhibit 40. Hospital Discharge Counts and Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016

Race/Ethnicity	Count	Rate per 10,000
White non-Hispanic	3,491	9.0
Hispanic or Latino	674	3.2
Black/African American	141	4.4
American Indian/ Alaska Native	614	21.2
Asian or Pacific Islander	31	1.3
Refused/Unknown	28	N/A

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Disparities in Drug Dependence, Abuse or Misuse

Males had slightly higher rates of inpatient discharges with drug dependence, abuse or misuse as the first-listed diagnosis than females (10.4 vs 9.3 per 10,000), and slightly higher rates of ED discharges (41.7 vs 32.9 per 10,000). White non-Hispanics had the highest rate of inpatient discharges (12.2 per 10,000) and blacks had the highest rate of emergency room visits (65.9 per 10,000) (See Exhibit 41).

Exhibit 41. Inpatient Discharge and ED Discharge Counts and Rates per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016

	Inpatient Discharge		ED Discharge	
Race/Ethnicity	**Count**	**Rate per 10,000**	**Count**	**Rate per 10,000**
White non-Hispanic	4,716	12.2	15,431	39.8
Hispanic or Latino	1,296	6.2	6,092	28.9
Black/African American	351	11.0	2,104	65.9
American Indian/ Alaska Native	256	8.8	1,423	49.1
Asian or Pacific Islander	59	2.4	266	10.9
Refused/Unknown	54	NA	178	NA

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Mortality

Mortality data are also published by the Arizona Department of Health for drug- and alcohol-induced deaths. Drug-induced deaths include deaths from "mental and behavioral disorders due to psychoactive substance use, accidental poisoning by and exposure to drugs, suicide by drugs, homicide by drugs; and poisoning by drugs, undetermined intent." Alcohol-induced deaths include deaths from "mental and behavioral disorders due to alcohol use, degeneration of nervous system due to alcohol, alcoholic polyneuropathy, alcoholic cardiomyopathy, alcoholic gastritis, alcoholic liver disease, finding of alcohol in blood, accidental poisoning by and exposure to alcohol, intentional self-poisoning by alcohol; poisoning by alcohol, undetermined intent" (ADHS, 2018).

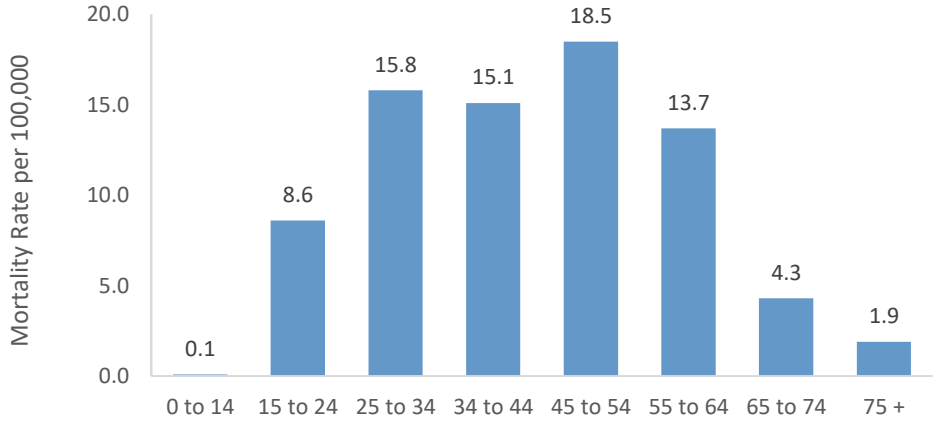
Age-Adjusted Alcohol-Induced Mortality Rates

The age-adjusted alcohol-induced mortality rate in Arizona in 2016 was 17.6 per 100,000. According to the CDC data from 2015, Arizona ranked 4th in the country for alcohol poisoning deaths with an age-adjusted rate of 1.87 per 100,000 people (CDC, 2015). Arizona also ranked 4th in death rates from chronic liver disease and cirrhosis. Although not all liver disease is caused by alcohol, there is a strong association between heavy alcohol consumption and liver disease, and an estimated 10-15% of heavy drinkers will develop cirrhosis (Mann et al, 2004). In 2016, Arizona's age-adjusted death rate for chronic liver disease and cirrhosis was 14.9 per 100,000 compared to 10.7 per 100,000 nationally.

Age-Adjusted Drug-Induced Mortality Rates per 100,000

The age-adjusted drug-induced mortality rate in Arizona in 2016 was 20.1 per 100,000 (1,470 deaths), and the age-adjusted opioid-induced death rate was 11.1[4]. The Arizona Department of Health Services released early data for opioid-induced death rates in the summer of 2018 (ADHS, 2018). Based on these data, the number of reported deaths in 2017 attributed to opioids was 949. For opioids, death rates peaked for those aged 45 to 54 (18.5 per 100,000), and then declined steadily for ages over 55 (See Exhibit 42).

Exhibit 42. Opioid Average 10-Year Death Rate per 100,000 Population in Arizona by Age Group, 2007-2017



Source: Arizona Department of Health, Bureau of Public Health Statistics, 2016 Arizona Opioid Report

Trends in Alcohol-Induced Mortality Rates

Trend data were available for mortality counts (not rate), for alcohol-induced deaths. In Arizona, the overall death count for alcohol-induced deaths increased from 637 in 2006 to 1,310 in 2016. Multi-year Data were also available to estimate mortality rates from chronic liver disease and cirrhosis in Arizona, which showed an increase from an age-adjusted death rate in 2006 of 11.4 per 100,000 to 14.9 per 100,000 in 2016.

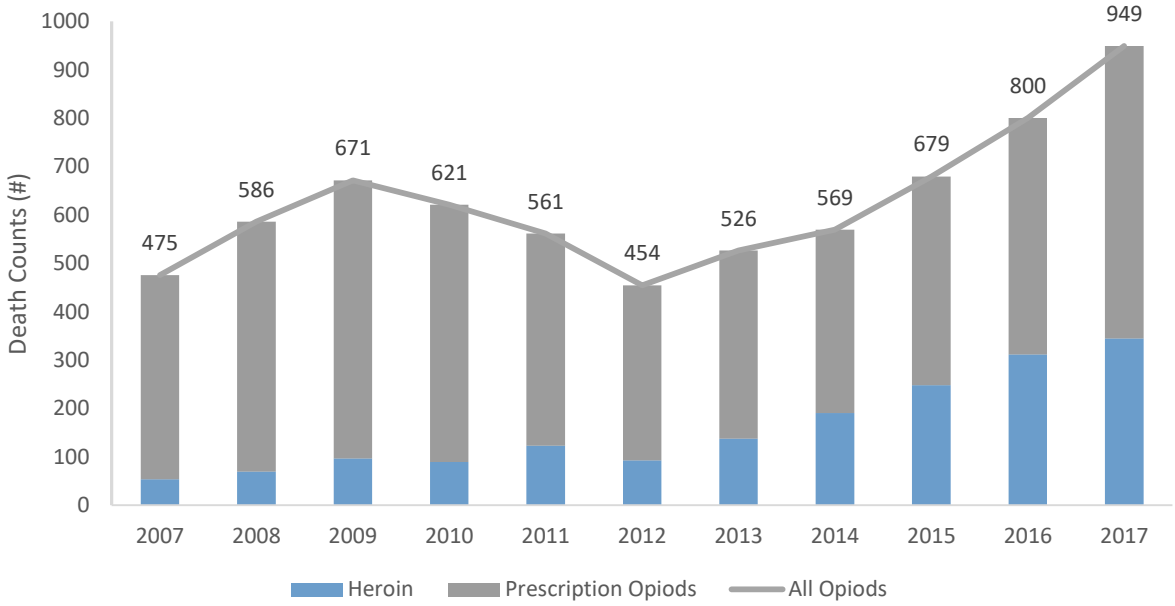
Trends in Drug-Induced Mortality Rates

Trend data were available for mortality counts (not rates) for drug-induced deaths. In Arizona, the overall death count increased overtime from 910 in 2006 to 1,470 in 2016. Mohave County saw the greatest increase in deaths in this time from 20 to 70 (250%), based on 2-year averages (2006-2007 and 2015-2016, respectively).

[4] The 2016 opioid mortality rate was based on a death count of 790; updated data were released in 2018, and the mortality count was adjusted to 800. Updated rates for 2016 were not published based on the revised death count – all 2016 rates presented in this report are based on the 790 count.

In Arizona, opioid deaths declined between 2009 and 2012, but have reversed that trend in recent years. (See Exhibit 43). Opioid deaths have increased 109% since 2012. Heroin related deaths increased significantly in the past decade, from 11% of opioid deaths in 2007 to 39% in 2016, before dropping slightly to 36% in 2017. Prescription and synthetic opioid deaths have also been increasing (ADHS, Opioid Report, 2018).

Exhibit 43. Trends in Number of Opioid Deaths by Heroin and Prescription Opioids in Arizona, 2007-2017



Source: Arizona Department of Health, Bureau of Public Health Statistics, 2017 Arizona Opioid Report

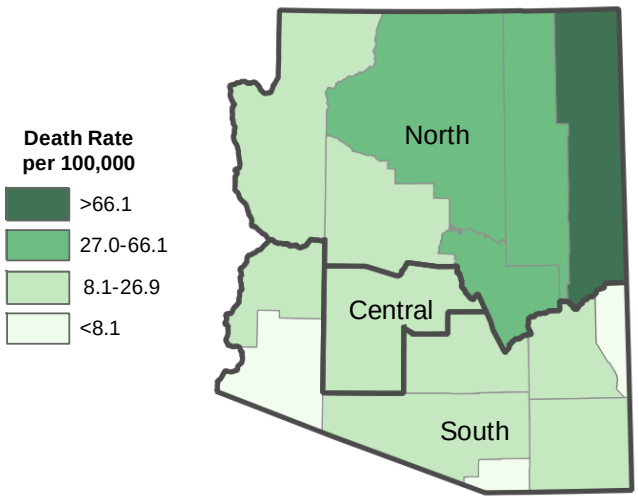
Mortality Rates for Alcohol-Induced Deaths by Arizona County

In 2016, Apache County had the highest alcohol-induced death rate (87.9 per 100,000), and Yuma County had the lowest death rate (6.6 per 100,000) (See Exhibit 44). Chronic liver disease and cirrhosis death rates were highest in La Paz County (56.8 per 100,000) and Gila County (55.9 per 100,000), with the lowest in Greenlee County (7.2 per 100,000). High alcohol-induced mortality rates are concentrated in the counties in the North Region of Arizona, mirroring risks observed for hospital and Emergency Department discharge rates.

Mortality Rates for Drug-Induced Deaths by Arizona County

Gila County had the highest drug-induced death rate (41.0 per 100,000) and Apache and Greenlee Counties had the lowest death rates (7.2 per 100,000 and less than 1 per 100,000) (See Exhibit 45). La Paz County had the highest opioid induced death rate (36.5 per 100,000) and Yuma and Greenlee Counties had the lowest death rate (less than 1 per 100,000) (See Exhibit 46).

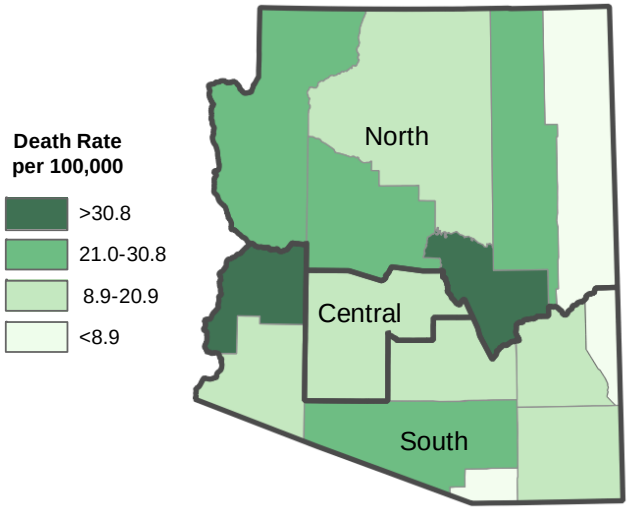
Exhibit 44. Alcohol-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	Apache	87.9
2	Gila	66.1
3	Navajo	65.9
4	Coconino	48.0
5	La Paz	26.9
6	Mohave	22.4
7	Graham	19.2
8	Yavapai	18.1
9	Pima	17.1
10	Pinal	14.7
11	Cochise	14.1
12	Maricopa	14.0
13	Santa Cruz	8.0
14	Greenlee	7.2
15	Yuma	6.6

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

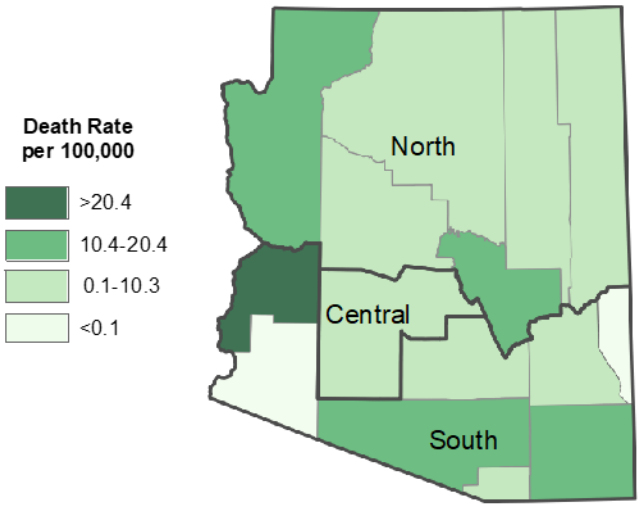
Exhibit 45. Drug-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	Gila	41.0
2	La Paz	39.1
3	Mohave	30.8
4	Yavapai	27.8
5	Pima	25.4
6	Navajo	22.9
7	Yuma	20.9
8	Graham	20.2
9	Cochise	19.1
10	Maricopa	17.8
11	Pinal	14.7
12	Coconino	14.5
13	Santa Cruz	8.8
14	Apache	7.2
15	Greenlee	0.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Exhibit 46. Opioid-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	La Paz	36.5
2	Mohave	20.4
3	Pima	17.3
4	Gila	16.8
5	Cochise	15.1
6	Maricopa	10.3
7	Yavapai	9.0
8	Santa Cruz	8.8
9	Pinal	8.1
10	Navajo	6.2
11	Graham	5.7
12	Coconino	4.4
13	Apache	4.1
14	Greenlee	0.0
14	Yuma	0.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Opioids in Arizona
Data and Response

In 2017 there were 949 deaths due to opioids in Arizona, an increase of 109% since 2012. On June 5, 2017, Governor Douglas A. Ducey declared a public health emergency to address the opioid crisis. The Arizona Opioid Action Plan was released in September 2017 and implemented over the next year. The plan had numerous goals to address the opioid crisis, including improving prescription and distribution practices. The opioid crisis is now monitored closely with weekly opioid surveillance data provided by the Arizona Department of Health Services.

These data indicate that between June 15, 2017 and August 30, 2018 there were:

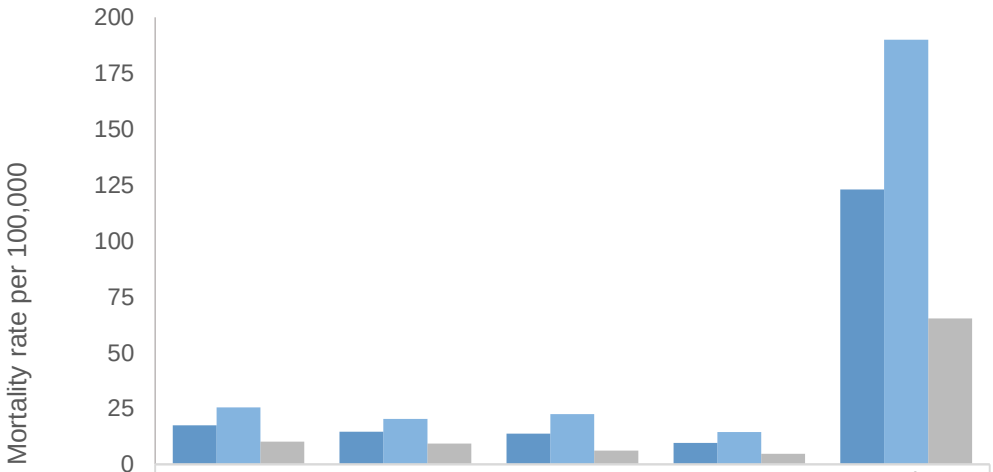
- 1,677 suspected opioid deaths
- 10,974 suspected opioid overdoses
- 25,660 naloxone doses dispensed
- 6,866 naloxone doses administered, and
- 952 Arizona babies born with neonatal abstinence syndrome.

On January 26, 2018, Governor Ducey signed the Arizona Opioid Epidemic Act. The public health emergency ended May 29, 2018. The emergency response and next steps are summarized in the Arizona Opioid Emergency Response Report- June 2017 to June 2018.

Disparities in Alcohol-Induced Death Rates

- Gender: The age-adjusted alcohol-induced mortality rate differed by gender. Males were more likely to die from alcohol than females (25.5 per 100,000 vs 10.2 per 100,000) (See Exhibit 47).
- Race/Ethnicity: There were also pronounced disparities in the alcohol-induced death rates by race/ethnicity. American Indian/Alaska Natives had a disproportionately high rate of alcohol-induced deaths at over eight times higher than any other racial/ethnic group (See Exhibit 47). The death rate for males was higher for each racial/ethnic group. Male American Indian/Alaska Natives had an alcohol death rate of 190.0 per 100,000.

Exhibit 47. Alcohol-Induced Death Rates per 100,000 by Gender and Race/Ethnicity in Arizona, 2016



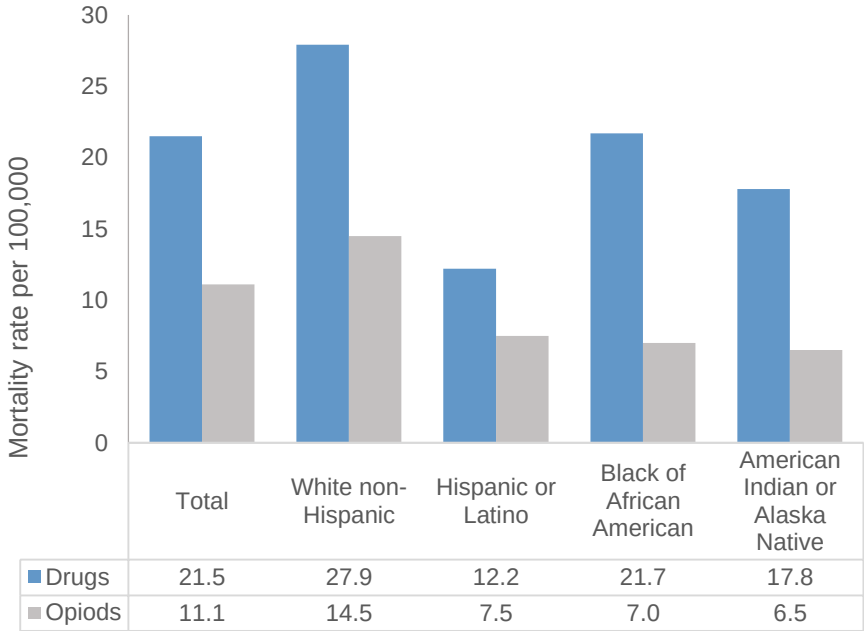
	Total	White non-Hispanic	Hispanic or Latino	Black/ African American	American Indian/ Alaska Native
Total	17.6	14.7	13.8	9.7	123.0
Males	25.5	20.4	22.5	14.5	190.0
Females	10.2	9.3	6.1	4.8	65.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Disparities in Drug-Induced Death Rates

In 2016, males were more likely to die from drug-induced deaths than females (28.2 vs 24.8 per 100,000), and from opioid-induced deaths than females (14.5 vs 7.6 per 100,000). Non-Hispanic whites had the highest rate of any drug-induced death or opioid-induced deaths (See Exhibit 48).

Exhibit 48. Opioid and Drug-Induced Death Rates per 100,000 by Race/Ethnicity in Arizona, 2016



	Total	White non-Hispanic	Hispanic or Latino	Black of African American	American Indian or Alaska Native
Drugs	21.5	27.9	12.2	21.7	17.8
Opiods	11.1	14.5	7.5	7.0	6.5

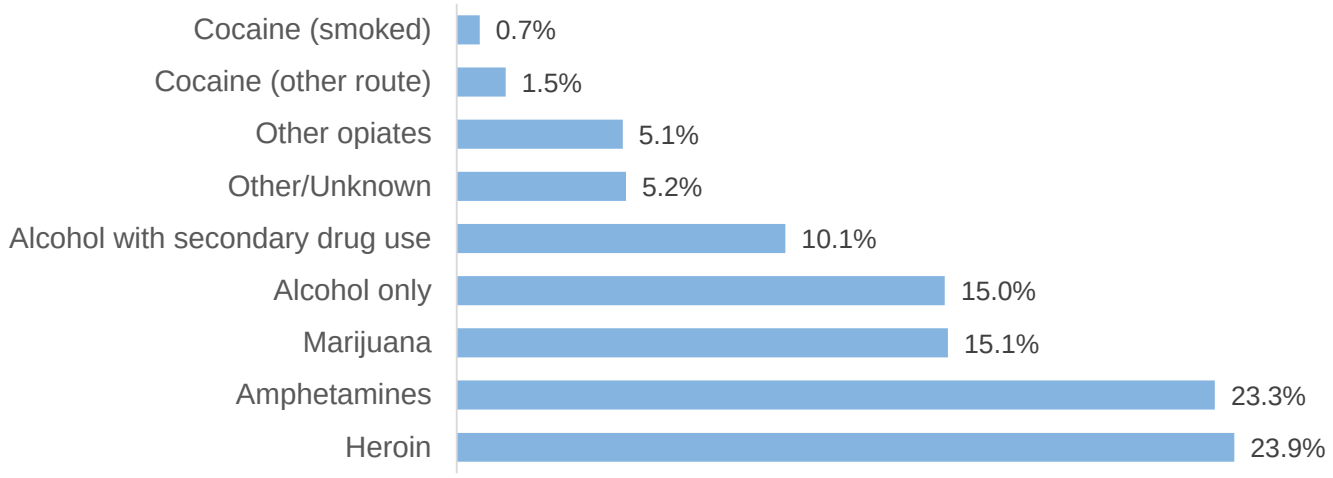
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Substance Use Treatment Admissions

The Center for Behavioral Health Statistics and Quality at SAMHSA maintains the Treatment Episode Data Set (TEDS), which tracks administrative data on substance use admissions for each state. Based on data submitted to TEDS through April 3, 2018 for the treatment year 2017, there were 26,615 substance use admissions in Arizona in 2017.

Most admissions were for heroin (23.9%) and amphetamines (23.3%). The greatest percentage of admissions occurred in those aged 26 to 30 (21.6%), and among whites (84.6%). More than half of those in treatment were male (57.4%) (See Exhibit 49).

Exhibit 49. Percentage of Substance Use Admissions by Primary Substance of Misuse among Arizonans Aged 12 and Older, 2017



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administrations, Treatment Episode Data Set

Suicide

Suicide is a leading cause of death among individuals who misuse alcohol and drugs, and there is a large body of research demonstrating an association between substance use and suicide (SAMHSA, 2016; Center for Substance Abuse Treatment, 2009; Wilcox et al, 2004). Individuals who misuse, or are dependent on, alcohol have a suicide risk 10 times greater than the suicide risk of the general population; the risk of suicide for injecting drug users is 14 times greater than the general population's risk (SAMHSA, 2016). Nationally, approximately 22% of suicide deaths involve alcohol intoxication, and 20% involve opiates (Center for Substance Abuse Treatment, 2009).

This report presents data on three indicators of suicide:

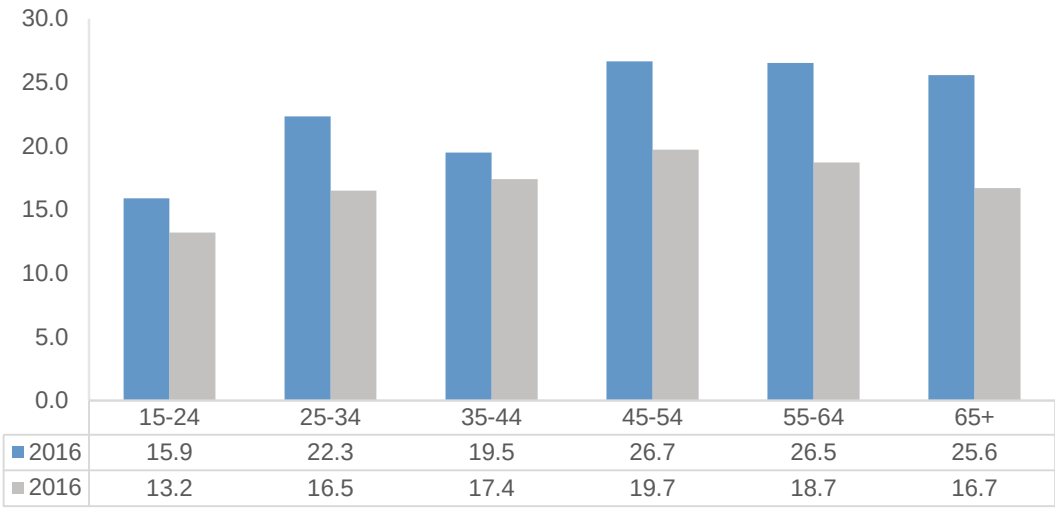
- suicide death rates,
- suicide attempts, and
- serious thoughts of suicide.

Suicide Death Rates

According to data from the 2016 National Center for Health Statistics, the age-adjusted suicide death rate in Arizona was 17.7 per 100,000, which was higher than the national suicide death rate of 13.5 per 100,000. Arizona ranked 17th of all states in terms of suicide rates. The Arizona Department of Health Services (ADHS) reported that in 2016 there were 1,256 suicide deaths in the State, and 60% were carried out by firearms.

For all age groups, suicide rates were higher in Arizona than the United States. The greatest absolute difference in suicide rates between Arizona and the United States occurred for those aged 65 or older (25.6 vs. 16.7 per 100,000). In Arizona, rates peaked among adult 45 and older (See Exhibit 50).

Exhibit 50. Age-Adjusted Suicide Mortality Rates per 100,000 by Age Group for U.S and Arizona, 2016



	15-24	25-34	35-44	45-54	55-64	65+
2016	15.9	22.3	19.5	26.7	26.5	25.6
2016	13.2	16.5	17.4	19.7	18.7	16.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Veteran Suicide Death Rates

Arizona is home to seven military bases located in five counties: Maricopa, Yuma, Pima, Cochise, and Coconino. A 2015 census report indicated there are 522,188 veterans residing in Arizona. Easy access to military and veteran accommodations and entitlements such as discounted groceries and retail stores, free or discounted prescriptions, medical and mental health treatment, and social activities make Arizona a popular state for veterans to retire in. Services provided on military bases also keep the cost of living nearly four percent lower than the US average and fosters a sense of social norms and connectedness that comes with the commonality of having served in the armed forces. An updated study completed by the U.S. Department of Veterans Affairs (2018) reported that in 2016 Arizona lost 227 veterans to suicide (217 male and 10 females) and that they commit suicide at quadruple the rate of civilians, with most committing suicide by gunshot (79.3%). After accounting for differences in age, the Veteran suicide rate in Arizona was significantly higher than the national Veteran suicide rate ($p<0.0001$) (Exhibit 51) as well as the overall national suicide rate ($p=<.00001$) (Exhibit 52).

Exhibit 51. Arizona, Western Region, and National Veteran Suicide Deaths, by Age Group, 2016

Age Group	Arizona Veteran Suicides	Western Region [a] Veteran Suicides	National Veteran Suicides	Arizona Veteran Suicide Rate [b]	Western Region Veteran Suicide Rate [b]	National Suicide Rate [b]
Total	227	1,576	6,079	44.1	35.0	30.1
18-34	31	224	893	68.9	47.9	45.0
35-54	49	418	1,648	41.9	38.8	33.1
55-74	89	595	2,259	39.9	30.6	25.9
75+	57	337	1,274	43.8	33.4	28.3

[a] States included in the western region were Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming
[b] Rates presented are unadjusted rates per 100,000
Source: Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

Exhibit 52. Arizona Veteran and Overall Arizona, and National Suicide Deaths, by Age Group, 2016

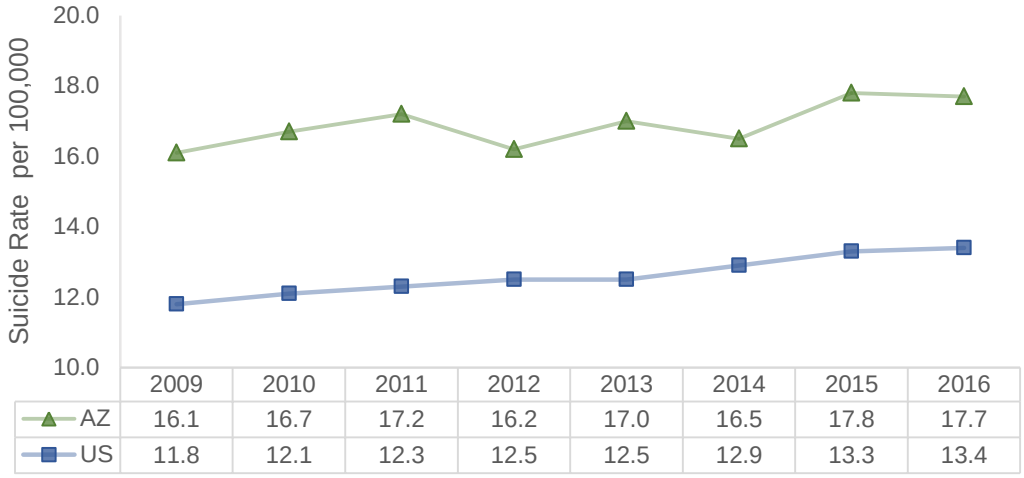
Age Group	Arizona Veteran Suicides	Arizona Total Suicides	Western Region [a] Total Suicides	National Total Suicides	Arizona Veteran Suicide Rate [b]	Arizona Suicide Rate [b]	Western Region Suicide Rate [b]	National Suicide Rate [b]
Total	227	1,236	11,105	43,427	44.1	23.4	19.0	17.5
18-34	31	333	3,061	11,997	68.9	20.9	16.6	16.1
35-54	49	396	3,854	15,467	41.9	23.4	19.5	18.6
55-74	89	373	3,155	12,162	39.9	24.6	19.9	17.3
75+	57	134	1,035	3,801	43.8	27.6	23.0	18.5

[a] States included in the western region were Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming
[b] Rates presented are unadjusted rates per 100,000
Source: Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

Trends in Suicide Death Rates

Data from the Arizona Department of Health Bureau of Vital Statistics reveal an overall increase in suicide death rates between 2009 and 2016, from an age-adjusted mortality rate of 16.1 per 100,000 to 17.7 in 2016. From 2009 to 2016, Arizona consistently had a higher suicide rate than the national rate. Increases in suicide death rates in Arizona were observed for all age groups except for those aged 35-44, whose rate decreased slightly from 20.7 per 100,000 in 2006 to 19.5 per 100,000 in 2016. The greatest absolute increase in suicide rates was observed for youth aged 25 to 34, from 15.3 per 100,000 in 2009 to 22.3 per 100,000 in 2016 (See Exhibit 53).

Exhibit 53. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 for U.S. and Arizona, 2009-2016



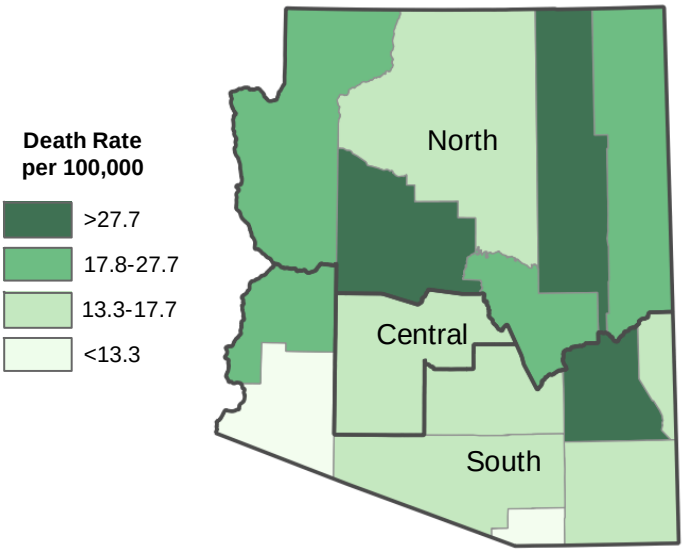
	2009	2010	2011	2012	2013	2014	2015	2016
AZ	16.1	16.7	17.2	16.2	17.0	16.5	17.8	17.7
US	11.8	12.1	12.3	12.5	12.5	12.9	13.3	13.4

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Suicide Death Rates by County

Suicide mortality rates in Arizona differed substantially by county. Yavapai, Navajo and Graham Counties all had suicide mortality rates over 30 per 100,000, while Santa Cruz County had a suicide mortality rate of 9.7 per 100,000. Most of the counties with high rates of suicide were concentrated in the Northern Region (See Exhibit 54). .

Exhibit 54. Age-adjusted Suicide Mortality Rates per 100,000 by Arizona County, 2016



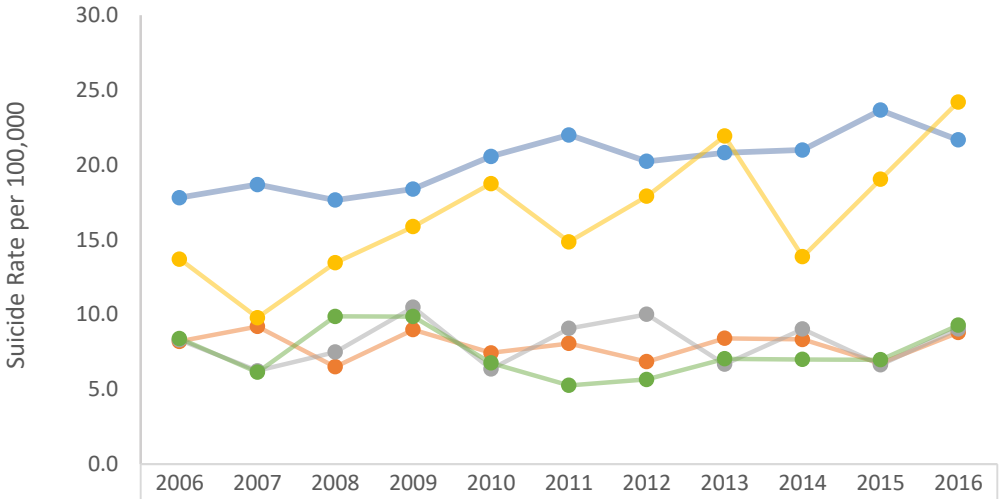
Rank	County	Rate
1	Yavapai	32.7
2	Navajo	32.0
3	Graham	30.5
4	Mohave	27.7
5	Apache	25.9
6	Gila	25.4
7	La Paz	22.2
8	Cochise	17.7
9	Pima	17.2
10	Greenlee	16.4
11	Maricopa	15.9
12	Coconino	15.8
13	Pinal	15.5
14	Yuma	13.2
15	Santa Cruz	9.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. Age Adjusted Mortality Rates for Selected Leading Causes of Death, 2016

Disparities in Suicide Death Rates

- Racial/Ethnic Disparities: Based on 2016 data, American Indian/ Alaska Natives and non-Hispanic whites experienced the greatest age-adjusted suicide rate of all racial/ethnic groups in Arizona (24.2 per 100,000 and 27.7 per 100,000, respectively). Rates for Hispanics, blacks, and Asian/Pacific Islanders were all less than 10.0 per 100,000. Additionally, trend data showed that not only did American Indian/Alaska Natives and non-Hispanic whites have a higher suicide rate in 2006 than their peers, but that their suicide death rates continued to accelerate overtime. (See Exhibit 55).

Exhibit 55. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Race/Ethnicity, 2006-2016



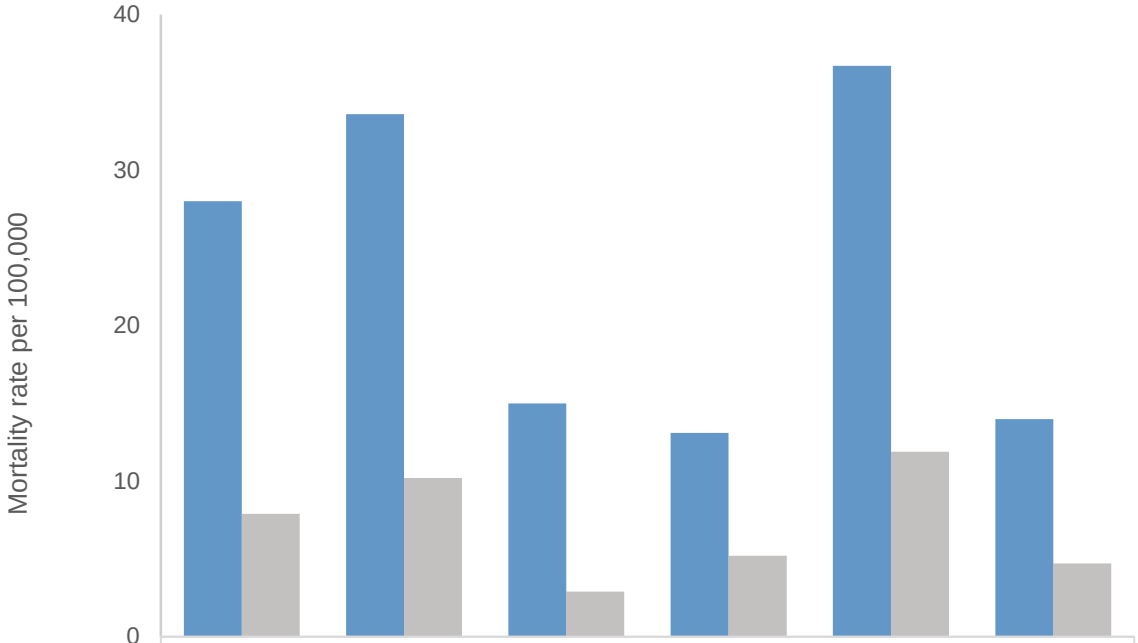
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
White	17.8	18.7	17.6	18.4	20.6	22.0	20.2	20.8	21.0	23.6	21.7
Hispanic	8.2	9.2	6.5	9.0	7.4	8.1	6.8	8.4	8.3	6.7	8.8
Black	8.3	6.2	7.5	10.5	6.4	9.1	10.0	6.7	9.0	6.6	9.0
American Indian	13.7	9.8	13.5	15.9	18.7	14.9	17.9	21.9	13.9	19.0	24.2
Asian/PI	8.4	6.1	9.9	9.9	6.8	5.3	5.7	7.0	7.0	7.0	9.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

- Gender Disparities: Across all examined age groups and years, males experienced much higher suicide rates than females. In 2016, the age-adjusted suicide rate for males was 28.0 per 100,000 compared to 7.9 per 100,000 for females. This means males were over three times more likely to die from suicide than females. Males also saw increases in age-adjusted suicide rates between 2009 and 2016 (2009: 24.6 per 100,000; 2016: 28.0 per 100,000) while female suicide rates remained relatively constant (2009: 8.1 per 100,000; 2016: 7.9 per 100,000). (See Exhibit 56)
- For females, the death rate peaked for those aged 55-64 (13.3 per 100,000). For males, the death rate peaked for those 65 and older (46.6 per 100,000) with risk continuing to

increase with increasing age. Specifically, the rate among males 75-84 was 55.3 per 100,000, and rose to 75.6 per 100,000 among those 85 and older. Certain other sub-groups of males also had disproportionately high suicide rates. American Indian/Alaska Native males had a suicide rate of 36.7 per 100,000, and white non-Hispanic males had a rate of 33.6 per 100,000.

Exhibit 56. Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Gender and Race/Ethnicity, 2016



	Total	White non-Hispanic	Hispanic or Latino	Black of African American	American Indian or Alaska Native	Asian/Pacific Islander
Males	28	33.6	15	13.1	36.7	14
Females	7.9	10.2	2.9	5.2	11.9	4.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Self-Inflicted Injuries

Data on inpatient hospitalizations and emergency department visits for self-inflicted injuries were taken from the 2016 Suicide Prevention Report prepared by the Arizona Department of Health Services, Office of Injury Prevention. The report used data from Arizona's 2012 to 2016 vital statistics.

Inpatient Hospitalizations for Self-Inflicted Injuries

- Rates in Arizona: For every completed suicide in Arizona in 2016, there were two self-inflicted injury-related hospitalizations. The age-adjusted hospitalization rate for self-inflicted injuries was 42.8 per 100,000 residents in 2016 (2,843 inpatient hospitalizations). Hospitalization rates peaked for those aged 15-24.
- Trends Overtime: Hospitalizations due to self-inflicted injury have decreased in Arizona from 2012 to 2016 (58.4 per 100,000; 42.6 per 100,000). Given the increase in the suicide mortality rate observed over the same time period, these data suggested suicide attempts are more likely to result in fatalities than in the past.
- Disparities in Hospitalization Rates:
    - Race/Ethnicity: White non-Hispanics and American Indian/Native American residents had the highest hospitalization rates (55.3 per 100,000; 53.3 per 100,000, respectively).
    - Gender: Overall, females were more likely to be hospitalized for self-inflicted injuries than males. This is in contrast to the gender disparities in suicide mortality rates that indicated males were over three times more likely to commit suicide than females. For females, those aged 15 to 19 had the highest rate of hospitalization (122.6 per 100,000).

Emergency Department Visits for Self-Inflicted Injuries

- Rates: For every completed suicide in Arizona in 2016 there were five self-inflicted injury-related emergency department (ED) visits. The ED rate for self-inflicted injuries was 103.1 per 100,000 residents in 2016 (6,750 ED visits). ED rates peaked for those aged 15-19 (344.6 per 100,000), and then decreased with increasing age.
- Trends Overtime: ED visits due to self-inflicted injury have increased slightly in Arizona from 2012 to 2016 (96.7 per 100,000; 103.1 per 100,000).
- Disparities in Hospitalization Rates:
    - Race/Ethnicity: White non-Hispanics had the highest ED hospitalization rate (130.4 per 100,000), followed by American Indian/Native Americans (120.0 per 100,000), and black non-Hispanics (119.3 per 100,000).
    - Gender: Overall, females were more likely to visit the ED for self-inflicted injuries than males. This is in contrast to the gender disparities in suicide mortality rates that indicated males were over three times more likely to commit suicide than females. For females, those aged 15 to 19 had the highest rate of ED visits (482.0 per 100,000).

Self-Reported Suicide Attempts Among High School Youth

Data on self-reported suicide attempts in the past year were collected during the 2017 YRBS and are only available for high school students.

- Prevalence of Suicide Attempts: According to data from the 2017 YRBS, high school students in Arizona were significantly more likely to report that they attempted suicide in the past year than youth nationally. Approximately 11.3% of Arizona high school students attempted suicide in the past 12 months, compared to 7.4% nationally (p=0.02).
- Trends in Suicide Attempts: There were no significant changes in reports of suicide attempts among Arizona high school students between 2008 and 2017.
- Disparities in Suicide Attempts: Disparities in suicide attempts existed across sub-populations of youth by sexual identity and race/ethnicity.
    - Sexual Identity: Compared to their peers, Arizona high school students identifying as gay, lesbian or bisexual were over four times more likely to report they attempted suicide (34.7% vs 8.2%, p<0.001), and more than eight times as likely to report that their suicide attempt resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse (20.5% vs 2.5%, p<0.001).
    - Race/Ethnicity: Compared to non-Hispanic whites, Hispanic high school students reported a higher prevalence of attempted suicide (13.3% vs 7.7%, p<0.001).
    - Suicide attempts among Arizona high school students did not differ significantly by gender.

Suicidal Thoughts

Prevalence of Suicidal Thoughts in Arizona

- Youth: Data from the 2017 YRBS estimated 19.2% of Arizona high school students seriously considered committing suicide during the past year, which did not statistically differ from the national estimate of 17.2%. NSDUH does not estimate serious thoughts of suicide among youth 12 to 17.
- Adults: Data from the 2015-2016 NSDUH estimated that 4.0% of Arizonans had serious thoughts of suicide in the past year; a prevalence of 4.0% was also reported nationally. Serious thoughts of suicide were most common among those 18 to 25 (8.9%), decreasing to 3.2% among those 26 or older.

Trends in Suicidal Thoughts

- Youth: There were no significant changes in the prevalence of suicidal thoughts among Arizona high school youth between 2008 and 2017.
- Adults: The prevalence of serious suicidal thoughts also did not change overall for adults between 2008 and 2016. However, there were significant increases in this time period for young adults aged 18 to 25 (6.6% to 8.9%, p=0.039). Similar increases were observed for young adults nationally. There was no significant change overtime for adults 26 or older.

Prevalence of Suicidal Thoughts by RBHA

There were no statistically relevant differences in suicidal thoughts by RBHA in Arizona.

Youth Disparities in Suicidal Thoughts:

Disparities in suicidal thoughts in the past year existed across sub-populations of youth by sexual identity and race/ethnicity.

- Sexual Identity: Compared to their peers, Arizona high school students identifying as lesbian, gay or bisexual were three times more likely to report they seriously considered suicide in the past year (15.1% vs 49.9%, $p<0.001$). This means nearly half of all students identifying as gay, lesbian or bisexual reported that they seriously considered suicide in the past year.
- Gender: Females were more likely to report that they seriously considered suicide than males (23.8% vs 14.0%, $p<0.001$). Suicidal thoughts among Arizona high school students did not differ significantly by race or ethnicity.

Drug Related Arrests

The Arizona Department of Public Safety publishes the *Crime in Arizona Report* which includes data on drug-related arrests in the State. According to this report, there were 1,240 arrests for the sale or manufacture of marijuana, and 15,839 arrests for marijuana possession in 2016. With the exception of driving under the influence, the largest number of drug related arrests were for marijuana possession.

Between 2010 and 2016, there were decreases in arrests for the sale or manufacture of marijuana, as well as the manufacture of "opium, cocaine, or derivatives" (1,254 to 1,010). However, there were substantial increases in arrests for the possession of "opium, cocaine, or derivatives" between 2010 and 2016 (from 1,980 to 3,360). (See Exhibit 57)

Exhibit 57. Drug-Related Arrests in Arizona in 2010 and 2016

	# of Arrests 2010	# of Arrests 2016
Drugs: Sale or Manufacturing		
Opium, cocaine, derivatives	1,254	1,010
Marijuana	1,659	1,240
Synthetic narcotics	535	705
Other dangerous non-narcotics	720	867
Drugs: Possession		
Opium, cocaine, derivatives	1,980	3,360
Marijuana	18,076	15,839
Synthetic narcotics	2,750	4,516
Other dangerous non-narcotics	4,981	5,235
Driving Under the Influence	37,981	21,883

Source: Arizona Department of Public Safety, Crime in Arizona Report, 2010 and 2016

Alcohol Related Crashes

The National Highway Traffic Administration reported 232 crash fatalities involving at least one driver with a BAC of 0.08% or higher in Arizona in 2016. This means approximately 24% of all traffic related fatalities were alcohol related in Arizona. Nationally, alcohol accounts for 28% of all crash fatalities.

- Prevalence Overtime: Long-term trends show alcohol-impaired driving fatalities decreased between 2005-2007 and 2014-2016 (370 vs 234).
- Prevalence by County: Alcohol related fatality rates per 100,000 people were highest in Apache (19.2) and La Paz (14.7) Counties.

The *2016 Motor Vehicle Crash Facts for Arizona*, prepared by the Arizona Department of Transportation (ADOT), provided additional data on alcohol related crashes. In this report, alcohol related crashes included all crashes where an investigating officer indicated that a driver, pedestrian or bicyclist had been drinking alcohol, whether or not it was substantiated by a blood or breath test. According to this report, the number of alcohol related crashes in 2016 was 4,942 and the number of alcohol crash fatalities was 302.

- Prevalence by Age: Data from this report indicate that in Arizona approximately 31% of drivers involved in alcohol related crashes were 25-34 years old. The risk of being a driver in an alcohol related crash declined for older and younger age groups.

- Disparities in Alcohol Related Crashes: ADOT data also show that males were more likely to be drivers involved in alcohol related crashes than females (73.0% vs 26.2%).

DUI Arrests

According to the *State of Arizona Highway Safety Annual Report FY2017* published by the Arizona Governor's Office of Highway Safety, there were 26,077 Driving Under the Influence (DUI) arrests, 5,028 drug impaired driving arrests, and 1,349 under-21 DUI arrests in FY2017. As seen in Exhibit 55, there were 37,981 DUI arrests in 2010 and 21,883 DUI arrests in 2016 indicating a significant reduction over that time, but in 2017 this number increased notably.

Although the number of total DUI arrests and under-21 arrests decreased between 2012 and 2016, the number of drug impaired DUIs increased between 2012 and 2016 (from 4,511 to 5,028). However, increased surveillance over that time period makes it difficult to know the true increase of drug impaired driving.

Self-Reported Alcohol Impaired Driving

In considering impaired driving it is important to note that arrests and fatalities capture only a small portion of all drug and alcohol impaired driving. Survey data seek to estimate the actual prevalence of alcohol impaired driving. The most accurate estimates of alcohol impaired driving came from the National Roadside Survey (NRS), which ended in 2013-2014. The NRS randomly sampled weekend nighttime drivers to test for the presence of alcohol and drugs. Data from this survey revealed a substantial decrease in the prevalence of alcohol impaired driving, from 7.5% in 1973 to 1.5% in 2012-2014 (Berning et al, 2015). Unfortunately, state-specific data were not estimated by the NRS.

Today, data on alcohol and drug impaired driving are collected by the YRBS and the BRFSS. These data are based on self-report, and thus limited in their accuracy as compared to the NRS.

<u>Youth Prevalence of Alcohol Impaired Driving</u>

According to data from the 2017 YRBS nearly 1-in-5 (19.2%) Arizona high school students rode with a driver who had been drinking alcohol in the 30 days before the survey. An estimated 6.2% of high school students reported that they personally drove after drinking alcohol in the prior 30 days. Neither estimate of alcohol impaired driving in Arizona differed from national estimates.

<u>Adult Prevalence of Alcohol Impaired Driving</u>

Data from the 2016 BRFSS provided recent state and national estimates of alcohol impaired driving in the past month. In Arizona, an estimated 2.5% of respondents 18 and older reported driving under the influence.

Youth Trends in Alcohol Impaired Driving

The 2017 YRBS did not begin asking about alcohol impaired driving until 2013. Between 2013 and 2015, there were significant decreases in overall reports of drinking and driving (9.0 vs 6.2, p=0.04). However, the decreases were predominately due to declines in male drinking and driving from 10.8% to 6.7% (p=0.03). The prevalence of drinking and driving did not decline significantly for females (6.7% vs 5.7%, p=0.60), although females still reported less drinking and driving overall than males. High school students in Arizona were significantly less likely to report that they rode with a driver who had been drinking between 2003 and 2017 (36.2% vs 19.2%, p<0.001).

Adult Trends in Alcohol Impaired Driving

Data on alcohol impaired driving in Arizona could be sourced from the BRFSS as early as 2012. These data showed minor but not statistically significant declines in reports of alcohol impaired driving in the past month during this time (2012: 3.2%, 2014: 3.3%, 2016: 2.5%). There were more pronounced declines for males between 2012 and 2016. The prevalence for females remained constant at 1.3% between 2012 and 2016.

Prevalence of Alcohol Impaired Driving by Region:

No data were available on self-reported alcohol impaired driving by region.

Youth Disparities in Alcohol Impaired Driving:

Hispanic students in Arizona were significantly more likely than non-Hispanic white students to report that they rode with someone who had been drinking (22.8% vs 16.2%, p <0.001), although there were no racial/ethnic differences in students' self-report of drinking and driving. There were no significant disparities in alcohol impaired driving by sexual identity or gender.

Adult Disparities:

Males were significantly more likely to report impaired driving than females (3.4% vs 1.3%, p=0.004). The prevalence of alcohol impaired driving was significantly lower for non-Hispanic whites (2.1%) and Hispanics (2.4%) than non-Hispanic blacks (4.7%), or other racial groups (5.2%), with an overall chi-square of p=0.004. There were no significant differences in reports of impaired driving by educational attainment or employment status.

Marijuana and Other Drug Impaired Driving

According to the *2017 Report to Congress on Marijuana-Impaired Driving* (Compton, 2017), marijuana is the second most commonly detected drug in crash-related drivers (alcohol is the first). However, the definitive effects of marijuana use on driving are poorly understood; the report cites numerous reasons for this. First, there is no gold standard method to identify

marijuana impairment. Blood tests, which are frequently used, are limited because the level of Tetrahydrocannabinol (THC) in the blood and the degree of impairment are not highly correlated. Specifically, peak levels of THC are observed right after smoking, while peak impairment occurs one or two hours later. Additionally, chronic marijuana users may have detectable levels of THC in the blood even if they have not recently used marijuana. This means it is difficult to evaluate impairment based on the presence of THC.

Additionally, the report notes that studies seeking to estimate the actual effects of marijuana on driving have been inconclusive, and it remains unknown how much marijuana use actually contributes to crashes. The only large-scale case-control crash risk study in the United States found that after adjusting for age, gender, ethnicity and alcohol concentration, there was no significant increase in risk associated with THC (Romano et al., 2014). More research is needed to understand the specific driving risks associated with marijuana consumption. Risks from other drugs are similarly poorly understood. The *2017 Report to Congress on Marijuana-Impaired Driving* provides recommendations about monitoring and addressing marijuana impaired driving based on these limitations.

Not surprisingly, there are limited reliable data on the effects of marijuana and other drug impaired driving, particularly at the state level. The National Roadside Survey showed a substantial increase in the prevalence of drivers that had used marijuana, from 8.6% in 2007 to 12.6% in 2014. By comparison, alcohol impaired driving nationally decreased during the same period from 12.4% to 8.3% (Berning et al, 2015).

Arizona specific data from the National Highway Traffic Safety Administration Fatal Reporting System (FARS) indicated increases in the percentage of traffic fatalities that involved marijuana from 2.9% in 2010 to 5.1% in 2014. However, given the unresolved limitations as noted above, it is unclear if the increases in the prevalence of THC truly indicate meaningful increases in marijuana impaired driving.

Qualitative Findings: Substances

Several community members and professionals across regions acknowledged the difficult of "aligning a substance with a demographic" because there are many contributing factors that go into why a person chooses a particular substance. However, there are a few overall trends from the focus groups and interviews that should be noted: *Alcohol* was reported to be a substance use issue for all subpopulations; *marijuana* use was reported to be common among youth, veterans, Native Americans and some older adults; *methamphetamine* was reported to be used frequently by veterans and Native Americans; *opioid* use was recognized as a significant substance use issue by the veteran, older adult and Native American communities; *prescription drugs* and *over-the-counter drugs* were reported to be used heavily by older adults and youth.

Other substances that came up during the focus group discussions and interviews included heroin, fentanyl and spices (synthetic marijuana). Several respondents reported fentanyl and spices were extremely strong and often caused a lot of harm. As stated above, these qualitative findings should not be generalized to these subpopulations, as they are a small sampling of perspectives from across the State.

Youth

Substances Most Used

Across regions, youth and adults serving youth who participated in focus groups reported youth most frequently use alcohol, marijuana, and vaping substances (containing nicotine or THC). Similarly, professionals serving youth across regions who were interviewed reported alcohol and marijuana as the biggest issues among youth, including college students. While some community members and professionals from the Northern and Central regions reported opioid use as an issue for youth in their community (including one professional from Mohave County who stated opioids are creating the most harm for youth in that county due to overdoses), many professionals reported youth are not using opioids very much in their communities and noted the "opioid conversation is overshadowing other issues". For example, one adult-serving-youth focus group participant in Sierra Vista reported there is a "buzz about opioids, but I haven't met any families personally with a kid who had issues with it." Professionals serving youth across regions noted marijuana is a growing problem for youth because it impacts the brain development and because society's "perceptions of harm and legality" have changed. One professional in the Southern region explained how marijuana affects children's brains by stating, "When you have a youth who normally activates the reward center in the brain [by] getting a good grade or making a sports team… they will continue with goal setting and achieving goals. Let's say the same youth smokes marijuana and the reward cells are activated with weed instead, they get that same good feeling without having done anything. If you feel that good, why would you study on a test? When a youth can seek artificial high why do they need parental approval for that reward?"

A youth focus group member in the Central region recalled that at his school last year, students as young as eighth grade "used to smoke weed." A professional serving youth in the Northern region cautioned, "We haven't begun to see the impact of early [marijuana] use impacting life success. It may hinder kids from launching into adulthood." In addition, one professional in the Southern region noted marijuana appears be a more serious issue for Native American students than students from other ethnic groups, as a larger percentage of Native American youth are referred to juvenile court.

Vaping (either nicotine or THC-laced substances) was mentioned as a popular substance for youth in all four adult-serving-youth focus groups. The flavors that manufacturers put into

these substances "gets these kids hooked," according to one adult-serving-youth focus group participant in the Southern region. Another adult-serving-youth participant in the Southern region explained, "Kids are vaping in the restrooms in middle school," while a third adult-serving-youth Southern region focus group participant stated, "My boyfriend's son, a sophomore, sees kids vaping in the class, teacher turns their back, they take a puff, everybody's waving their notebooks around." Youth in the Central and Northern regions confirmed that some youth vape behind teachers' backs. Moreover, a youth participant in the Northern region stated on the bus, "People usually duck down under the seats to vape."

In addition to alcohol, marijuana and vaping, prescription drug use was mentioned as a serious substance use issue for youth at adults-serving-youth focus groups in the Southern, Northern and Central regions. Focus group participants reported that children get prescription drugs from their parents and mix them with other things such as cough syrup. A focus group participant in West Phoenix mentioned that some youth use Adderall®, which is prescribed for attention deficit hyperactivity disorder (ADHD), as a recreational drug. Additionally, a professional in the Southern region who was interviewed reported some students in the region use Xanax.

Notably, multiple professionals serving youth in the Northern region who were interviewed agreed this area sees significant meth and heroin use among youth. One professional in the Northern region reported the community "is experiencing a resurgence of meth and heroin". Adult-serving-youth focus group participants in the Northern region also reported that meth is a significant issue for youth in the area, especially for 18 to 20-year-olds. According to one adult-serving-youth focus group participant in the Northern region, heroin is popular because it's cheaper than marijuana. The use of meth by youth was also brought up by adult-serving-youth during the Central region focus group. In addition, multiple professionals serving youth in the Southern region noted that gummy bears and chocolates laced with fentanyl or other substances have caused a lot of harm for youth in the community, including at least one fatality. Other substances used by youth which focus group participants mentioned included tobacco (Central and Southern regions); over-the-counter medication (like cough syrup; Central and Northern regions), energy drinks (with or without alcohol; Central and Northern regions), caffeine pills and black tar heroin (Central region); spice, bath salts, and adulterants such as fentanyl (Northern region); cocaine (used by football players and cheerleaders) and LSD (used by high school students; Northern region).

Most Harmful Substances

Alcohol, marijuana and opioids (including hospitalization and death due to accidental opioid overdose) were reported to cause the most overall harm across regions by participants in the adults-serving-youth focus groups. However, professionals serving youth also had different opinions about which substance is currently creating the most harm for youth in their

communities. One professional serving youth in the Southern region stated, "Alcohol is the worst because it is the most easily accessible and the most widely abused." However, another professional from the Southern region noted, "Students on more serious drugs cause trouble in school and are disruptive and defiant. They require time for evaluation, their parents have to take them to hospital – it disrupts the education flow for the student and for staff who have to process it. It creates the need for public relations management for the school and causes legal troubles for the student."

Consequences of Use

Common consequences of youth substance use that were noted during focus groups and interviews (aside from overdose, hospitalization and death), include crime, school suspensions, legal problems, developmental harm (from marijuana), inability to get a job, sexual assault, trafficking, teen pregnancy, domestic violence, homelessness, sexually transmitted diseases, child abuse, severance of parental rights, and suicide (especially related to marijuana use). In addition, one focus group participant in the Northern region reported sometimes youth cannot fully recover after using a substance like spice (synthetic marijuana) only once, and this sometimes prevents youth from returning to school/college after summer break.

Acquisition of Substances

Adult-serving-youth focus group participants in all regions reported multiple times that youth get substances at school from other youth. One focus group participant in the Southern region stated, "It's in the schools, hallways, bathrooms… The kids know who [and] where they can get it from." One adult-serving-youth focus group participant from the Southern region explained, youth are bringing prescription drugs to school and "kids are being told that a pill is cure… Youth say to each other, 'If you're feeling that way, I'll share mine with you.'"

In addition, adults-serving-youth from all regions reported youth get substances at parties (including desert parties, bonfires, house parties, and skittles parties). According to youth focus group participants, skittles parties are where youth ask people to bring different kinds of pills from home, combine them all together, and youth at the party reach in and swallow whatever they grab.

Focus group participants from all regions reported youth commonly obtain substances from parents or caregivers and steal prescription drugs like oxycodone or over-the-counter drugs like cough syrup from their parents' or grandparents' medicine cabinets. Adults-serving-youth focus group participants in the Central region reported parents sometimes give cigarettes to younger adolescents because they think it will prevent them from experimenting with other drugs and parents often let older adolescents experiment with other drugs at home because they consider it to be safer than the youth experimenting with them outside of the home.

In addition, in Central and Northern regions, participants reported youth often get substances through younger family members such as siblings and cousins. Participants in the Central region explained that in their region, doctors readily prescribe substances like Xanax and Percocet, making these substances readily available in addition to already accessible drugs such as marijuana, heroin, and hard drugs One adult who serves youth in the Central region stated that in that area, youth sometimes steal prescription drugs from homes up for sale during open houses. Adults serving youth in the Central and Southern regions reported some youth buy drugs from drug dealers. In addition, one participant in the Northern region noted that stores and pharmacies do not monitor the cough medicine merchandise closely enough.
Other places respondents reported youth get substances included Mexican pharmacies (which historically have had more lax regulation and cheaper prices), community members who sell prescription medication, truck stops, and from community members with marijuana cards. Additionally, youth see marijuana advertisements on social media and may find out where to get marijuana that way.

Veterans

Substance Use

A professional serving veterans in the Southern region (who was also a veteran himself) reported that for those in the military, alcohol is the main substance that is used and "there is definitely a trend towards [prescription] opiates with so much of us coming out with pain…..all of us have chronic problems, chronic back problems and all of our joints …[and]…we do get prescribed opiates pretty regularly without any real issue." According to this professional who serves veterans, the substances veterans use most frequently are alcohol, opioids, methamphetamine and combinations of the same. Vietnam-era veterans tend to use alcohol, marijuana and meth, while younger veterans tend to use opioids and some marijuana. Meth is used less frequently in the military population than the veteran population, "because no one cares about how much you drink when you're on active duty and you get the opiates from your doctor."

Veterans at focus groups in all three regions also reported meth is a substance use issue for veterans in their communities. One participant in the Southern region stated meth is readily available and affordable. In addition, focus group participants in the Southern and Central regions stated that many homeless veterans use meth to stay awake at night as a way of staying safe. One female veteran focus group participant in the Central region explained, "Meth was great for staying awake and staying protected, especially as a female."

Veterans at the Northern focus group reported that alcohol is a substance use issue for veterans because veterans often grow up in families where alcohol is misused, and alcohol is a gateway drug that "leads to all other drug use". Several veterans at the Northern region focus group

agreed that alcohol is readily available on base, such as one veteran in the Northern region who stated, "… when I was in the Navy, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work."

In the Southern region, one veteran explained marijuana is used by some veterans partly because it is cheaper than other drugs, while a veteran in the Central region asserted, "People claim [marijuana] is a gateway drug and I agree. I also agree it is an exit drug. As a heroin addict, the craving is strong… [and] you get sick if you don't have it. Once I quit, I had all of this, 'I want to get high, not self-medicate, I want to get high'. So, I knew that I didn't want to do heroin, I knew what I'd been through… So, I jump on the weed… Smoking the weed eased up my cravings for anything else."

Northern veteran focus group participants reported substance use among veterans often results in crime, homelessness and sometimes death. Moreover, veterans in the Southern focus group reported many veterans don't pay for drugs; rather they barter for drugs by offering food and space for parties in exchange. Veterans in the Southern region also stated that the proximity to the border means many substances such as cocaine, meth and marijuana are readily available. Lastly, several veterans in the Central region agreed some veterans "will say [their] drugs are not working in order to get the narcotic".

Older Adults

Substance Use

Focus group participants in all three regions reported that alcohol is frequently used by older adults in Arizona. In the Northern region, one participant reported that the small rural nature of many towns gives older adults the most access to alcohol. Another Northern region focus group participant explained alcohol is readily available at events held by older adult communities or older adult homes. This participant related, "I was totally amazed at the number of people who were there [at a senior facility's wine and cheese night] and the size of the wine glasses that they had. And a lot of these people have dementia or trouble walking or whatever… and the [glasses] were almost full…"

Southern and Central focus group participants also reported general use of prescription drugs in addition to specifically benzodiazepines as a substance use issue for older adults in their communities. One focus group participant in the Southern region reported older adults' slowed metabolism made misuse of prescription drugs more dangerous. Sometimes misuse is intentional, but often times it is accidental, according to a focus group participant in the Central region. In addition, poly-drug use (such as mixing marijuana pills with other medication or

alcohol) was mentioned as an issue in the Southern and Central regions. Focus group participants in the Southern and Central regions also highlighted that many times older adults are not aware of possible interactions with other medications. Focus group participants reported that other substances sometimes used by the older adult population include opioids, marijuana (often used initially to improve sleep and alleviate pain), methamphetamine, and heroin.

Consequences

Older adult focus group participants in all regions reported injurious falls (often requiring hospitalization) were a common result of substance use in the older adult population. Focus group participants explained other consequences of substance use in the older adult population include: overdose (Southern and Central regions), death (Northern region), liver problems (Central region), and DUI (Central region). One focus group participant in the Southern region noted some older adults who have cognitive decline or who lack money for food are manipulated into transporting drugs over the border.

Acquisition

In the Southern and Northern regions, several focus group participants reported that older adults frequently trade or share medications with friends and neighbors; two participants in the Southern region explained sometimes older adults steal or buy substances from their peers. In the Central and Northern region, participants stated sometimes caregivers take older adults to the store in order to buy alcohol or other substances and in the Southern region, and one participant reported some older adults go to Mexico to buy prescription medication because it is cheaper there and/or "they are not getting what they want here". Similarly, in the Southern and Central regions, several participants reported some older adults "physician-hop" (i.e., go to multiple physicians and get multiple simultaneous prescriptions to use). As one older adult focus group participant who works with older adults in the Southern region stated, "If they're not happy with their doctor, [some older adults] switch doctors to find one that agrees with their belief system." This participant also explained, while there are shared databases that aim to prevent simultaneous prescription misuse of controlled substances, they are not being used regularly by most doctors.

LGBTQ Populations

Substances Used

LGBTQ focus group participants in the Southern region reported what gets used by individuals in the LGBTQ communities depends on trends, availability, socioeconomic status, and personality type. As one participant explained, "When you are a regular user of a substance … its connected to personality… Someone who is an opioid user will not one day, say, use crack." Another participant concurred by stating, what substance someone uses depends on whether

"you're a 'downer girl' or an 'upper girl'". A focus group participant in the Central region stated, "My friends do a lot of 'I need to relax drugs' downer drugs, like low dose heroin, pot, pills, mind numbing pills." A Southern region focus group participant reported, "Meth is always popular everywhere," and some participants in the Southern region explained that they felt meth is causing the most harm for the LGBTQ populations in their community. In addition, LGBTQ focus group participants across regions reported alcohol is used by the LGBTQ populations. Other substances LGBTQ focus group participants noted as widely used by the LGBTQ populations include marijuana, cocaine, fentanyl, and prescription medication (including Adderall®).

Consequences

LGBTQ focus group participants reported that domestic violence, violence in the community and sexual assault at parties often result from substance use in the LGBTQ populations, as well as individuals falling victim to over-policing for nonviolent drug offenses with little to no rehabilitation options instead of drug charges.

Acquisition

Across all three regions, LGBTQ focus group participants stated members of the LGBTQ communities commonly get substances through their friends or "friends of friends". As one participant in the Southern region put it, "Queer people don't venture out, they don't want to risk it." According to focus group participants, other ways the LGBTQ populations gets access to substances include: drug dealers (Southern and Central regions), relatives (Southern and Northern regions), parents/caregivers or friends' parents (Northern region) and shoplifting or using fake IDs (Northern region).

Tribal Populations

Substance Use

Tribal leaders that were interviewed reported the Tribal members often use alcohol, opioids, and methamphetamine. A Pascua Yaqui elder who was interviewed reported youth often hide alcohol in their "Polar Pop Styrofoam cup" so that adults can't tell what they are drinking. He also noted that marijuana is a substance use issue in the Pascua Yaqui community in the Central region and that "kids say, 'It's legal, why can't I smoke it?'"

Pascua Yaqui focus group participants also reported that alcohol and methamphetamine are substance use issues in the community that cause a lot of harm. One Pascua Yaqui member explained, "Older people are more alcoholics because back in the day there weren't as much drugs, now today they are most used to drinking alcohol… to cope. Younger [people], they go for whatever is out there… they don't care about the alcohol." While another Pascua Yaqui member rejoined, "Alcohol … is slower acting, but it's still killing people in our community…

It's still killing my family members. Do they dabble in other drugs too? Yes, but what started it? It's the alcohol and it's a legal drug. I think it's important to recognize that alcohol is a drug. It's where it starts." Multiple Tribal members explained that alcohol use in their communities lead to high rates of cirrhosis of the liver and affects "everyone that lives in [the] home", often leading to domestic violence, grandparents raising children, and/or children failing in school. A Pascua Yaqui member added, "Now that [doctors] are having more control over [prescription opioids] … now [people] turn to using heroin and meth because they can't get the opiates anymore." As stated above, these findings represent a small sample and should not be generalized across all Tribal communities, or the Tribal communities in which the respondents are members of.

Refugee Populations

Professionals who work with the refugee populations in the Southern region reported that the major substance use issues in the refugee community are alcohol and cigarettes, with alcohol causing the most harm. In addition, youth also talk about themselves or family members using "weed", but lack understanding that this is marijuana. The professionals interviewed were not aware of any refugee youth involved in substance use. Respondents indicated Congolese men and Bhutanese men and women seem to have higher rates of substance use compared to other refugees, likely because both populations have spent a long time in refugee camps and experienced "pretty intense trauma."

Respondents reported alcohol affects not only refugees' health but also refugees' family and community. Dependency interferes with daily life, job, school, relationships, and carrying out daily activities. Consequences include loss of jobs, which exacerbates financial strain and increases risk of domestic violence. Alcohol issues lead refugees to use their partners' money to buy alcohol rather than spending money on basic needs. Respondents emphasized that possible consequences of substance use are particularly dire for this population, as criminal charges for domestic violence will affect their potential for a green card or citizenship. According to respondents, substance use "definitely affects the resettlement process."

Promotores

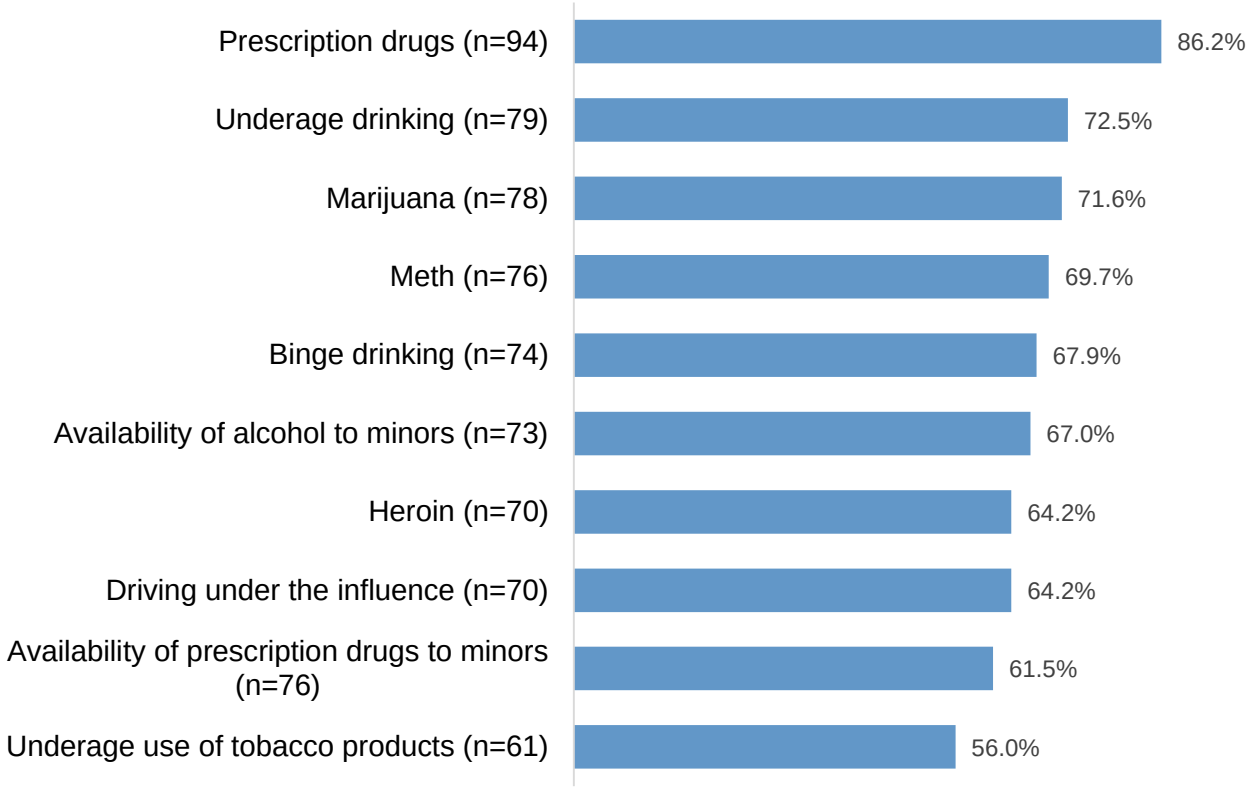
A Promotora is a Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker and serve as liaisons between their community, health professionals, and human and social service organizations. Promotores in the Phoenix area reported that the substances they see most used are alcohol (due to the low cost), and marijuana for both youth and adults because it is considered normal. Youth are often using e-cigarettes because they do not see them as harmful. Both youth and adults are using cocaine, crystal meth, prescription drugs, paint

thinner, benzodiazepines, spice (synthetic marijuana) and prescription drugs. Respondents talked about the unintentional overdose of prescription medication often seen in older adults in their communities. For youth, they acquire substances from friends at school, and are sometimes offered them for free. They also steal from parents and grandparents to use or sell. Sometimes, parents buy alcohol for youth because they feel it is better to learn how to drink at home, "where in general" drinking tends to be a cultural norm for men. Benzodiazepines tend to enter the home after being brought in from Mexico. Marijuana acquisition routes include marijuana dispensary cards, home deliveries of marijuana and other drugs, easy access on the street, getting marijuana from people they know who have a marijuana card, and growing marijuana. There was agreement that many individuals in their community have a serious addiction problem and that some of the major consequences of this use are unemployment and loss of one's family.

Workforce Survey

Respondents were asked about what substances were the major issues in their community. Respondents could report more than one type of substance issue (See Exhibit 58). The most commonly reported major substance use issue was prescription drugs.

Exhibit 58. Major Substance Issues* (N=109)



*Respondents could choose more than one substance use issue.

Sixteen respondents reported one or more "other" major substance use issues in their community, which fell into the following themes:

- Availability of marijuana to minors/Marijuana use in minors during ongoing brain development
- Vaping
- All Opioids
- Drugs and Suicide
    - Over medicating with drugs - risk for suicide
    - Substance use related suicide
- All tobacco products at all ages
- Accessibility of alcohol
- Selling alcohol to already intoxicated people
- Older adult medication mismanagement
- Siblings supplying to family members
- Specific drugs
    - Prescription stimulants
    - Prescription benzodiazepines
    - Fentanyl (synthetic opioid)
    - Spice
    - Cocaine
    - Ecstasy

Prevention: Current Efforts

Community Prevention Inventory

The Community Prevention Inventory (Appendix D) includes a wide spectrum of coalitions, organizations, and programs from across Arizona, although it should not be considered an all-inclusive listing of prevention resources in the State. Altogether, 41 prevention coalitions are included in the inventory. Most of the coalitions are associated with a specific geographic area and are organized around a population, while a few work around a single issue (e.g., opioids) statewide. Approximately one third of the coalitions are in Maricopa County, and about one fifth are located in Pima County. Based on the Statewide Substance Abuse Coalition Leaders in

Arizona (SACLA) membership list, additional information obtained from the RBHAs and prevention organizations, all counties except for Greenlee, La Paz, and Yuma have prevention coalitions. However, there may be additional prevention coalitions operating that do not participate in SACLA. The data collected also suggests that prevention coalitions cannot be universally viewed as stable entities providing prevention resources in a community. The leader of a coalition included on the SACLA's list reported that their coalition was not currently functioning; another noted that their coalition is only in a formative stage, and other coalition leaders did not respond to information request e-mails.

The target substances of prevention coalitions show great variation. Most prevention coalitions target multiple substances, with alcohol (i.e., underage drinking) being most commonly reported, followed by marijuana, opioids, and prescription drugs. Three coalitions included synthetics as one of their targeted substances and two mentioned tobacco, although these may also be targeted by coalitions that reported targeting "all" substance or "other substances" in addition to a named one. The most commonly cited combination of targeted substances was alcohol, marijuana, and prescription drugs. No prevention coalitions explicitly named methamphetamine as a targeted substance, and it is not clear whether the coalitions that address tobacco also address e-cigarettes and vape pens.

It is clear from the inventory that capacity varies greatly by coalition. Some coalitions are implementing multiple programs in their community, sometimes at multiple sites (e.g., schools). Some coalitions provided a detailed list and description of programming and activities while others offered only a broad view of their work (e.g., Strategic Prevention Framework). Although there are more coalitions in larger, urban counties, some rural counties have coalitions that have substantial outreach capabilities to youth and other community members, based on the types and amount of programming and activities they implement. The most commonly mentioned types of programs and activities included public awareness campaigns, prescription drug take back events, school assemblies, youth groups, community presentations/town halls, parent education, life skills programs, and safe graduation/prom events. About 30% of the coalitions reported using one or more evidence-based programs, with Rx-360 being the most commonly cited. Only a small number of coalitions mentioned having programs or events that specifically target marijuana, although they may address marijuana as part of broader drug education efforts.

State universities, particularly Arizona State University and the University of Arizona, reported having an extensive array of prevention programs and activities, the majority of which focus on alcohol and/or other drugs. The universities utilize a number of evidence-based programs including substance use education and screening (some of which are online), substance-free social programming, challenging social norms around alcohol and other drugs through social marketing/media, and evidence-based environmental strategies such as substance-free residence halls.

Non-profits (other than prevention coalitions), educational institutions, and government agencies also provide community prevention resources, with most of the information gathered from these types coming from RBHAs and on-line research. The prevention programs provided by these entities include ones that target the needs of seniors as well as supporting harm reduction.

The inventory's section on Tribal organizations' prevention efforts includes programs both geographically-focused (e.g., Guadalupe, Maricopa Counties) and more regional efforts. The former includes youth skills and parent education. Of particular interest in all of the Tribal prevention efforts is a focus on incorporating American Indian values and cultural knowledge. Additionally, Tribal programs are some of the few in the inventory that specifically address methamphetamine use and/or misuse. Information is needed from additional Tribes to present a more complete picture of substance use prevention in those communities.

Qualitative Findings: Current Prevention Efforts

In all focus groups and interviews conducted, the question was asked:

> "What does the community do to try to prevent use of substances in your community?"

Asking this question assisted in filling gaps of understanding pertaining to any statewide prevention efforts not being captured by the community inventory or the workforce survey. Findings below include data from focus groups and interviews conducted across the State. The types of prevention efforts presented are those with evidence supported by these conversations. Not all focus groups shared current prevention activities in their communities often due to a lack of knowledge or understanding about what types of programs and efforts existed. Also, in general, the prevention programs listed in the community inventory is not repeated below if it was reiterated by a focus group participant or interviewee.

Youth (and those serving youth)

Youth, and those serving youth, provided some examples of current prevention efforts including:

- Public Service Announcements (PSAs) and Public Awareness Campaigns
- Pro-Social Programs
- Student Led Groups and Youth Conferences
- Family Nights
- School Presentations
- Fairs and other Community Prevention Events
- Conferences/Summits
- Teacher Education about Substance Use and/or Misuse
- Peer-to-Peer Advocacy and Youth Clubs
- Substance Free Peer Leadership Programs
- Videos
- Parental Engagement
- Red Ribbon Week

- RX Drug Take Back Programs
- Harm Reduction Programs including Needle Exchanges and SBIRT
- Re-enforcing Tribal youths' connection to their culture, customs, and traditions so they use the coping skills their ancestors established before they were introduced to alcohol and other substances.
- Governor's Office of Youth, Faith and Family's "I've Got Something Better" campaign
- Governor's Office of Youth, Faith and Family's "Overcome Awkward" Campaign
- Governor's Office of Youth, Faith and Family's "Healthy Families, Healthy Youth" middle school program
- Governor's Office of Youth Faith and Family's "High School Health and Wellness" Program
- Governor's Office of Youth, Faith and Family Prevention and Treatment Locator website
- School Mazes (offering education on the impact risky choices such as substance use have on a youth's life)
- Collaboration with Collegiate Recovery Programs
- Community education on the use of Adverse Childe Experiences (ACES) to identify youth at risk for substance use/self-medication
- Prevention Related Games

> *When we do our Campaign norms at the middle school planning to do that again… game….last time we did cup pong… like beer pong almost, questions in the cups that related to marijuana, alcohol, or prescription drugs and they answer questions…..the … 6th and 7th graders really enjoyed that game… so we're doing something again like that and we are doing something for the high school, which is good because they wanted us to be at the high school*. (Maricopa County adult)

Veterans

Veterans provided some examples of current prevention efforts in their community including:

- Coalitions that help to provide a variety of services and resources to veterans.
- Veteran Transition Programs

- VA Buddies Program
- Tribal Ceremonies for veterans returning from service.
- Organizations that provide some prevention programs, including the RWB, the Legion, the Vet Center, National Community Health Partners, VFW (Veterans of Foreign Wars), Arizona Western College Veteran Services, and DAV (Disabled American Veterans).
- Diversion Programs
- Social Activities that do not include substances.

Older Adults

Older adults provided some examples of current prevention efforts going on including:

- Education and Outreach
- Companionship Programs
- Peer Discussion Groups
- Alternative Health Classes
- Medication Disposal Programs
- Medication Reconciliation Programs

Tribal Populations

In a Key Informant interview with a member of the Inter-Tribal Council of Arizona (ITCA), the interviewee mentioned that they do not have a program that addresses substance use and/or misuse and they do not receive funding to address any of these topics. Their prevention programs focus mainly on teen pregnancy prevention, crime prevention, and disease prevention (including sexually transmitted infection). The respondent was not familiar with individual Tribes' prevention programs. ITCA prevention programs however, do discuss culture resilience and how it is important to go back to traditional ways to heal from historical trauma, "going back to our ceremonies and our kinship responsibilities and … learning how to eat or reintroducing our indigenous foods." Furthermore, many programs try to use a holistic focus on the individual and their family, without emphasizing one specific area of health, with the goal of connecting mental health, physical health, spiritual health, and emotional health. A lot of Tribes are trying "to bring in their indigenous ways or knowledge along with the Western way to help the individual. Because you still need both to help that person." "We have our prayers. We have our ceremonies. We have our stories… so it's just going back to that."

Although ITCA does not provide any substance use and/or misuse prevention programs, over the last four years they have been helping Tribes develop their skills to do health and other prevention; learning how to conduct an assessment or put a survey together, report-writing, and leadership training for coalition members. "So, we've done a lot of capacity building skills building over the last four years." These activities help Tribes organize programming for their SAMHSA grants.

For prevention efforts, the Gila River Indian Community has health initiatives through the Recreation Department and the Hospital such as fitness programs and fitness challenges. One community key informant interviewed from the Gila River Indian Community shared that avoidance of substances is a general goal of these efforts but that they do not discuss it directly. The community has a block grant-funded prevention coalition (the Gila River Prevention Coalition) that puts on events and has a booth at health initiative events. They are mostly suicide-focused and have suicide prevention events that they sponsor at district service centers targeting the whole community and include promotional items. They do have pamphlets on substance use targeting different substances. The key informant did not know how effective these efforts were, but felt that tracking success stories could be helpful.

The Navajo Nation reaches its Tribal members around the world through the use of their radio program. Substance abuse prevention and education are provided in both the Navajo and English languages by a father and daughter team. The male broadcaster provides the messaging in the Navajo language and his daughter repeats what he stated in English. The ability to reach its Tribal members anywhere in the world is particularly meaningful for Tribal members who serve in the armed forces because they can feel isolated when away from the reservation and their culture. The use of the father and daughter team promotes the Tribe's sense of family, as well as models its customary respect for its elders.

The Yavapai Apache Nation's substance abuse prevention program fuses culture with substance use prevention education by helping youth develop coping skills to manage symptoms related stress and boredom. This is achieved through teachings from their elders about what the youths' ancestors did to cope prior to colonialism and the introduction of alcohol. The Yavapai Apache Nation also incorporates the development of youth leaders and peer support through their implementation of MPWRD program.

Centered Spirit, a Pascua Yaqui Tribal behavioral health program in Guadalupe, offers educational programs and holds community events where they distribute educational material and have educational games for children about substance use and/or misuse. The programming includes instruction how to live a healthy lifestyle and follow Pascua Yaqui customs and traditions and is the only prevention program in Guadalupe. Children attend schools in different school districts in nearby towns, so there are not any school prevention programs in Guadalupe. The fact that the Tribe is supporting the Centered Spirit program is

one of the community's strengths and is a strong indicator that the Tribe is committed to substance use and/or misuse prevention. Additional funding would help the Tribe strengthen and expand the program.

Refugee Populations

Interviews with two key informants that work with refugee populations agreed that there are ongoing prevention efforts for refugees. In the Tucson area, Family Passages at La Frontera (the "only program of its kind") offers one-on-one or group prevention efforts in the populations' first languages and from volunteer facilitators from the target populations (Iraqi, Somali, Congolese in the past, Russian).

Four prevention strategies are currently available in the community serving refugee populations:

(1) *Botvin's Life Skills*, which includes substance use and/or misuse topics, it is used with kids and adults. A first language facilitator translates for adults/parents, who are often illiterate in their own language. The kids are provided the program in English using the Botvin curriculum that corresponds to their language level (rather than grade);

(2) *RX 360 about Prescription Drug Misuse Program* from the State (for adults and kids);

(3) *ASU/Parent Institute's American Dream Curriculum* addresses protective factors by assisting parents to help their children to be successful in education. The educational focus is important to the refugee community;

(4) the *Youth to Youth Peer to Peer Program* for children.

La Frontera's respondent reported that they have great success with American Dream. Parents stay engaged and "outcome measures are through the roof." La Frontera does not collect data on actual use by participants in prevention efforts (because of social bias that undermined honesty) but reported that all the programing is effective in changing attitudes towards alcohol and drugs and noted that efforts are effective "because they are delivered in first [native] languages."

Refugee and Immigrant Service providers (RISPNet) is a coalition that all settlement agencies, the Health Department, law enforcement, and service providers are a part of and includes refugee community representatives. RISPNet discusses different topics at community meetings and 1-2 sessions a year are on substance use and/or misuse. The refugee community representatives take information from these monthly meeting back to their communities in an effort to "raise awareness."

Although the IRC (International Rescue Committee) used to do substance use support groups,

(which participants liked) they no longer have the capacity. When IRC encounters a client with an alcohol issue, they meet with them one-on-one and refer them to counseling. "When we talk with a person with issues, we talk about available treatment but also the possible consequences" – extreme consequences for this population.

Tangential prevention efforts include a soccer team for kids from dysfunctional families.

Promotores

Promotores conduct workshops and trainings for parents to model how not to let youth touch alcohol. Principals often allow promotores to present at schools, but parents do not attend. Programming also occurs at churches to help the community learn how to "say no". Community centers and public places have posters with prevention messages, but respondents indicated they are boring and people most likely don't pay attention. A desire to be more creative and more culturally appropriate in prevention programs was expressed. Some examples of this more creative programming included a drug prevention drama performance at a mall and a Drug Prevention Expo conducted by a church organization that had stations with different drugs and interactive role play with actors at each station.

Innovations in Prevention Programs

A selection of some innovations in prevention programs that were mentioned by key informants are noted below:

> "At the high school we work hard on building relationships with kids and making sure they have their social and emotional needs met. Because we have a lot of kids coming from non-traditional families and single parent households. We have a relationship building class that is 30 minutes a day and keep kids all four years to build that trust. Each teacher stays with 20 kids over four years. Then we know every kid has one adult for help if they need it. To primarily give students a sense of belonging. If there are issues they are having they can have at least one adult that they can trust and talk to. A place where someone cares about them. If you have those things in your life you have a shot at saying no to drugs. We have seen kids struggling in other communities and they come here and are successful. The difference is the relationships we build. I know it works." (Central Arizona School Administrator Key Informant)

> "Since the juvenile detention center was closed, a Navajo County after-school program at an at-risk high school was started. The program was designed by the Navajo County School District using the Kids of Hope program as a model. This model is used in juvenile detention facilities and many schools are starting to adapt it to their own needs. The program offers different activities including life skills and activities that are interest driven by the students. The aim of the program is to try and create positive lifelong

change. Some children come voluntarily and children in probation also attend. From 2:00 to 4:00 there are youth care workers (not probation officers) in one building right next to the office space for probation officers. Their proximity has proven to be very useful. Currently there are 22 attendees, but we are just scraping the surface. Part of the issue is transportation. It takes a long time for kids to travel to the program, and this is a real challenge. In addition to this after school program, the probation office offered a summer program and some at-risk youth who were going to be sent to Florence for juvenile detention were able to participate and work their way out of their sentences. The after-school program is only two years old, so any evidence is just anecdotal at this point. However, the reasoning behind the program is that if kids are engaged during those time frames, there will be less substance use, because availability is reduced." (Navajo County Key Informant)

"More recently in Maricopa County, environmental strategies (such as enforcing social host ordinances) have been integrated with traditional prevention efforts, such as life skills programs in schools and parenting programs. Adding in the enforcement of social host ordinances has had a greater combined impact than life skills and parenting programs alone. In addition, prevention experts are using social media campaigns to expand the reach of coalitions. The social media campaigns target research findings specific to each population. For example, one social media campaign targets parents who thought that youth were getting drugs from outside of the home when they were really getting drugs from the parents' medicine cabinets." (Maricopa County Key Informant)

Workforce Survey

As stated above, a workforce survey was developed to collect information from statewide members of the Substance Use Prevention Workforce. A number of questions contained in the survey assisted in adding information and insight about what current prevention efforts are occurring in Arizona, and also described the background and expertise of this workforce. There were 142 respondents to the Prevention Workforce Survey. Although it is not possible to determine the formal generalizability of this findings without knowing the degree to which this number represents the entire Substance Use Prevention Workforce, this number is substantial and includes one or more individuals representing every county in Arizona, making the results a useful resource to guide planning.

Demographics

Exhibit 59 illustrates the distribution of education levels across respondents. The majority of respondents (53.6%) had a postgraduate education.

Exhibit 59. Distribution of Education Levels (N=140)

	Number	Percentage
High school graduate	4	2.9%
Some college	23	16.4%
College graduate	38	27.1%
Postgraduate	75	53.6%
Total	140	100%

Exhibit 60 illustrates the distribution of languages spoken fluently by the respondents. The majority of respondents spoke only English. Languages other than English and Spanish that were reported were German, Portuguese, Samoan, and Apache.

Exhibit 60. Distribution of Languages Spoken Fluently (N=141)

	Number	Percentage
English only	112	79.4%
English and Spanish	23	16.3%
English and another language	5	3.5%
Spanish only	1	0.7%
Total	141	100%

Exhibit 61 illustrates the length of time respondents had worked in substance use prevention at the time of the survey. The largest percentage (35.9%) had worked in substance use prevention for over 10 years.

Exhibit 61. Length of Time Working in Substance Use Prevention (N=142)

	Number	Percentage
Less than one year	23	16.2%
2-4 years	36	25.4%
5-7 years	17	12.0%
8-10 years	15	10.6%
More than 10 years	51	35.9%
Total	142	100%

Exhibit 62 illustrates the work status of respondents. Most respondents reported they work full time in substance use prevention.

Exhibit 62. Work Status of Respondents (N=142)

	Number	Percentage
Full time	109	76.8%
Part time	17	12.0%
Volunteer	10	7.0%
Other	6	4.2%
Total	142	100%

Six respondents reported that they had an "other" work status and five elaborated in an open-ended question. "Other" responses included:

- Administrative supervision for a prevention program
- Member of recovery community
- Coalition coordination for education, prevention and advocacy
- General Administrative functions
- SAMHSA grant - FR-CARA

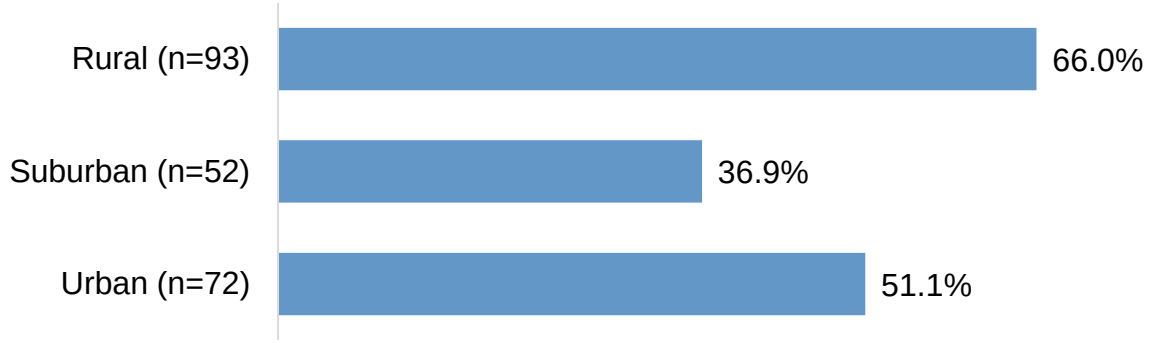
Exhibit 63 illustrates the counties in which the respondents reported working. Respondents could report more than one county and several respondents reported working in more than one county (n= 28); most respondents (n=113) reported working in only one county. There was representation reported in every Arizona county, with the largest representations serving the two counties with the largest urban centers – Maricopa (n=54) and Pima (n=31).

Exhibit 63. Counties where Respondents Engage in Substance Use Prevention (N=141)

County	Number
Apache	8
Cochise	15
Coconino	18
Gila	20
Graham	14
Greenlee	10
La Paz	8
Maricopa	54
Mohave	17
Navajo	12
Pima	31
Pinal	17
Santa Cruz	12
Yavapai	22
Yuma	9

Exhibit 64 illustrates the type of communities served: rural, suburban and urban. Respondents could report more than one type of community and many respondents (n= 54) reported working in more than one type of community; most respondents (n=87) reported working in only one type of community. Rural communities were the most commonly represented.

Exhibit 64. Types of Communities Served (N=141)



*Respondents could report more than one type of community.

Workforce Qualifications

Exhibit 65 illustrates what training respondents reported they had received to help them be more prepared to support substance use prevention efforts. Respondents could report having more than one kind of training. The most frequently identified training was Cultural Competency, which 71.1% of respondents reported they received. There were indications that suicide prevention training such as Applied Suicide Intervention Skills Training (ASIST) and SafeTALK may be more accessible to those working in substance use prevention than more directly relevant training such as SAPST (Substance Abuse Prevention Specialist Skills Training). This may also reflect a joining of prevention efforts in both areas in this workforce.

Exhibit 65. Training related to substance use prevention that respondents reported they had received (N=97)

	Number	Percentage
Cultural Competency 101	69	71.1%
Strategic Prevention Framework - Introduction to the Strategic Prevention Framework	47	48.5%
ASIST	46	47.2%
Strategic Prevention Framework - Strategic Planning/Logic Models	45	46.4%
Strategic Prevention Framework - Coalition Capacity Building/Coalition Development	40	41.2%
SafeTALK	38	39.2%
Strategic Prevention Framework - Conducting a Community Needs Assessment	37	38.1%
SAPST (Substance Abuse Prevention Specialist Skills Training)	33	34.0%
Strategic Prevention Framework - Evaluation/Sustainability	32	33.0%
QPR (Question, Persuade, Refer)	23	23.7%

Twenty-one respondents reported obtaining "other" training to help them be more prepared to support substance use and/or misuse prevention efforts, providing responses that fell into the following themes:

- Screening Brief Intervention and Referral to Treatment (SBIRT)/Motivational Interviewing
- Academic Degrees/Certifications (e.g., MSW)
- Mental Health First Aid
- Trauma
    - Adverse Childhood Events (ACEs)
    - Domestic/Sexual Violence
    - Child Abuse Training
- General Curricula
    - Substance Use
    - Youth Mental Health
    - General Mental Health

    - Ethics
    - Life Skills
    - Adolescent Brain Development
- Specific Curricula
    - Rx-360
    - Stand Up Speak Up (Cultural Competence/Empowerment)
    - Indian Country Drug Endangered Children (DEC)
- Training in Program/Practice Implementation
    - 7 Challenges Teen
    - Harm Reduction
    - Collaborative Assessment & Management of Suicidality (CAMS)
- Administration (e.g., Case Management, Substance Abuse Train the Trainer)

Two respondents volunteered that they had no specialized training in substance use and/or misuse prevention.

Exhibit 66 illustrates where respondents reported getting substance use prevention-related trainings and certifications. Respondents could report receiving training from more than one source.

Exhibit 66. Where Respondents Reported Getting Substance Use Prevention-Related Trainings and Certifications (N=89)

Training Source	Number	Percentage
SAMHSA (Substance Abuse and Mental Health Services Administration)	78	87.6%
CADCA (Community Anti-Drug Coalitions of America)	41	46.1%
TRBHA (Tribal/Regional Behavioral Health Authority)	34	38.2%
OJJDP (Office of Juvenile Justice and Delinquency Prevention)	15	16.9%
SPRC (Suicide Prevention Resource Center)	8	9.0%

Thirty respondents reported obtaining training from an "other" source different from those provided; responses fell into the following themes:

- Federal Government

    - HRSA (Health Resources & Service Administration, Fed)
    - HIDTA (High Intensity Drug Trafficking Area Program, DEA) (n=3)
    - ONDCP (Office of National Drug Control Policy)
    - DOJ (Department of Justice)
    - National Conferences
- State Government
    - Governor's Office
    - State Conferences
    - "Some trainings offered by [the] State"
- Community Training
    - Coalitions and Partnerships (n=5)
    - Trainings held within the community
    - WYGC (West Yavapai Guidance Clinic)
    - Northern Arizona Council of Governments (ACOG)/Area Agency on Aging (AAA)
- Non-Profits
    - NIDA (National Institute on Drug Abuse)
    - drugfree.org
    - Drug Policy Alliance
    - End Violence Against Women International (EVAWI) (trauma-informed care)
    - National Center on Domestic Violence, Trauma and Mental Health (trauma-informed care)
- Healthcare Organizations
    - Health Choice Arizona
    - Cenpatico
    - Touchstone Health Services
- Continuing Education
    - Online Continuing Education Units (CEUs) (e.g., Relias Academy) (n=3)
    - CEU for Arizona Board of Behavioral Health Examiners (AZBBHE)
    - Continuing Medical Education (CME)

    - American Society of Addiction Medicine (ASAM)
    - National Commission for Health Education Credentialing (NCHEC/CHES)
- Academic Institutions
    - ASU (e.g., Southwest Interdisciplinary Research Center (SIRC)) (n=4)
- Journals (e.g., American Family Physician) (n=2)
- Conferences and Seminars (e.g., American Academy of Family Physicians conferences) (n=2)
- Moral Reconation Therapy (MRT)

Thirty-four respondents reported that they were qualified to conduct trainings in substance use and/or misuse prevention. They reported being qualified in the trainings as illustrated in Appendix E, organized by the counties in which prevention work was reported. No one working in Apache County reported having training capacity.

Respondents were asked if they have Arizona Certified Prevention Professional (ACPP) certification. Of 116 respondents who answered the question, only nine (7.8%) reported that they had ACPP certification. Of these, most (n=7) had a Level IV; one had a Level II and one had a Level I. In addition to ACPP, The Arizona Board for Certification of Addiction Counselors (ABCAC) also offers a Certified Prevention Specialist (CPS) designation. Respondents were not asked directly about this certification.

Respondents were asked to report on the types of substance use prevention in which they engaged. Respondents could report more than one type of substance use prevention in which they engaged. Most respondents (n=119 of 140) reported engaging in more than one type of substance use prevention effort. Exhibit 67 illustrates the number of individuals who reported engaging in each type of prevention work. The most common type of prevention that respondents reported engaging in was providing information, followed by enhancing skills and providing support.

Exhibit 67. Types of substance use prevention respondents engaged in. (N=140)

	Number	Percentage
Provide information (e.g., presentations, PSAs, billboards, programs, classes)	111	79.3%
Enhance skills (e.g., training, classes, programs)	102	72.9%
Provide support (e.g., mentoring, referrals, youth clubs, providing alternate activities)	91	65.0%
Enhance access/reduce barriers (e.g., transportation, housing, childcare, access to treatment, education)	61	43.6%
Modify/change policies (e.g., public policy, laws)	35	25.0%
Change consequences (e.g., incentives/disincentives including citations, fines, rewards)	23	16.4%
Change physical design (e.g., parks, landscapes, signage, lighting)	14	10.0%

*Respondents could report more than one type of substance use prevention they engaged in.

Seven respondents reported that they engaged in an "other" type of prevention work, providing responses that fell into the following themes:

- administration/oversight (n=7),
- substance use treatment (n=4),
- change systems (e.g., cross-sector integration),
- training for First Responders, and
- provide funding to community groups doing substance use and/or misuse prevention work.

Respondents were asked to report on the types of substance use prevention happening in their community and were provided with the same response options as the above question. Respondents could report more than one type of substance use prevention happening in their community. Almost all respondents (132 of 140) reported more than one type of substance use prevention effort happening in their community. Exhibit 68 illustrates the number of individuals who reported each type of prevention effort happening in their community. The most common type of prevention that respondents reported was happening in their community was providing information, followed by enhancing skills and providing support. These types of efforts were reported by a very high percentage of respondents.

Exhibit 68. Types of Substance Use Prevention Happening in Respondents' Communities* (N=140)

	Number	Percentage
Provide information (e.g., presentations, PSAs, billboards, programs, classes)	131	93.6%
Enhance skills (e.g., training, classes, programs)	125	89.3%
Provide support (e.g., mentoring, referrals, youth clubs, providing alternate activities)	117	83.6%
Enhance access/reduce barriers (e.g., transportation, housing, childcare, access to treatment, education)	88	62.9%
Modify/change policies (e.g., public policy, laws)	50	35.7%
Change consequences (e.g., incentives/disincentives including citations, fines, rewards)	49	35.0%
Change physical design (e.g., parks, landscapes, signage, lighting)	31	22.1%

*Respondents could report more than one type of substance use prevention they engaged in.

Two respondents reported an "other" type of prevention work in their community, providing the following responses:

- [developing a] coalition; and
- change systems (e.g., cross-sector integration).

Respondents were asked, "What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?" The most common responses relating to primary prevention are illustrated in Exhibit 69. See Appendix E for the full list of responses, including responses related to treatment.

Exhibit 69. The Most Common Response Themes to "What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?"

Theme	n
Activities available (e.g., for youth, low-cost/free after school care)	15
Meeting basic needs (e.g., career training/jobs/economic mobility, financial assistance, housing, education, healthcare/mental healthcare, transportation)	13
Education/training generally	13
Education/awareness efforts for the community	8
Education/awareness classes/efforts at the family level	7
Education/awareness classes address danger/ long term effects of substance use and/or misuse	6
Coalitions/community-driven efforts	6
Honest dialogue (e.g., with youth)	5
Education/awareness classes/efforts at the school level	5
Programming for youth/adults with emotional risk factors (e.g. trauma, children of addicts/users)	5
Comprehensive/holistic strategies at multiple levels of the community with common messaging	5
Schoolchildren/youth	5
Mentoring	4
Creating connectedness (e.g., with family, school, community	4
Reach kids before they become at risk/before use starts	4

The following quotes highlight themes related to the question asked above:

> "There needs to be prevention information in the schools, in the home and the community. The best people to do this are primary preventionists. They are always out in the community. When prevention coalitions are funded they multiply each dollar spent by bringing 100s of people together to help do the work. The prevention force is strong and needs to be funded and fully utilized as a first line of defense. People need to hear face to face from people they know and trust that they are supported and to engage them in prevention education.....Local efforts go a long way and they are best facilitated by local prevention groups. This helps the messaging be on target for the local community as well."

"A comprehensive mix of strategies addressing a multitude of domains (individual, family, community, institutional, environmental), so the same messages reach everyone in the community and are consistent over time. We need to change the conditions in the communities we serve (i.e. address the intervening variables about why substance use is happening) in order to reduce substance use. We also need to be able to fund adequate evaluation efforts to be able to support effective prevention programs and make modifications as needed. One-time parent nights are not enough. Collaborations with community-based coalitions are critical."

"Social and emotional learning skills, coping and wellness skills, and reality-based education (i.e. real-life stories and people who have overcome substance use disorder). Most critical is that the efforts are truth based, not fear based, and are accurate, not full of "worst case scenarios" or inflated harm statistics."

Respondents were asked, "What substance use prevention activities have you seen that have been the most successful in engaging the community?" The most common responses relating to primary prevention are illustrated in Exhibit 70. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 70. The Most Common Response Themes to "What substance use prevention activities have you seen that have been the most successful in engaging the community?"

Theme	n
Community-building/Social events (e.g., town halls, community fairs, programs with food, for the whole family)	13
Coalitions	10
Family/parent-oriented	9
Alternative activities (e.g., generally, after prom, after graduation)	7
Information-sharing (that lets people make their own decisions)	6
School-based	5
Casual Face to face interactions/not "professional"	4
Enhance skills (e.g., Teaching critical thinking skills/life skills to schoolchildren)	4
Promoting youth leadership	4
Fun/ Associated with a fun event	4
Community education (e.g., Symposiums that highlight educational warning signs of substance use and/or misuse.)	4

Respondents were asked, "Are there any types of substance use prevention efforts that you don't think help much or at all?" The most common responses relating to primary prevention are illustrated in Exhibit 71. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 71. The Most Common Response Themes to "Are there any types of substance use prevention efforts that you don't think help much or at all?"

Theme	n
Scare tactics	15
General handouts/posters/marketing material/commercials/media campaigns	10
Just say no strategies	9
Programming that demonizes drug users/negative messaging	6
Single presentations/events not connected to a larger strategy (e.g. town halls)	4
Relying on untrained staff (e.g. at schools) to deliver the program unsupported (rather than partnering with prevention experts/coalitions)	4

Addressing Demographic Characteristics and Underlying Causes

Respondents were asked, "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program (race/ethnicity, urban/rural, veterans, LGBTQ, youth, seniors, foreign language users, etc.)." The most common response relating to primary prevention was taking primary language into consideration. In order to effectively highlight all strategies that respondents are using to take into consideration demographic characteristics of participants, all responses relating to primary prevention are illustrated in Exhibit 72. See Appendix F for the full list of responses, including responses related to treatment.

> "Before implementing program or PSAs for a target population we will talk to our target population to receive feedback. In all of our prevention activities, we ask for feedback and speak with our target population to learn if it is culturally competent for that population."

> "CLAS standards are in force, and each contracted program has guidelines on each standard. These include making program tools accessible, making adaptations to reading level, language, font size, method of dissemination, etc. For example, our LGBTQ program uses tools to capture a variety of gender identification options, and our older

adult program uses large font on their evaluation and program materials."

"One has to be aware and willing to adapt to the needs of the ones you are trying to help. If poverty is huge with a specific group, having food anytime you work with them (and maybe some left over for them to take home is important)."

"We are required to complete an educational program aimed at increasing understanding and awareness around how to foster and inclusive and welcoming climate for the LGBTQ community."

Exhibit 72. All Themes to "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program?"

Theme	n
Primary language taken into consideration (e.g., interpretation provided; hire bilingual staff)	19
Program tailored to/inclusive of the population (e.g., youth, seniors, LGBTQ)	17
Be ready to serve everyone from any demographic/treat everyone with respect	17
Tailoring materials/evaluation tools (e.g. language, font, gender options)	8
Training staff in subpopulation issues (e.g., cultural competency, LGBTQ, trauma-informed)	7
Seek feedback from the target population (e.g., before or while implementing a strategy)	7
Recognize/Identify/understand the demographic characteristics/needs of the target population/community (e.g., needs assessment)	6
Hire staff/recruit coalition members/volunteers from the community/demographic	5
Collaborate with partners/agencies that work with the target population (e.g. LGBTQ)	5
Promote accessibility (e.g., Reach them in a common/convenient location/schedule at a convenient time)	3
Financial considerations (e.g. providing food, no cost services)	2
Awareness in facility management (e.g., bathrooms not segregated by gender, disability-accessible bathrooms, microphones at trainings for seniors)	2
Aware of potential for prejudice by participants/try to address	2
Adapt programs to be culturally relevant	1
Inclusive marketing materials	1

Tailor referral options	1
Outreach efforts to marginalized communities	1

The following quote is an example of an agency seeking to recognize and integrate demographic characteristics in a holistic way:

> "We use specific strategies for specific populations. For example- we know that our rural, oppressed populations living in poverty are never going to throw away their drugs. So, for them we educate and propose locking caps and lock boxes. We have to be culturally sensitive and realistic. These people do not have access to nor can afford Rxs so they do keep them even after the ailment has subsided. Whatever population we are working with we make sure that we have representatives of that population working on the team to guide strategies and to deliver interventions. We use local translators vs. "professional" translators who often use commercial translating programs that do not speak to the local populations served. We use someone from the community we are speaking to do the translation. It is cheaper and more effective. For elderly populations it is important to have microphones as many are hard of hearing."

Respondents were asked, "How does your agency/coalition/organization address underlying causes of addiction (e.g., poverty, historical trauma, systematic oppression, poverty)?" The most common responses related to educating staff/providers/coalition leaders. In order to effectively highlight all strategies that respondents are using to address underlying causes of addiction, all responses relating to primary prevention are illustrated in Exhibit 73. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 73. All Themes to "How does your agency/coalition/organization address underlying causes of addiction?"

Theme	n
Providing general resources and referrals to meet basic needs	9
Educating staff/ providers/coalition leaders (e.g. on ACES; systemic oppression; cultural awareness)	8
Youth-focused poverty-prevention strategies (e.g. teen pregnancy prevention, decision-making; social skills; general education)	4
Collaborating with the local community	3
Whole family education	2
Addressing social isolation for seniors	2
Not ignoring the issue	2
Tailoring programming for the population (e.g., language awareness/using primary language)	2
Addressing mental health	2
Including underlying causes information shared (e.g., using a curriculum that recognizes underlying risk issues	2
Educating community (e.g. on ACES; underlying causes of addiction)	2
Adult-focused poverty-prevention strategies (e.g. resume development; healthy relationships)	2
Teaching participants to advocate for themselves	2
Recognizing local historical trauma	2
Hiring from within the local community	1
Youth shelters	1
Collaboration with other agencies (e.g. working with high risk youth)	1
Utilizing available resources from the State, etc.	1
Diversion program	1
Providing access (e.g., going to the community)	1
Providing positive alternate activities	1
Advocate for policies that address underlying causes	1

"Our agency hires from within the communities we serve to get an "insider" perspective and to have someone who is aware of any historical considerations."

"Being mobile and bringing our information and resources to communities, rather than always making them come to us."

Other volunteers indicated that they did not address underlying causes and six respondents specifically noted that they did not have sufficient resources to do so:

"It doesn't do it well. We do not have enough money or staff to do this justice. We are just barely scratching the surface of a huge problem for our community."

"It is difficult to do any of this work with the constant reductions to funding and resources."

"Our organization's prevention and education section is unfortunately very small, and thus are not able to address upstream factors/underlying causes as much as we wish to."

"Very little to none. We are funded by a grant to concentrate on working with the medical community. There are no funds available to address this issue. All mental health facilities in our community are at capacity and only focus on their current members- no outreach is done."

"We never have enough funding, but the community looks to us to do it all. Coalitions really bring people and resources together and without funding it becomes difficult to do this."

Causal Factors

Secondary Data Analysis

Substance use prevention efforts aim to modify the underlying factors that are associated with substance use and/or misuse, either by preventing known risk factors, or by enhancing protective factors (Hawkins, Catalano & Miller, 1992). Epidemiological data can help estimate the prevalence of risks and protective factors, identify areas of relative susceptibility and strength, monitor changes overtime, and guide practitioners and policymakers to make the most informed decisions regarding prevention services.

Risk and protective factors are often organized using a socio-ecological framework, which helps highlight unique risks that exist across different levels of influence (e.g., the individual, relationship, society and community levels). For instance, at the individual level risk factors may include a genetic predisposition to substance use and/or misuse or a negative self-image. At the relationship level, pro-social and supportive relationships are protective against substance use and/or misuse, while maltreatment or lack of parental involvement are

considered risk factors. At the community level, neighborhood poverty, violence, and school environments influence risks for substance use. Finally, at the societal level, substance use norms and laws can influence patterns of use and misuse (SAMHSA, 2018).

It is important to note that interpreting risk and protective factors is not straightforward. The causal mechanisms of substance use and/or misuse are thought to be multifaceted and complex. The exact pathways that lead some individuals to substance use and/or misuse while other individuals do not engage in these behaviors are not completely understood. Additionally, risk factors important to one subgroup, or at one specific developmental period in the life course, may be less influential for other subgroups or at other times (Swendsen et al, 2009). It is generally accepted that risk factors are correlated with one another and cumulative in nature. Stated another way, this means that the presence of a single risk factor predicts additional risk factors, and that the quantity of risk factors an individual has is highly correlated to their likelihood of using or misusing alcohol, tobacco or drugs (SAMHSA, 2018).

Although numerous factors have been shown to be associated with substance use, epidemiological data are regularly collected for only a limited number of indicators. This section of the report summarizes the available quantitative data on risk and protective factors for adults and youth. In reviewing this section, please note that certain sociodemographic factors are also correlated with substance use and/or misuse risk, including lower educational attainment, poverty, unemployment, and other indicators of social disadvantage. Many of these indicators were already presented in the section on "Arizona's Demographics" and are not revisited in detail in this section of the report. As previously stated, these factors are not uniformly distributed across Arizona, with numerous areas across the State experiencing disproportionate levels of social disadvantage that may influence substance use and/or misuse risks.

Perceived Risks from Substance Use

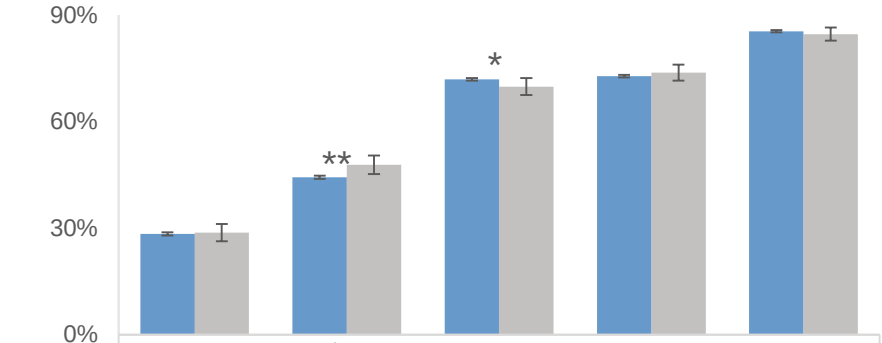
Research demonstrates that greater perceptions of harm from alcohol, tobacco or drugs is associated with lower rates of substance use (Lipari et al, 2017). NSDUH asks respondents how much risk of harm they perceive from the following substance use behaviors:

- smoking marijuana once a month
- drinking five or more alcoholic beverages once or twice a week
- using cocaine once a month
- smoking one or more packs of cigarettes a day
- trying heroin once or twice

In Arizona, perception of harm was highest for "trying heroin once or twice" (84.6%), and lowest for "smoking marijuana once a month" (28.7%). Arizona's 12 and older population

perceived marginally less risk from cocaine use than national estimates (69.9% vs 71.9%, p=0.078), and more risk from binge alcohol use (47.8% vs 44.3%, p=0.007) (See Exhibit 74).

Exhibit 74. Prevalence of Perceptions of Great Risk of Harm from Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



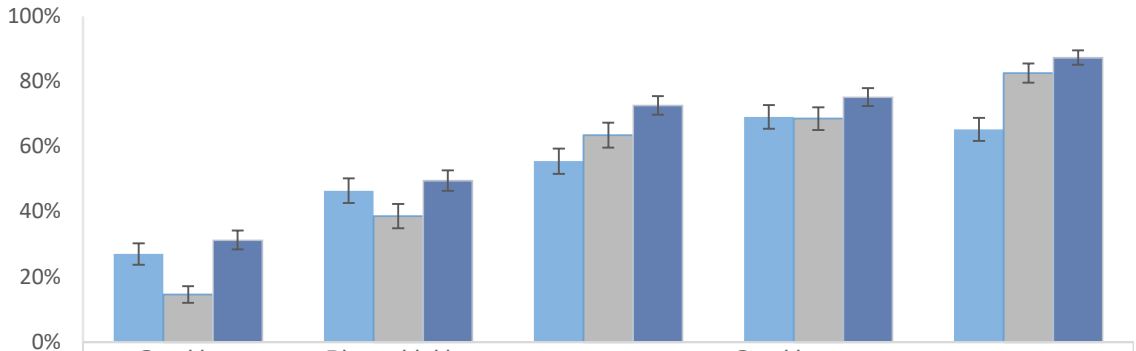
	Marijuana	Binge Drinking	Cocaine	Smoking	Heroin
U.S.	28.4%	44.3%	71.9%	72.8%	85.4%
Arizona	28.7%	47.8%	69.9%	73.8%	84.6%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<0.10, or significant at p<0.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Differences by age group

There were differences in patterns of perceived risk by age group for each measure of substance use. Specifically, in Arizona youth 12 to 17 perceived the least amount of risk for heroin and cocaine use of any age group. Adults aged 18 to 25 perceived the least amount of risk for binge drinking and marijuana use (See Exhibit 75).

Exhibit 75. Prevalence of Perceptions of Great Risk of Harm from Substance Use by Age Group for Arizona, 2015-2016



	Smoking marijuana once a month	Binge drinking once or twice a week	Using cocaine once a month	Smoking one or more packs of cigarettes per day	Trying heroin once or twice
12 to 17	27.1%	46.5%	55.6%	69.1%	65.3%
18 to 25	14.6%	38.7%	63.6%	68.6%	82.6%
25 and older	31.4%	49.6%	72.7%	75.2%	87.4%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Mental Health

The co-occurrence of mental and substance misuse disorders is well-documented in the literature. Prospective studies have confirmed that individuals with serious mental illness (SMI) are more likely to transition to substance use, misuse, dependence and abuse than their peers without SMI (Swendsen et al, 2010). These data suggest mental health status is not only correlated with substance use but is an independent risk factor for substance use.

Data from the 2015-2016 NSDUH estimated the prevalence of past year major depressive disorder (MDE) and serious mental illness (SMI). Serious mental illness (SMI) is defined by SAMHSA as "adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities". MDE is defined as "a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities." The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Current national surveys do not have an indicator of SED.

In Arizona, an estimated 310,000 (6.0%) of the adult population 18 or older experienced past year MDE and 208,000 (4.0%) of the adult population met the criteria for SMI. National estimates did not statistically differ from Arizona estimates for the population overall.

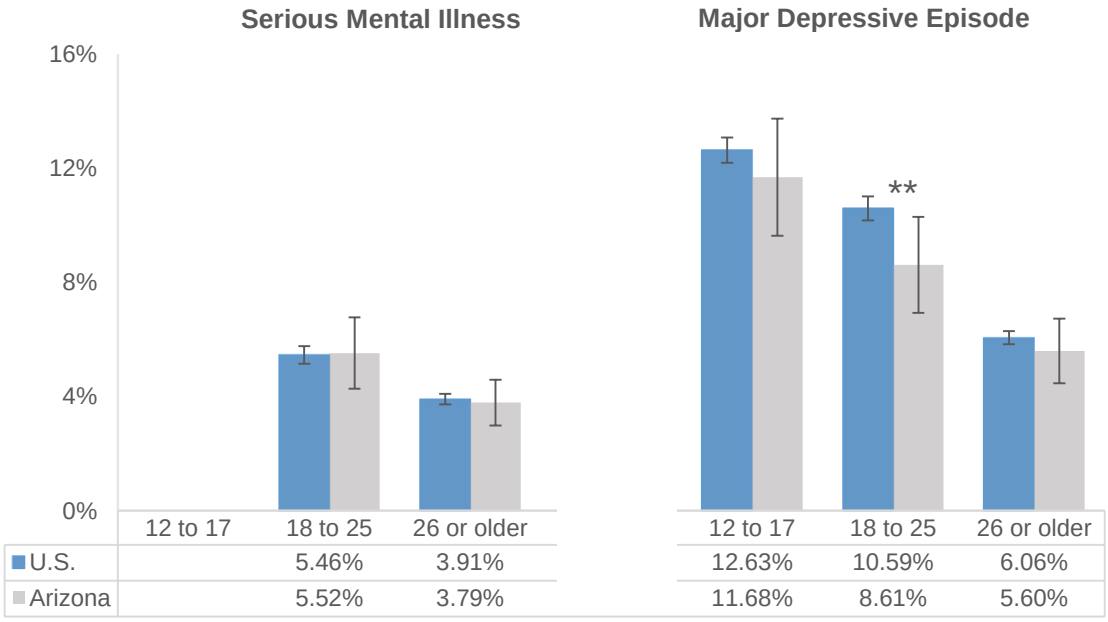
Youth Prevalence

According to data from the NSDUH, the prevalence of MDE peaked for those aged 12 to 17, with an estimated 11.7% of youth reporting past year MDE. This did not statistically differ from national estimates (12.6%) (See Exhibit 76). Caution should be used when comparing NSDUH estimates with MDE between youth and adults because separate questionnaire modules were administered for adults over 18 and youth ages 12 to 17.

The 2017 YRBS also estimated the percentage of high school students that "felt sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities, during the 12 months before the survey." According to these data, high school students in Arizona were significantly *more* likely to report poor mental health than youth nationally (36.4% vs 31.5%, p=0.02).

The somewhat contradictory findings regarding NSDUH and YRBS estimates could be explained by true differences in prevalence of MDE (i.e., Arizona high school students reported more MDE than youth nationally, while Arizona's youth in general reported less MDE than youth nationally). These differences could also be explained by chance, or by differences in sampling and estimation methodology (including differences in the years of data collection) between the two surveys.

Exhibit 76. Prevalence of Serious Mental Illness and Major Depressive Episode in the U.S. and Arizona by Age Group, 2015-2016



	Serious Mental Illness			Major Depressive Episode		
	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.		5.46%	3.91%	12.63%	10.59%	6.06%
Arizona		5.52%	3.79%	11.68%	8.61%	5.60%

**Difference between the prevalence estimate for the total U.S. and Arizona is significant at $p<0.05$
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Another indicator of mental health and substance use risk come from the 2016 Arizona Youth Survey. Students in 8th, 10th and 12th grades were asked about their reasons for using substances in 2012, 2014 and 2016. Reasons related to mental health were among the top five most commonly endorsed reasons for using substances. Although the prevalence increased from 2012 to 2016 for each of the top five reasons, the percent increase was greatest among those reasons related to mental health (See Exhibit 77). Specifically, there were larger increases in students that endorsed the personal use of substances to "deal with stress" (27.2% vs 37.3%), and those who used substances to "avoid being sad" (20.9% vs. 29.8%).

Exhibit 77. Trends in the Prevalence of the Top Five Reasons for Using Substances Among Arizona Students in 8th, 10th and 12th Grades, 2012-2016

Reasons for substance use	2012	2014	2016
To have fun	42.2%	40.1%	49.3%
To deal with stress	27.2%	28.5%	37.3%
To avoid being sad	20.9%	23.1%	29.8%
To get high	30.1%	30.4%	36.9%
New and exciting	18.8%	18.7%	22.7%

Source: Arizona Criminal Justice Commission. Arizona youth survey 2016: State of Arizona

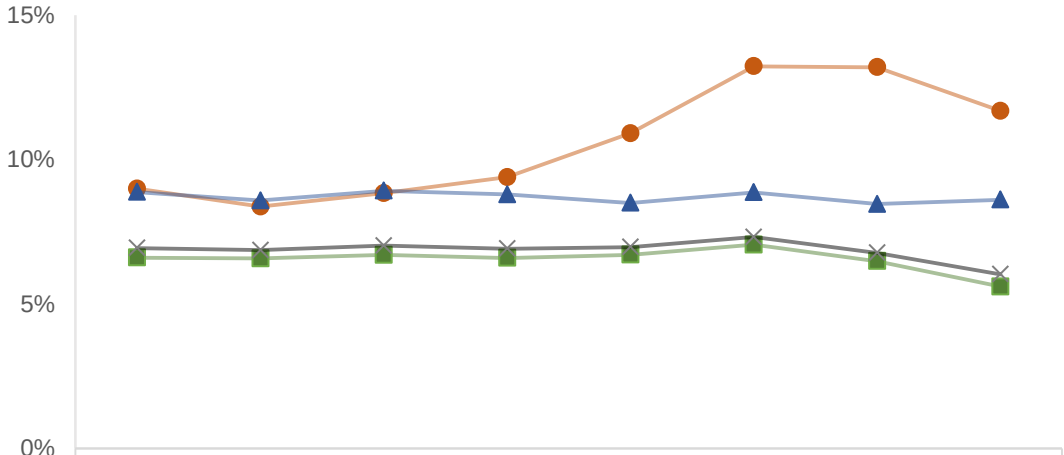
Adult Prevalence

Data from the 2015-2016 NSDUH indicated the prevalence of SMI was highest for those aged 18 to 25 (5.5%) and then decreased slightly for those aged 26 or older (3.8%)(See Exhibit 76). SMI estimates in Arizona did not statistically differ from national estimates. MDE also decreased with increasing age (See Exhibit 76). MDE estimates in Arizona did not statistically differ from national estimates for any age group except young adults, who reported significantly less MDE in Arizona than nationally (8.6% vs 10.6%, p=0.044).

Youth and Adult Trends

In Arizona, there were marginally significant increases in the prevalence of MDE between 2008 and 2016, but only for youth aged 12 to 17 (9.0% vs 11.7%, p=0.05) (See Exhibit 78). Prevalence peaked in 2013-2014 (13.2%), with a similar trend being reported nationally, suggesting MDE for youth may be on the decline; additional years of data are needed to confirm this trend. There were also significant increases in the prevalence of SMI between 2008 and 2016, but only for those aged 18 to 25 (3.7% vs 5.5%, p=0.025) (See Exhibit 79). Significant increases in the prevalence of SMI were also observed nationally for young adults.

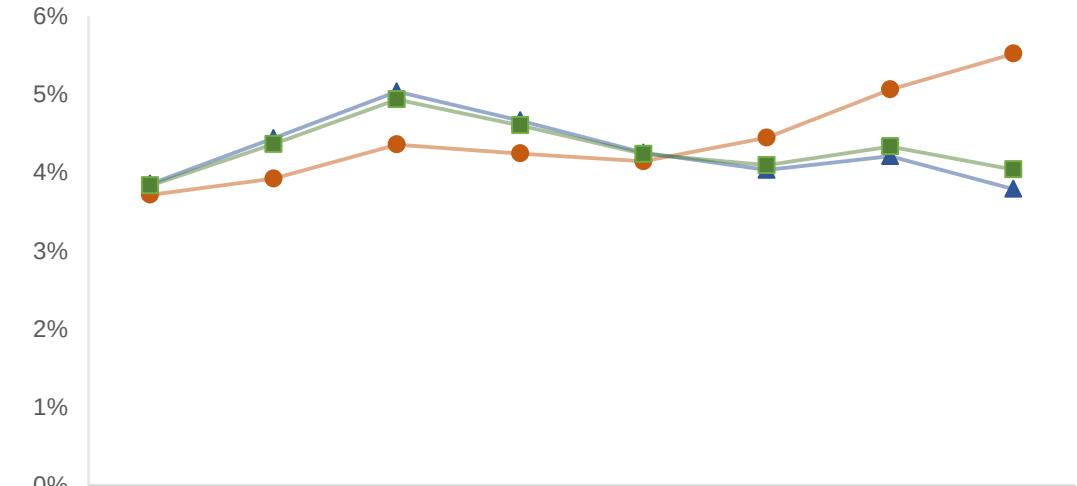
Exhibit 78. Trends in Prevalence of Past Year Major Depressive Episode in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	9.0%	8.4%	8.8%	9.4%	10.9%	13.2%	13.2%	11.7%
18 to 25	8.9%	8.6%	8.9%	8.8%	8.5%	8.9%	8.5%	8.6%
26 or older	6.6%	6.6%	6.7%	6.6%	6.7%	7.1%	6.5%	5.6%
18 or older	6.9%	6.9%	7.0%	6.9%	7.0%	7.3%	6.8%	6.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016
Note- NSDUH does not calculate the prevalence of MDE for the 12 and older population because of differences in the questionnaire module for those under 18.

Exhibit 79. Trends in Prevalence of Past Year Serious Mental Illness in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
18 to 25	3.7%	3.9%	4.4%	4.2%	4.1%	4.4%	5.1%	5.5%
26 or older	3.9%	4.4%	5.0%	4.7%	4.3%	4.0%	4.2%	3.8%
18 or older	3.8%	4.4%	4.9%	4.6%	4.2%	4.1%	4.3%	4.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016
Note: SMI is not calculated for those under 18

Prevalence by RBHA

There were no statistical differences in MDE or SMI prevalence across RBHAs in Arizona.

Youth Disparities

The 2017 YRBS data revealed disparities in mental health status among sub-populations of Arizona's high school students.

- Gender: Female high school students in Arizona were significantly more likely than males to report poor mental health (46.4% vs 26.3%, p=<0.001).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of poor mental health (31.6% vs 69.7%, p<0.001). The risk was most pronounced for females identifying as gay, lesbian or bisexual, with three out of four (75.8%) reporting a depressive episode. In fact, gay, lesbian and bisexual female students experienced significantly more depressive episodes than heterosexual females (75.8% vs 40.5%, p<0.001), and marginally more than males identifying as gay or bisexual (75.8% vs 54.5%, p=0.05).
- Race/Ethnicity: There were no significant differences in alcohol consumption indicators between non-Hispanic White and Hispanic high school students. There were no data available to estimate disparities in mental health in YRBS for American Indian youth.

Adult Disparities

Data were not available to estimate disparities in mental health for adults.

Early Age of Substance Use

Numerous studies have found that early age of first substance use, in addition to being detrimental to youth's health and development, is an important predictor of later substance use, misuse, dependence and abuse (Grant et al, 2001; Nkansah-Amankra et al, 2016). Data from the 2017 YRBS provided estimates of the percentage of Arizona high school students that tried alcohol, tobacco, or marijuana before the age of 13.

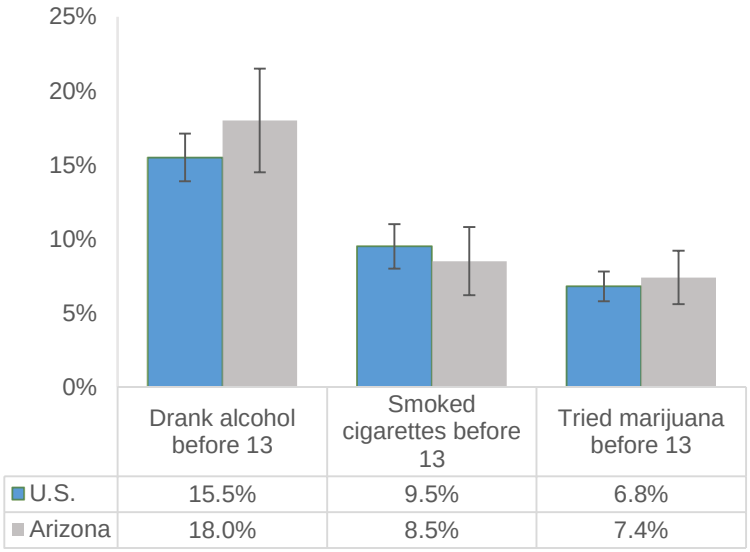
Alcohol Use

An estimated 18.0% of Arizona high school students reported that they had their first drink of alcohol, other than a few sips, before the age of 13 (See Exhibit 80). Arizona's estimate of early alcohol use did not differ significantly from the national estimate. Trend analyses reveal there were significant decreases in the prevalence of early alcohol use between 2009 and 2017 (29.5%vs 18.0%, p<0.01).

The YRBS 2017 revealed important disparities in early age of alcohol use among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly less likely than males to report early alcohol use (15.0% vs 20.8%, p=0.01).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early alcohol use (27.5% vs 16.6%, p=0.01).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they drank alcohol before 13 than non-Hispanic white students (21.4% vs 14.6%, p=0.02). Estimates for other racial and ethnic groups were not available.

Exhibit 80. Prevalence of Early Age of Substance Use Initiation among High School Students for the U.S. and Arizona, 2017



	Drank alcohol before 13	Smoked cigarettes before 13	Tried marijuana before 13
U.S.	15.5%	9.5%	6.8%
Arizona	18.0%	8.5%	7.4%

Source: Centers for Disease Control and Prevention. High School Youth Risk Behavior Survey Data, 2017.

Cigarette Smoking

An estimated 8.5% of Arizona high school students reported that they first tried cigarette smoking before 13, which does not differ significantly from national estimates (See Exhibit 78). No trend data were available for this measure.

The YRBS 2017 revealed important disparities in early age of cigarette smoking among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were less likely than males to report

early cigarette smoking, although the differences were only marginally significant (6.8% vs 9.9%, p=0.05).

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early cigarette smoking (7.2% vs 15.8%, p<0.001).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they tried cigarette smoking before 13 than non-Hispanic white students (10.5% vs 5.6%, p<0.001). Estimates for other racial and ethnic groups were not available.

Marijuana Use

An estimated 7.4% of Arizona high school students reported that they tried marijuana before the age of 13. Arizona's estimates of early marijuana use do not differ significantly from the national estimate. There were significant decreases in the prevalence of early marijuana use between 2009 and 2017 (2009: 11.8% vs 2017: 7.4%, p<0.01)

The YRBS 2017 reveal important disparities in early age of marijuana among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly less likely than males to report early marijuana use (5.1% vs 9.7%, p<0.001).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early marijuana use (14.4% vs 6.2%, p=0.02).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they used marijuana before 13 than non-Hispanic white students (10.5% vs 3.7%, p<0.001). Because of sample size limitations, estimates for other racial and ethnic groups were not available.

Availability of Substances

Ease of access to substances is another important risk factor for youth substance use. Additionally, where and how youth gain access to substances can provide important information for prevention programmers and policymakers seeking to limit access to youth substance use and/or misuse.

Alcohol Use

The 2017 YRBS asked high school students who reported current drinking if they "usually got the alcohol they drank by someone giving it to them." Approximately 38.8% of Arizona

students endorsed this risk factor. This prevalence did not statistically differ from national estimates.

The YRBS 2017 revealed important disparities in ease of access of alcohol use among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly more likely than males to report that someone gave them the alcohol they consumed in the past month (44.6% vs 32.5%, p=0.03).

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual were less likely to report that someone gave them the alcohol they consumed (28.3% vs 41.2%, p=0.01).

No other significant disparities were reported by race/ethnicity or grade level. Additionally, the prevalence of this risk factor did not change significantly between 2009 and 2017.

The 2016 AYS asked 8th, 10th and 12th graders in Arizona where they obtained the alcohol they consumed in the previous 30 days. The most common places were at a party (42.3%), or by giving someone else money (25.7%).

Drugs on School Property

The 2017 YRBS asked high school students if they were "offered, sold, or given an illegal drug on school property (during the 12 months before the survey). Nearly 30% of high school students endorsed this risk factor, which was significantly higher than youth nationally (29.1% vs 19.8%, p<0.001). However, the prevalence of this risk factor decreased significantly in Arizona between 2009 and 2017 (34.6% vs 29.1%, p=0.02)

The YRBS 2017 investigated disparities in this risk factor by gender, race/ethnicity, grade level and sexual identify. Of these groups, only sexual identity significantly predicted differences in the prevalence of drug availability at school:

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual were significantly more likely to report drug availability at school (45.4% vs 27.3%, p=0.01).

Parental Substance Use

Parental substance use is directly correlated with youth substance use. Data from the 2016 Arizona Youth Survey (AYS) estimated the percentage of Arizona youth who ever lived with an alcoholic or drug user (See Exhibit 81). Approximately one quarter of Arizona youth reported that they lived with an alcoholic, and between 14% and 19% reported that they lived with a drug user.

Exhibit 81. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Substance Use 2016

Indicator	8th Grade	10th Grade	12th Grade
Ever lived with an alcoholic	23.1%	25.2%	26.4%
Ever lived with a drug user	13.8%	17.2%	19.2%

Source: Arizona Criminal Justice Commission. *Arizona Youth Survey 2016: State of Arizona.*

Parental Attitudes Toward Substance Use

Research has also indicated that youth who perceived their parents as more tolerant of substance use are more likely to use substances. Data from the 2016 AYS asked 8th, 10th and 12th graders in Arizona their reasons for not using substances. An estimated 59.7% of students said they did not use substances because they thought their parents might be disappointed in them. The 2016 AYS also asked participants if their parents think it is wrong for them to use cigarettes, alcohol or drugs; higher scores reflected less favorable parental attitudes towards youth substance use (See Exhibit 82).

Exhibit 82. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Disapproval of Substance Use by Grade, 2016

Parents believe it would be wrong for me to…	8th Grade	10th Grade	12th Grade
Use prescription drugs without a doctor's recommendation	98.2%	97.9%	96.9%
Smoke marijuana	97.7%	95.8%	92.9%
Smoke cigarettes	98.7%	98.2%	96.4%
Drink nearly every day	98.0%	97.0%	94.6%

Source: Arizona Criminal Justice Commission. *Arizona Youth Survey 2016: State of Arizona*

Experiences of Violence, Assault and Bullying

Numerous other risk factors are associated with youth substance use. In their national analysis of risk factors for adolescent substance use and dependence, Kilpatrick et al (2000) concluded that "adolescents who had been physically assaulted, who had been sexually assaulted, who had witnessed violence, or who had family members with alcohol or drug use problems had increased risk for current substance abuse/dependence." Dube et al (2003) found the risk of future substance use and/or misuse increased as the number of adverse childhood experiences

(ACEs) increased, and that those with five or more ACEs were 7 to 10 times more likely to report drug use.

The YRBS provided prevalence estimates for a number of these risk factors, including experiences of forced sexual intercourse, violence and bullying. Arizona and national estimates do not differ significantly for most risk factors, however Arizona youth were significantly less likely to report they were in a physical fight in the past 12 months (6.2% vs 8.5%, p=0.02), and were significantly more likely to report that they did not go to school because they felt unsafe (10.2% vs 6.7%, p=0.02)

The 2017 YRBS data revealed important disparities in these risk factors among sub-populations of Arizona's high school students. For almost all indicators, males were significantly more likely to report the risk factor than females; gay, lesbian and bisexual students were more likely to report the risk factor than heterosexual students. Risk factors specific to students identifying as gay, lesbian or bisexual are detailed in a separate section of this report.

Exhibit 83. Percentage of High School Students Reporting Substance Use Risk Factors in the U.S. and Arizona and P-Values for Significant Difference Between Estimates, 2017

Risk Factor	AZ	US	p-value
Were ever physically forced to have sexual intercourse	8.2	7.4	0.50
Were in a physical fight- Past 12 months	21.1	23.6	0.19
Were in a physical fight on school property-Past 12 months	6.2	8.5	0.02**
Were electronically bullied- Past 12 months	15.2	14.9	0.86
Were bullied on school property- Past 12 months	19.2	19.0	0.90
Did not go to school because they felt unsafe at school or on their way to or from school- Past 30 days	10.2	6.7	0.02**
Were threatened or injured with a weapon on school property- Past 12 months	7.9	6.0	0.08*
Carried a weapon- Past 30 days	15.6	15.7	0.99
Carried a weapon on school property- Past 30 days	3.5	3.8	0.69

Source: Centers for Disease Control and Prevention. *High School Youth Risk Behavior Survey Data, 2017.*

Community Risk Factors for Arizona Youth

At the state-level, poorer economic status, lower educational attainment, and lower estimates of family and community well-being are associated with youth substance use and/or misuse. The Annie E. Casey Foundation's KIDS COUNT data monitors key indicators of children's well-being on a state basis. As of 2018, Arizona ranked 45th in the nation for children's well-being, suggesting substantially above average risks exist for Arizona youth.

KIDS COUNT Data
https://datacenter.kidscount.org

Arizona ranked 45th in the nation for our children's overall well-being

- **Economic Rank: 46th**
  - Percent of children living in poverty: 24% (2016)
  - Children living in families where no parent has full-time, year-round employment: 31% (2016)
  - Children living in households that spend more than 30% of their income on housing: 32% (2016)
  - Teens aged 16 to 19 not attending school and not working: 11% (2002)
- **Education Rank: 45th**
  - Children aged 3 and 4 not in pre-kindergarten program 62%
  - 4th grade reading achievement levels: 70% below proficient
  - 8th grade math achievement levels: 66% below proficient
  - High school students not graduating on time: 13% of those 25 to 34 had not graduated from high school; the four-year graduation rate was 80% (2016)
- **Family and Community Rank: 46th**
  - Children in single-parent households: 38% (2016)
  - Children by household head's educational attainment: 17% had not graduated high school (2016)
  - Children living in areas of concentrated poverty: 23% (2012-2016)
  - Total teen births: 37 per 1,000 females aged 15-19 (2012)

Community Risks: Practices and Laws

At the community-level, common practices and laws can influence substance use and/or misuse. The two community-level risk factors explored in this section are opioid prescription practices and legalization of medical marijuana.

Opioid Prescription Practices

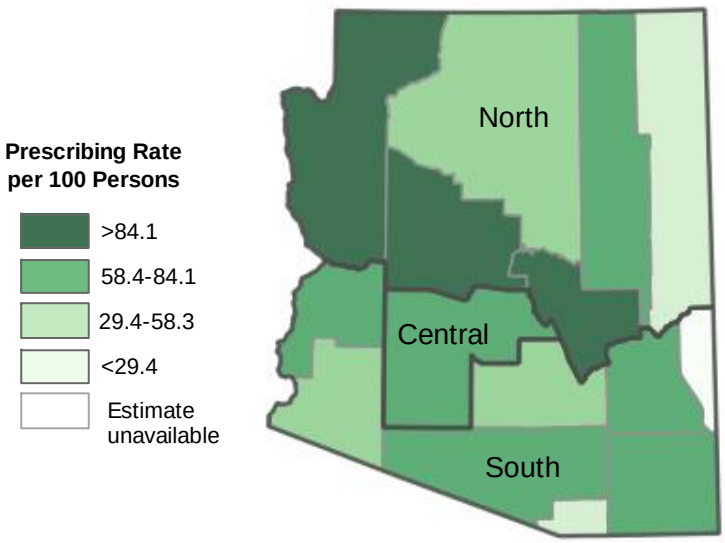
There is a strong association between opioid-related deaths and the opioid prescription practices of medical professionals. According to the CDC, "prescription opioid-related overdose deaths and admissions for treatment of opioid use disorder have increased in parallel with increases in opioids prescribed in the United States, which quadrupled from 1999 to 2010." (MMWR, 2017, p. 698).

The CDC provides data on opioid prescription rates at the county, state and national levels. These data come from the QuintilesIMS Transactional Data Warehouse, which provides "estimates of the number of opioid prescriptions dispensed in the United States based on a sample of approximately 59,000 pharmacies, representing 88% of prescriptions in the United States" (MMWR, 2017, p. 697). A prescription is defined as "an initial or refill prescription dispensed at a retail pharmacy" and does not include mail order data.

The national prescription rate peaked in 2012 at 81.3 prescriptions per 100 U.S. residents. By 2016 the rate had fallen to 66.5 prescriptions per 100 U.S. residents. The 2016 rate in Arizona was slightly higher at 70.2 prescriptions per 100 people. There were substantial differences in opioid prescription rates by individual counties across Arizona. Mohave and Gila Counties both had more opioid prescriptions than residents (127.5 and 110.0 per 100 people, respectively), while Apache County had only 18.5 prescriptions per 100 people. Data were not available for Greenlee County (See Exhibit 84).

A number of actions have been taken to improve, among other things, opioid prescription practices in Arizona in the past year. These accomplishments are summarized in the Arizona Opioid Emergency Response Report- June 2017 to June 2018. A complete list of enacted opioid-related legislation in Arizona can also be found on the National Conference of State Legislatures website. The opioid prescription data presented in this report are from 2016 and may not reflect recent improvements.

Exhibit 84. Opioid Prescribing Rates by Arizona County, 2016



Rank	County	Rate
1	Mohave	127.5
2	Gila	110.0
3	Yavapai	97.8
4	Graham	84.1
5	Cochise	79.0
6	La Paz	78.3
7	Pima	74.0
8	Maricopa	68.2
9	Navajo	67.5
10	Pinal	58.3
11	Yuma	56.6
12	Coconino	51.4
13	Santa Cruz	29.3
14	Apache	18.5
	Greenlee	--

Source: Centers for Disease Control, Opioid Prescribing Rates by County, 2016

Arizona Medical Marijuana Act

On April 14, 2011 the Arizona Medical Marijuana Act (AMMA) went into effect, legalizing medical marijuana use in the State for seriously ill patients with a doctor's approval. Nationally, studies investigating the effects of marijuana legalization on prevalence of marijuana use have been mixed, with some samples showing a near doubling in prevalence of past year use among adults (Hasin et al, 2015), while other studies have demonstrated only modest increases in past year use and no increases in the prevalence of current use, or marijuana use disorder (Gruzca et al, 2017). A recent national analysis of the effects of marijuana laws on adult marijuana use concluded that marijuana laws enacted in US were associated with some increased marijuana use, but only among adults aged 26 and older, and only in states with recreational marijuana laws, not medical marijuana laws (Williams et al, 2017).

It is unknown what percentage of Arizona marijuana users have medical marijuana cards or are using marijuana only for medical reasons. Data published by ADHS for May 2018 indicate there were 169,478 active medical marijuana qualifying patients in the State, including 207 active cardholders under 18. Data from the NSDUH suggest there were approximately 696,000 past year marijuana users in 2016 and 422,000 past month users. In Arizona between 2008 and 2016, past year marijuana use increased significantly for adults aged 26 or older (7.3% to 9.5%, p=0.035). Increases were not observed for other age groups, or for past month marijuana use. Given the significant increase in marijuana use for older adult populations, it is noteworthy that as of May 2018 approximately 75% of medical marijuana cardholders in Arizona were older than 30.

One hypothesized risk of medical marijuana is increased marijuana access for those without a medical marijuana card. The 2016 Arizona Youth Survey (AYS) asked 8th, 10th and 12th graders in Arizona where they obtained the marijuana they used. Approximately 17.0% said they got their marijuana from someone with a medical marijuana card, up from 10.8% in 2012. As noted earlier, there has been no change in the prevalence of marijuana use for youth aged 12 to 17 between 2009 and 2017, making it difficult to understand how medical marijuana access impacts marijuana consumption patterns among youth.

Qualitative Findings: Causal Factors

In the statewide focus groups and interviews conducted, two of the questions asked sought to understand what the causal factors for substance use and/or misuse might be (in that community):

What causes people in your community to use [these] substances?

Are there any particular issues people in your community have that are contributing to using these substances?

Findings below include those from focus groups and interviews conducted across the State. The themes presented are those with evidence supported by these conversations.

Overall

A number of themes related to causation of substance use and/or misuse were identified across all or most populations /communities visited and in interviews conducted with key informants. These major causes included:

- Self-medication via substance use and/or misuse, resulting from unaddressed behavioral health needs due to a lack of behavioral health services, the inability to access mental health services or the identification of a behavioral health disorder

  > "There are a lot of mental health issues and the county and school district level have limited resources. There are not enough school counselors, mental health supports, or psychologists in the county. We have zero juvenile psychologists in our county! Zero! The county does its best with telemedicine, but it is limited and doesn't reach everyone." (Interview with Navajo County Key Informant)

- Easy access to a variety of substances for all age groups, populations and communities.

- Isolation, a lack of social support, and/or someone to talk to for help can lead to substance use and/or misuse.

- The reduction and regulation of prescribed opioids leading to street drug use (e.g.

heroin).

> "Some of the top doctors writing prescriptions for opioids were in Mohave county even though the population is really low. Three doctors were investigated in Mohave County that were prescribing huge amounts of opioids. These doctors were shut down… Then when you can't get prescriptions you move to street drugs." (Interview with Mohave County Key Informant)

- Unsupervised youth leads to substance use and/or misuse.

- Limited funding and the requirements of core competencies in schools prohibiting effective prevention programs from occurring, thus leading to substance use and/or misuse.

- Normalization of marijuana and other substances through social media, peers, entertainment, advertising and culture leads to substance use and/or misuse.

> "There's 15 positive messages about marijuana for every one that talks about the harms and risks. So, when you're up against that kind of an environment… (in our county we have the highest per capita of marijuana cardholders… there's only so much that you can do to fight social norms. It's really difficult in a culture where the supply of marijuana is so socially acceptable." (Interview with Pima County Key Informant)

- A feeling of hopelessness about the current state of the world.

> "If people are already feeling hopeless, this constant daily occurrence of people striving so hard and they see people of power misusing that power, and that that erodes people. People need relief, they want it to be better so they might act better themselves. Or they want to be better so they pick a victim or scapegoat. Then there are those that just want to get away from it all so they smoke a joint. So as a community when we see youth that are marginalized and are oppressed, those are the people that they need something better and higher to ascribe to. When they ask, why be a part of all of this, it is not going to make a difference anyway - so they party to bring relief or fun for them. Not realizing it can make their life even worse." (Interview with Pima County Key Informant)

Youth and those serving youth

Youth and those serving youth provided in depth insights into the causal factors that lead to substance use issues for Arizona youth. Some key themes that came forward were:

1) Youth are self-medicating with substances due to mental health issues/trauma and a lack of or inability to access mental health services.

"Family drama, bullying, school, divorce making you so depressed you drink your feelings away." (Phoenix youth)

"One reason why people might lean towards substance abuse, they have a lot of family problems, some families are horrible to kids. A lot of kids at my school are so young and they can't get away from their families, drug use is a release from that toxic environment." (Prescott youth)

"'I want to kill myself' is so normalized, we say it all the time without thinking. A lot of people associate drugs with that. I know a lot of people affected by depression and anxiety and have gone to rehabs, so it is associated with hurting yourself. If we made progress to help people with suicidal thoughts, it's just another topic. 13 reasons why [television show], it's so normalized, its numbing us, video games where you go and pick up hookers and shoot people, you are numbing your mind. So many people have family issues and no one pays attention to their issues, when they say they want to kill themselves it is their way sometimes to get attention. No one is listening to them." (Prescott youth)

"I can talk about the suicide attempts, part of parent groups, kid come from all over, a lot of parents with children with depression, trauma in their lives, don't have the coping mechanisms, parents don't know how to help. Kids cutting themselves. Parents whose kids have attempted/committed suicide say their kids are using marijuana is commonly reported as used. Not an issue in one part of town, a lot of kids who are hurting. Kids who need other resources and substances, that's how their trying to cope." (Sierra Vista adult)

"[They] Want an Escape. For youth and adults. Kids have to deal with a lot today. Adults as well. A sense of peace and euphoria sense and they want that escape …then you have to increase to something stronger...then it just dominoes from there. It is a mental health thing, but people just want an escape, a quick escape." (Sierra Vista adult)

"My child struggled…we called ahead and they said there were resources, counselors but no, there is one counselor for three schools. One counselor for all those kids. My child didn't see a school counselor for the first year we were here. I had to find resources for him myself. I'm the parent who knows how to do that. There are a lot of parents who don't or don't have the ability to. …I'm at that school and I see the kids who have the same issues and I see them struggling…sitting in the office crying…no counselor…eventually those kids will

turn to other things to cope… They aren't being taught coping mechanisms." (Sierra Vista adult)

"There is a lot undetected…. no behavioral health in town, Parents tell kids to cope, get over it. Therapist wants three times a week which is unstainable to travel out of town. Kids don't always want medication. Not enough quality mental health services in this community. And there is a stigma if seen going into the service center, it's an embarrassment." (Globe adult)

"Addressing the drugs problems… there is a huge stigma problem here and everywhere. When we talk about getting families involved, there's a problem, a mental health problem, a substance abuse problem, and we're not going to get that handled until we get a handle on those problems. …mental health care is missing; substance abuse care is missing…the whole continuum of care is not in place. Your doctor tells you to go to a counselor. Ok. You don't have to go because there's no follow up. Until we get continuum of care in place, we'll keep going on like this." (Globe adult)

"I think its trauma and lack of affordable mental health services that are available to anyone regardless of their political status… I have a lot of kids who are undocumented… there's a lot of trauma… it's the whole family (not just youth)." (Phoenix adult)

"Trauma, underlying stressors, broken families, depression, they are self-medicating to not feel." (Kingman adult)

"We have lack of resources for our youth. If my kid 17-18 has a drug problem, where do I take them? …There aren't enough beds for our youth. Where do you send a desperate parent? They want to help their child but there are no resources. You have to go to Phoenix because there is nowhere else to go." (Kingman adult)

"We generationally have seemingly created people that have poorer coping skills. So their ability and willingness to feel is not there. They want everything to be good and happy, they don't want to feel life." (Kingman adult)

"I have been trying to get my son help since the end of May [time of focus group was August]. His Doctor has never experienced addicts, so I was referred to Mohave mental health. It takes so long to get help, and after months the kid is further along [in their crisis]. There is not enough help in our health facilities to help everyone in their time of need." (Kingman adult)

2) Due to a lack of healthy, affordable, fun activities for youth, they engage in substance use and/or misuse.

> "There is nothing for children to do …since the bowling alley left …but there's nothing for adults as well, you have to dig in and find something to do. No money, can't do this. My six-year-old wants to know why we live here?" (Sierra Vista adult)

> "Pay to Play athletics is a problem… you have to pay to be on a sport... can't be involved in a positive activity if don't have the money… [otherwise] nothing to do." (Phoenix adult)

3) Youth today currently lack coping skills or the social/emotional tools to deal with life's challenges which leads them to substance use and/or misuse.

> "I think kids are not taught how to deal with stress, especially in the crucial years because parents don't know how to talk to them…about how to manage stress...if they turn to their parents they just say, 'You will get over it.' The kids turn to alcohol…marijuana…other drugs, and it ruins their life at a young age. They've been using it as self-medication for years." (Globe adult)

> "To teach coping skills its tough, they have this block, it's like this attitude of being spoiled, being entitled, being obstinate, their brains are still developing. I blame our generation that didn't teach them good coping skills. To not just go to a substance." (Kingman adult)

> "We generationally have seemingly created people that have poorer coping skills. So their ability and willingness to feel is not there. They want everything to be good and happy, they don't want to feel life. To teach coping skills it's tough, they have this block, it's like this attitude of being spoiled, being entitled, being obstinate, their brains are still developing. I blame our generation that didn't teach them good coping skills. To not just go to a substance." (Kingman adult)

> "It is a slow progression, and new drugs keep getting introduced. But if we switch our thoughts away to true prevention like stress and coping mechanisms then our youth will grow up learning how to manage their anger and stress so they don't turn to these substances and abuse them. There is room to improve." (Flagstaff Key Informant)

4) Peer pressure leads to substance use and/or misuse.

"Popularity is peer pressure and a want, if you have weed or access to it or you're 18 and can get Juuls [vape brand] immediately everyone loves you. You immediately become popular if you have access to this stuff." (Prescott youth)

5) The use of substances has been normalized by popular culture, social media, marketing, peers and the legalization of marijuana which is leading to substance use and/or misuse.

"It's very open, all the kids know. Kids think it is popular and the thing to do…Depends on what group you're in [but] there are a lot of goody two shoes using…If someone is drinking it is [considered] normal for young people." (Prescott youth)

"You are listening to these artists that talk about getting high – [there is] celebrity influence." (Prescott youth)

"People see things on social media… movies, it influences them, glamorizes it… they want to look cool like the people onscreen… like Brad Pitt… with alcohol or smoking … in movies people have to do that for their roles… influences [kids] …especially social media… people are posting themselves doing drugs… and [kids are] like 'oh, it looks cool… I want to do it.'" (Phoenix youth)

"Television and Netflix shows, you see a lot of people who will use Adderall ® or abuse just basically any kind of substance... it's like teens we look up to, and like the top 50 most influential kids… even people younger than us… just like getting into middle school or in middle school and they are role models to them…… and when you see these people on TV, and they are portraying that character, even if they don't take drugs themselves but their character is… I know from my little brothers… they take things way too seriously, watching anything, it sticks to them like glue… if you see another teen or adult you look up to using, it influences you… for younger kids it definitely influences them and I think that is a step towards using… and when you see peers using or playing around with it… it's baby steps… it's not something that just happens."(Phoenix Youth)

"Alcoholism is super normalized now, if someone is drinking it is normal for young people. Social media has a lot to do with it. People talk about drinking all the time. It's just so normalized. Alcoholism is the norm." (Prescott youth)

6) A lack of family values and lack of family supervision of youth (or a stable adult for youth) to turn to leads to substance use and/or misuse.

"[Kids feel like] No one loves me at home, they just don't care if I live or die, then I'm gonna go over to this group and see what they have for me." (Sierra Vista adult)

"Parents give it to the kids… alcohol… they'll just let them smoke … or they'll have a party and the parents are upstairs watching TV while the kids are having parties downstairs … with weed, drinking…I haven't been to the parties but I've heard… [there are a lot of middle school parties, they start in the 6th grade]."(Phoenix youth)

"When I say when I'm down I say I'm fine. I don't really tell my friends when I'm down. I didn't have good friends last year and it was rough. I don't want to annoy people, when you ask to talk to people they don't want to talk to me. I feel like I don't have anyone to talk to." (Prescott youth)

"Peer pressure is always a thing, goes back to communication with your kids, the kids who have someone in their life, it doesn't have to be parents – an aunt, a grandparent, clergy member, soccer coach – who is pouring into them and encouraging them is most likely to be that kid that's not gonna be influenced by anyone and everyone." (Sierra Vista adult)

"Lack of family values, lack of structure … no traditional families or examples of that.. that starts to wear; before you had kids had mom, dad, and could afford for mom to stay home with the kids, now you can't; Now nearly impossible for one to stay home. There is little involvement of parents doing things with the kids now –like hiking, going camping, to the lake, …there's tons of stuff to do here even outdoors but parents are busy on Facebook, on phones, online, they are tired, and I get it, I'm a parent, I'm tired but you have to make sacrifices. There is community lack...not a lot of motivation for family, more like, 'Let's give the kids something to do. Here's our kids, do something with them.' Not 'Can we do something with our kids.'" (Globe adult)

"The lack of supervision of the youth, the single parent, they are working 2-3 jobs to make ends meet. They don't have the funds to put them in proper care or programs so they are at home unsupervised." (Kingman adult)

"We do live in a rural impoverished community where a lot of the parents are working to just make ends meet so they don't have the time to spend with their kids and invest that time, so they do have a lack of supervision." (Kingman adult)

"There are a lot of family issues. The traditional family is not as commonplace as it once was, having mom and dad home every night and having expectations for the kids, expecting them to be followed, monitoring their social media, activities, where they are going, having family time each night, all of these things seem to be going away. A lot of kids come from single family households. We live in a mining community where parents have to do shiftwork late at night. So in single family homes, kids may not see their parents at all. Their interaction might be minimal. The degradation of the family and a serious lack of parenting skills, this is a downward slope and has been for a long time." (Interview with Greenlee County Key Informant)

7) Due to inadequate funding and resources given to schools, and the demands of Arizona's core competencies, there is not enough time or resources for effective prevention programs in schools which leads to substance use and/or misuse.

"Globe is considered a 'D' school, now focused on curricula issues to improve their 'sad' grade, they cut out all other services, just core subjects – math, science – become their main focus. All the extracurricular activities—these are not important right now…focus on getting our grade up Doesn't mean the kids don't need [the core curricula] but cutting out all this other stuff is a mistake, because kids can't focus if they are having all these other problems…I have a child in junior high. There is a lot of pressure to cram info in before state testing…pressure on the kids to study, study, study and score high…not because they want their students to do well but because they want their school to do well so that they can get money... not really about caring about the kids. We're gonna lose our jobs if we don't get our grade up." (Globe adult)

"They cut the school week to four days [because of education budget cuts]. So, for a four-day week, to try and get in there to teach something is hard. So, there is an extra day with a lack of supervision. Instead of two days to get in trouble they have three days to get in trouble. Many schools are going to the four-day week." (Kingman adult)

8) Substances are easy to hide now in schools (vapes and edibles) and teachers do not notice (or ignore) the use of substances leading to continued use.

"Kids are sneakier with it, get clear Vodka in water bottles… Kids do it at middle school too… carry water bottles… you can smell it." (Phoenix youth)

"[Students use] mostly at football games, teachers don't know… I went to a game and they went under the bleachers and in the bathroom smoking and

vaping… more common to do drugs in the bathrooms…a lot of hiding spots at the high school." (Phoenix youth)

"My boyfriend's son, a sophomore, sees kids vaping in the class, teacher turns their back, they take a puff, everybody's waving their notebooks around. The vaping is happening a lot." (Sierra Vista adult)

9) Prescription Drug use, and over prescription of drugs can lead to substance use and/or misuse. (This finding is also supported by a recent study that found among new heroin users, three out of four report having misused prescription opioids prior to using heroin (Cicero, Ellis & Surratt, 2014)).

"Kid started opioids due to sports injury… he was prescribed opioids and then he got addicted and moved on to heroin… I know that's what happened to a young man in my high school over here… he was a really good athlete." (Phoenix adult)

10) Pressure for youth to be perfect leads to substance use and/or misuse.

"The obvious - peer pressure- but also there's a huge push for perfectionism, overachieving, so kids who wouldn't have been drug users, are now using Xanax®, Adderall®, and even athletes using performance enhancing drugs… There's been an interesting shift in that lately. Drugs to keep you up longer, etc. It's the idea of being bigger, better, stronger, faster…" (Phoenix adult)

"Honors students put high stress on themselves… that's where you see suicide attempts… sometimes they cope through medicinal use or drinking, marijuana, etc. They are the forgotten group." (Phoenix adult)

Additional causal factors that emerged from focus groups and interviews included:

- Experimentation/curiosity
- Wanting to have fun and feel "good"
- Taking drugs to study
- Intergenerational substance use
- Easy access to substances
- Youth stealing medications from family and others and selling or using them
- Those that are prescribed medications selling these to others at school
- Youth feeling "invincible" from the harms of drugs and alcohol, and
- Community characteristics (e.g. poverty, rural setting, lack of transportation, transient community).

Veterans

Those affiliated with the Veteran community shared a variety of reasons why they felt veterans were using and/or abusing substances. Some key themes that came forward were:

1) Veterans miss the adrenaline rush they got in the service; that's why many turn to drugs.

> "When you are in the military, you have your good time boys to have fun together. You may be drinking excessively but are in good shape. When you are out, it's a downer without your buddies and new stresses… and you don't have the adrenaline rush from when in the service. There is nothing comparable to that which you did in the military, that can give you that kind of rush." (Yuma veteran)

2) Untreated chronic pain and dental pain leads to street drug use.

> "We have a lot of people who have chronic pain. Up here in rural AZ, we don't have the level of care other areas have. If you think of a vet in a rural area, where are those people with chronic pain going to get treatment. If they don't have the eligibility to get treatment, where are they going to go?" (Flagstaff veteran)

> "Well, military training is tough … you have all the injuries like loading bombs by hand… [carrying maybe over 100 pounds]. You have to come back and somehow prove that this happened to you and that you incurred that injury while in service. It is so hard to get approved… [and] with special ops, they don't want a thick medical file on them. They just want to get patched up and move on. So later in life they can't prove those injuries." (Flagstaff veteran)

3) Veterans use substances to self-medicate for untreated mental health issues related to military service including Post Traumatic Stress Disorder (PTSD) and other trauma.

> "I kind of feel there might be some psychiatric issue[s] to the whole measure of drug use, self-medicating..." (Phoenix veteran)

> "In the military you can't bring up mental health issues because you would be kicked out and … now you're trying to figure out navigating the V.A. system on your own when you're suffering from depression and you have financial strain." (Interview with Pima County Key Informant)

4) Substance use is normalized and encouraged in the military which leads to substance use and/or misuse.

"When I was in the NAVY, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work." (Flagstaff Veteran)

5) The difficulty in reintegrating into society once out of the military leads to substance use and/or misuse.

"A lot of times when we get out of the marine corps, you come from being a staff sergeant, a point of authority, and then you go to mopping floors… You don't feel important anymore… You used to say 'jump' and people would jump… and then you go into a place flipping burgers." (Yuma veteran)

"When vets come home they have PTSD, but the key to that is … they just need to find something to do to occupy their thoughts and time. It's way too easy to think they will just sit at the bar for the rest of their life, right? But they can heal themselves just by being occupied…It doesn't mean it goes away… you can still have nightmares, but you're just preoccupied with other things now that are more important to you in life. You see parolees get a dog, and all of the sudden they're not doing crime… let them go work on a ranch somewhere, give them something to do and a little bit of structure and let them deal with that emotional thing." (Flagstaff veteran)

"… So I get out service, I run around, I get a job at Target or whatever… it's not enough… Those barriers of life start to become an issue – and it might be… because I've been somewhere being catered to… I could go to my room, I could go get a chow, I don't pay for anything when I'm in the service, and when I come out, now I need a job. And for a lot of us, it's our first time [trying to find a job]." (Phoenix veteran)

"You are a badass, that steady pay check stopped…people don't realize there are no options. Mentally it [expletive] with you that you can't get a job at a 99 cents store. I started smoking and doing other things." (Yuma veteran)

6) Changes in prescription practices leading to street drug use.

"Until recently it was very easy for veterans to get prescription opioids from doctors, but regulations are changing abruptly to reduce opiate prescribing by doctors; doctors are prescribing alternative approaches such as 'stretching' for veterans with a history of chronic pain and there is concern they going to the street for opioids." (Interview with Pima County Key Informant)

Additional causal factors that emerged from focus groups and interviews included:

- Doctors overprescribing medications
- Lack of access to veteran medical care in rural areas (which leads to self-medication with drugs)
- Veterans not knowing where to access services and supports when they return home from service
- Loneliness
- Financial stressors
- Many veterans coming from military families where drinking is a family norm

Older Adults

Older adults shared a variety of reasons why seniors may be using and/or abusing substances. Some key themes that came forward were:

1) Loneliness and isolation lead to substance use and/or misuse.

> "Getting into and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse." (Prescott older adult)
>
> "I live in a senior apartment complex that has a sliding scale and its very nice… This is in Prescott Valley… [The apartment complex is] big… [350 apartments]. I will run into someone in the hall and I'll say, "Oh are you new?" and they'll say, "No, I've been here five years…" So [there's] isolation even in a confined area… And we do have events… but the same people 50 show up for those… So where are all of those other people?" (Prescott older adult)

2) Loss of role after retirement leads to substance use and/or misuse.

> "As a culture we identify so much with our role… [Once people retire], there's a loss of role, whether it's from an office, as a parent or as a grandparent… Role is what determines worth in this culture… and when you lose that there's of course the dependence on something else to alleviate that…" (Tucson older adult)

3) Prevention activities are not geared towards older adults, often only youth.

> "One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that if we get them younger, then that's prevention. We have a grant… we are getting people less isolated and more connected… the research is clear that it improves health, emotional health, all of that… But in terms of targeted

prevention efforts specifically about education, I don't know that there's anyone else doing it… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. Prevention that I learned has to be targeted to a population." (Prescott older adult)

4) Over-prescription of pain medications transitioning to street drug use after increased regulations.

> "I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else... I think it really is an issue of over-prescription that's happening today." (Tucson older adult)

Additional causal factors that emerged from focus groups and interviews included bodies responding differently to substances with age, and financial stress from living on a fixed income.

LGBTQ Populations

Individuals affiliated with the LGBTQ communities had a wealth of information to share about the reasons why they felt individuals in their community were using and/or abusing substances. Some key themes that came forward were:

1) Minority stress, including disconnection or rejection from family/community, leads to substance use and/or misuse.

> "When you are queer you experience a baseline level of stress that is higher, messages that you are wrong and gross." (Flagstaff youth)

> "When someone hits rock bottom, if their families neglected them, they feel alone, trapped or can't express themselves, or they don't know why their feeling this way or understand why people are attacking them, it brings you to do it because it makes you feel different and stop feeling the way you do to release all that pain." (Phoenix youth)

> "I think People feel isolated … that causes them to want to use something because using might feel like a community to them." (Tucson youth)

> "I know some people that their parents don't accept them for being LGBT and that causes a lot of stress and annoyance, so they try drugs to help stress and

anxiety." (Prescott youth)

2) A lack of safe substance-free areas to hang out or to engage with other LGBTQ in their community leads to substance use and/or misuse.

> "LGBT + alcohol, there are gay bars and events, there aren't like gay coffee shops so if you are a minor and wanting to avoid alcohol, the social events seem to revolve around alcohol." (Flagstaff youth)

3) A lack of, or the inability to access, appropriate and LGBTQ-friendly mental health services leads to self-medication via substance use and/or misuse.

> "I think substance use happens when your needs aren't being met. LGBT are more isolated and living in communities where we don't feel so accepted. People know these things are bad for us. Building social supports and mental health is so important. At NAU they have only 20-minute appointments with counselors at the mental health center because funding has been cut. Making those counselors have practices that are LGBT friendly, pronouns on intake forms, not assuming sexual practices, not being sensitive to gender, body parts. LGBT friendly practices are uncommon." (Flagstaff youth)

Additional causal factors that emerged from focus groups and interviews included peer pressure, addiction resulting from recreational experimentation, , curiosity and easy access to substances.

Tribal Populations

When speaking with Tribal members about causation of substance use and/or misuse, the dominant theme was that trauma, historical trauma and mental health issues lead to substance use and/or misuse. One community key informant interviewed from the Gila River Indian Community shared that emotional causes of substance use and/or misuse in the Tribal community could include feeling alone, unsupported or overwhelmed, and that substances provide numbness to pain and negative emotions. He stated that those who feel less connected to the Tribe and its culture are most vulnerable, most lost or feeling alone. These thoughts were also supported by members of the Pascua Yaqui Tribe:

> "It's really anything traumatic that happens to the kids… Any sort of pain, bullying, domestic violence, depression, anything that you went through. Even if you don't remember, there is something inside of you that remembers so there is this trigger, it's still inside you, so every time you are around it, just makes you feel worse, so you go and do something to yourself that makes you feel better, but it destroys your insides." (Pascua Yaqui Tribe Member)

> "Trauma… not only in communities of color but definitely Native Americans… we have to look at historical trauma that's unresolved, and that plays into intergenerational trauma… it all fits together … it's going to manifest itself…"(Pascua Yaqui Tribe Member)

Poverty was also mentioned as a causal factor of substance use by a member of the Pascua Yaqui Tribe:

> "One of the primary causes of alcohol and drug use in the community is poverty. Guadalupe has a large number of families who are living below the poverty line. There is not an outlet for children. Many children are being raised by grandparents or single mothers and they often drop out of school to work and earn money for the family. This causes stress and children turn to alcohol and drugs looking for relief. Interfamily relations also create stress which causes people to drink." (Interview with Pascua Yaqui Key Informant)

Other causal factors mentioned included community members being "desensitized" to alcohol use in that "parents would rather have their children drinking alcohol then using drugs", as well as peer pressure, lack of law enforcement, coping with deaths in the family, easy access to substances and the influence of social media, popular culture and entertainers.

Refugee Populations

Interviews with individuals that work with the refugee populations in Arizona shared some key insights into what might be causing substance use for this community. Causes of substance use and/or misuse for refugees may include extreme stressors and avoidance of mental health treatment. Although some refugees may possess pre-existing substance issues (especially alcohol, even from populations where it's forbidden, because it is common in refugee camps), people in the refugee community also have experienced challenges that make them especially vulnerable to substance use and/or misuse. They lack knowledge and "they come with trauma…have sometimes been tortured." They also may have PTSD, stress from the experience of coming to a new country (and starting a new life), having limited resources, and having limited money. In this context, substance use "can be a coping mechanism even for those who did not use before." Cultural taboos around getting mental healthcare or seeing a counselor, and the difficulty of addressing trauma through therapy may lead to use. One respondent noted, that it is "easier to access these types of things [alcohol, cigarettes] than to go see a counselor to process trauma." Men are especially likely to see therapy as stigmatizing and one respondent noted that men seem to be smoking specifically to deal with trauma. It has been noted that refugees are more comfortable with the idea of mental health treatment if they received some in a refugee camp.

Social influences may lead to use. Although staff try to integrate refugees around the city there

is limited housing such that most reside at a few apartment complexes and form social groups where drinking alcohol may be contagious. Youth want to fit in and are vulnerable to peer pressure.

Refugees also can have injuries that require pain medication. Prescription drug problems are linked to lack of health literacy for refugees and immigrants, who may use their prescribed medication "until they feel better" and then share them with someone who has the same symptoms. When addicted, adults get repeat prescriptions or "doctor shop", while youth primarily turn to street drugs.

Respondents also indicated that there are not a lot of "first language" or native language behavioral health services in the community for refugees, especially group therapy. It was reported that refugees often have trouble locating services even with court-mandated substance use and/or misuse treatment.

Promotores

The causal factors for youth substance youth reported by promotores in the Phoenix area were similar to many other causal factors mentioned above, including:

- Dysfunctional families leading to a lack of attention and contact with parents; youth not trusting parents enough to share their feelings with them
- Ignorance about effects of substance use
- Youth being bombarded with messaging in music, movies, TV, and media images that normalize substance use
- ACES (adverse childhood experiences), childhood stress and trauma (including intergenerational trauma), verbal, sexual, physical and emotional abuse in the home
- Depression in children and lack of mental health care
- Lack of coping skills and life skills
- Depression due to lack of opportunities for immigrant youth
- Normalization of substance use in the home
- Youth in foster system being abandoned at age 18 and falling through the cracks
- Doctors over-prescribing

Some causal factors of substance use and/or misuse were also mentioned for older adults including:

- Not having access to healthcare thus self-medicating.
- Switching doctors, pills, and treatments frequently.
- Not having enough money to care for themselves and using drugs to ease their pain and make the days go faster.
- Being unable to afford Obamacare, even for immigrants that have health insurance.

Promotores also shared that veterans in their community use substances to cope with mental and physical trauma.

Prevention Needs

Qualitative Findings

In the statewide focus groups and interviews conducted, two questions were asked related to what substance use prevention efforts are needed (in that community):

What kinds of substance use prevention approaches would work the best in your community?

What kind of prevention efforts does your community need more of?

Findings below include those from focus groups and interviews conducted across the State. The themes presented are those capable of being supported with evidence from these conversations.

Overall

A number of themes related to needs for prevention of substance use were identified across all or most populations/communities visited and in interviews conducted with key informants. These needs for substance use and/or misuse prevention included:

- Educating parents about substance use issues with youth as well as increasing parental (or other caregiver) involvement in their children's lives.
- Improving access and capacity of mental health services and resources.
- Addressing social isolation and the lack of individualized support for many populations.
- Allocating more resources and time for prevention programs in schools.
- Start prevention programs at younger ages and in lower grades.
- Better training and educating doctors about prescription drug issues.
- Training and educating medical and behavioral health providers to improve cultural competency and sensitivity towards unique populations.
- Creating and implementing more culturally competent and culturally sensitive prevention programs.
- Providing education to people who don't think they'll ever use substances or become addicted.
- Creating public awareness campaigns and prevention messaging that is creative, relevant, modern and persuasive.
- Informing people about prescription medication "takebacks".
- Educating the general public so they can be part of the solution (like Mental Health First Aid).
- Effective integrated care (medical and behavioral healthcare)
- Implementing more stringent liquor license regulations.
- Prison reform

Youth (and those serving youth)

Youth, and those serving youth, provided suggestions for substance use prevention efforts for Arizona youth. Some key themes that came forward were:

1) Suitable messaging for kids/not scare tactics.

> "Stop and think about what you are doing…We get told not to use all the time…kids know what they are doing" (Prescott youth)
>
> "You can't just say 'Don't use drugs and alcohol or else you die'… it's not gonna click in their head and won't come across them as that bad…so that's something that I've always wanted not to do…. just give them the facts and don't force it on them that they're gonna die if they use." (Youth from town of Maricopa)
>
> "Over time… it blends into just this attitude… don't do drugs… do start to take it as a joke." (Maricopa County youth)
>
> "You need someone dynamic ...someone who can built [sic] positive relationships [to teach the material]." (Interview with Tucson-based School Professional Key Informant)

2) Involve parents/direct messaging to parents.

> "Talk to the parents… so they can discipline their children more...lock up the medicine and get alcohol out of their reach, so they know not to do this, so they don't die or get lung cancer." (Youth from town of Maricopa)
>
> "All of the generations talking about this is the problem affecting the community…people who use drugs come and talk." (Maricopa County youth)
>
> "I think in the rural communities they tend to be conservative communities so promoting things that focus on family approaches to substance abuse prevention then some other approaches. Holistic approach is important." (Interview with statewide Key Informant)

3) Better parent support/engagement/Meaningful incentives to promote parent engagement (food, gas cards, etc.).

> "First time the school has done anything it was voluntary, we had to sign up for it this year, for 8th grade, a seminar on how to approach the subject with your child, what causes it, what they may be exposed to. A Family Night. A great thing, put on by the superintendent, funded by the governor's office. Of 600-800

kids at the school we didn't even fill up the cafeteria with parents." (Sierra Vista adult)

"One parent showed out of a 500-kid population. Head is in social media or the bar… They are not going to show up for anything like prevention – "Don't tell me what to do and don't tell me what I'm doing is wrong." (Globe adult)

4) Schools need to have enough support to focus on more than core curricula, raising their grade/Community-School Partnerships/Community collaboration.

"AZYP (Arizona Youth Partnership) had evidence-based programs but the schools do not have enough time to let them implement them…ends up being with kids in alternative schools when it's too late." (Kingman adult)

"How are schools supposed to do publicity/marketing, youth leadership, community coalition …all of these process together, they are not going to [pursue the grant money]... Trying to get this money to the schools for prevention, there has to be a different way to do it.. where they can participate but do not have to do too much work... it is a lot of the work, and I don't blame them for not taking the money." (Sierra Vista adult)

5) Ways to promote coping skills for kids.

"If we could figure out a way to provide our kids with goals, let them know that failure is ok, failure is part of success. Need to know that that's alright. The programs that we do have got to address that, bring families and kids into that." (Globe adult)

"If we switch our thoughts away to true prevention like stress and coping mechanisms, then our youth will grow up learning how to manage their anger and stress so they don't turn to these substances and abuse them." (Interview with North RBHA Key Informant)

6) Effective evidence-base programs for kids.

"The problem with the evidence-based programs is the time, number one, time consuming and they don't have the staff to run the evidence-based program." (Sierra Vista adult)

"Does anyone have a good program we can model ourselves after? We all have evidence-based, it's just evidence-based somewhere else …You need to take a little bit from Virginia, Tennessee, adapt it so it can work here." (Globe adult)

7) School counselors/mental health resources for kids/someone kids can talk to without risk/navigator for kids.

"There is one counselor for three schools. Pediatric psychologist moved away and now they just have teleconference counseling for kids." (Sierra Vista adult)

8) Community/parent education to meet basic needs/upstream prevention.

"The Strengthening Families program has been really effective because it engages families in substance abuse prevention even if the families don't realize that's part of the goal." (Interview with statewide Key Informant)

"It's mental health, parents who need help finding a job, getting a bus route through a safe area…advocacy for any issue, not just substance abuse...It is a breakdown in culture... that needs to be built back up." (Sierra Vista adult)

9) Start programming in lower grades.

"Schools don't have enough time, say 'just one time [single presentation] is all you need to do' and only for high school seniors when it should be for 4-5th grade." (Globe adult)

"The younger we can serve youth, 4-6th graders with Botvin Lifeskills I think that is so much more helpful with younger kids for prevention." (Interview with statewide Key Informant)

10) Prosocial things for kids to do/free opportunities to "de-stress"/ school clubs/sponsorships for sports.

Additional themes for primary prevention needs related by youth included:

- Presentation by people who have suffered consequences;
- Not shame-based;
- Anonymous call line for stress relief;
- Friends and social support;
- More people involved;
- More funding for efforts;
- Middle school programming;
- Videos at school and for parents;
- Pamphlets for all topics and aimed at all age groups;
- Prevention messaging from superstars/idols/celebrities;
- Engage more kids in youth prevention clubs;

- Facts, not scare tactics;
- Peer to peer advocacy/ "talk to your friends";
- Guest speakers in their age group;
- Prevention-related games in the classroom by school staff with prizes;
- Good props for classroom presentations;
- Not social media strategies; and
- Drug searches at school.

Some youth informants articulated that **current efforts for youth are not effective:**

> "Everything that we could have done has already been has been done, programs - don't drink, don't do drugs - Everything has been repeated and repeated and repeated...there is no approach right now that works." (Prescott youth)
>
> "They have a drug program, but kids don't do it because they want to continue to feel good from the drugs." (Phoenix youth)

Additional community-level themes for primary prevention needs related by youth-serving adults included:

- Accessible mental health services;
- PSAs & public awareness campaigns;
- Policies and laws;
- Education/interventions with doctors;
- Better regulation;
- Law enforcement funding and staffing;
- Municipal bodies on board;
- Unified messaging from the state level;
- Booklet of community resources;
- City investment in community infrastructure; and
- Emergency resource/support system/person for parents.

Additional program-related themes for primary prevention need related by youth-serving adults included:

- Safe place/drop in center;
- Suicide response;
- Realistic curricula;
- More than just one presentation;
- School involved in prevention/School-base curricula;
- Youth conference;
- More successful media connection to advertise efforts;
- School presentations of personal stories;

- Knowledge of how to evaluate efforts;
- Quality meeting space;
- Transportation;
- School-based training in basic skills (e.g., character);
- Youth speakers (popular kids, harmed kids);
- Mentoring program;
- Youth involvement/youth engagement; and
- Old program models/scare tactics (e.g. DARE; McGruff the Crime Dog; Red Asphalt)

Additional parent-related themes for primary prevention needs related by youth-serving adults included:

- Functioning parent groups at the junior high and high schools;
- Resource/navigator for parents seeking help with their teen;
- Intervention/support for using parents; and
- Parents on the same page with prevention.

Other themes for primary prevention needs related by youth-serving adults included:

- Youth having a chance to recognize that there are opportunities outside their rural community;
- Address prevention worker burnout;
- Recognize/acknowledge kids' pain; and
- Educate/provide programming in colleges.

Themes for secondary prevention needs related by youth-serving adults included:

- Reframe the marijuana issue to consider community acceptance as medicinal;
- Harm reduction; and
- Diversion Programs/decriminalization for kids/honest resource for help where they won't get in trouble.

A statewide key informant described the need for coordinated efforts:

> "Any community has to have a variety of different initiatives within the prevention world to make it a robust program and something that really works. Building on a community coalition is key to really make change, but also you need those EBPs, need to target community, youth and family. I think that's what missing a lot, things are pieced together here and there. We will have prevention funders that really force you into a box of what you can do, sometimes it's like you can only do coalition work no EBPs for example. So even if the community wants to educate kids about drugs, sometimes the funding doesn't cover that. A more

holistic approach that addresses all levels in the community...our communities need to fill in the gaps of prevention. There is prevention happening in almost every community, coalitions almost everywhere. Prevention has become so disjointed and there are so few resources, so it is like scraping the bottom and piecing things together. Need to fill in those gaps and let communities define what those gaps are."

Veterans

Individuals affiliated with the veteran community shared ideas for prevention. Some key themes that came forward that could address primary prevention were:

1) Programs with staff that can connect with veterans (e.g., employ veterans; help veterans feel genuinely cared for).

> "If you don't have providers that are genuinely trying to build relationships or trust with the veterans, they will see right through you and not want to participate with whatever it is you are trying to offer them. I think that's probably the biggest piece… If you don't have someone within your agency who can identify with them… talk their language and understand what they [or] their families may have experienced, then you have pretty much lost their attention or their respect. [Agencies are not successful because] they don't want to take themselves out of their office go and meet people where they are at, on the streets or in the community, to take 30 minutes and have a conversation and get to know a little bit about them… Providers need to have an understanding of what veteran culture is." (Flagstaff Veteran)

2) Programming that gets veterans involved in "something that's meaningful".

> "When vets come home they have PTSD, but the key to that is … they just need to find something to do to occupy their thoughts and time. It's way too easy to think they will just sit at the bar for the rest of their life, right? But they can heal themselves just by being occupied…It doesn't mean it goes away… you can still have nightmares, but you're just preoccupied with other things now that are more important to you in life. You see parolees get a dog, and all of the sudden they're not doing crime… let [veterans] go work on a ranch somewhere, give them something to do and a little bit of structure and let them deal with that emotional thing." (Flagstaff Veteran)

> "It goes against the mental health profession to give tasks but [veterans] really respond well to coming up with a written game plan, direction, time limits. They

are structure-oriented. You give us a daily schedule we're happy as can be because we know what we're doing every minute of the day. I think that's one strength that you can capitalize on with the veterans." (Interview with Tucson Key Informant)

3) Education and information-sharing for Veteran's Administration (VA) doctors (e.g., discussing accurate degree of risk for opioid addiction; scheduling in-person conversations between groups of VA doctors and groups of VA patients about opioid issues; helping doctor's approach patients "individually" and not assuming all are at high risk for addiction).

4) Prevention efforts to address homelessness for veterans (e.g., Crisis Center), alternatives for veterans that can respond quickly to poverty issues such as homelessness with a place to shower, eat, rest for 24/48 hours, get resources etc.; more communication/coordination between the State and veterans about homeless veterans.

Additional primary prevention needs related to programs that emerged for the veteran community included:

- A program that assigns a peer partner/sponsor/buddy to each vet who can help guide them through the transition/provide resources for at least three months like in Vet Court or in the service;
- Education/prevention/treatment of PTSD starting earlier;
- Making it mandatory for vets to check-in/attend meetings once per month with a central resource center when coming home in order to receive benefits;
- offering dental coverage to prevent vets from using drugs for pain; and
- More outreach staff willing to go into places on the street that other people not willing to go to meet with veterans.

Some secondary prevention needs emerged, particularly:

1) More effective outreach to veterans when they get out of the military including welcoming, screening, and offering resources.

"I think it would be good where someone could go and people there are actually knowledgeable of all of the [programs]… when I went to AWC I found about the Legion, and here at the Legion I found out about DAV, VFW and all of the other programs; at the VFW I found out about other programs, and through NHCP I found out other programs. But if there was one place I could have gone at the

beginning to find out about all of the programs, it would have benefited me a lot." (Yuma veteran)

"When people get out you just need to ask them, 'Are you doing ok? Is there anything we can help you with?'" (Flagstaff Veteran)

"You can see some… especially the older vets… tear up because nobody welcomed them back or honored them. The non-native people come back [and] drag [the trauma] with them." (Flagstaff veteran)

A key informant in Tucson also noted several secondary prevention needs, including:

- During treatment with veterans, it is important not to focus on the substance use to the exclusion of the underlying cause (e.g. depression, anxiety) when someone is dual diagnosed;
- Communication between agencies should be improved but is undermined by billing practices (among other things). Veterans might be simultaneously involved with the VA and with community providers to meet different needs, as well as have AHCCCS and own their insurance, but "no communication goes along with that" so agencies do not collaborate; and
- The treatment community struggles with two secondary prevention approaches - total sobriety and reduction on use/harm reduction. The "total sobriety approach" can seem arbitrary; some AA meeting "won't accept you if you on [prescribed] Xanax…but medical marijuana is ok." Some harm reduction strategies such as the Housing First model and reducing use to medical marijuana can be effective.

Older Adults

Older adults shared variety of ideas about what substance use prevention efforts are needed for seniors. Some key themes that came forward were:

1) Providing older adult-specific education and support for older adults that meet their unique needs.

"When I was in graduate school for higher and adult education in the 80's, the whole emphasis was the 'Aging of America' and the whole baby boomer population… and 'This is where all of our programming needs to focus'… and there's been absolutely zilch, especially in mental health." (Prescott senior)

"One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that

if we get them younger, then that's prevention. We have a grant… we are getting people less isolated and more connected… the research is clear that it improves health, emotional health, all of that… But in terms of targeted prevention efforts specifically about education, I don't know that there's anyone else doing it… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. And then there are different generational issues for shame… what you admit to and what you don't." (Prescott senior)

"For older adults the physical organs change, and their metabolism changes and it could be something as 'benign' as an antihypertensive medication mixed with something else and something else that they used quite well when they were young. When you get older, these can become dangerous… There's a risk of being affected adversely by a number of medications just because of the changes as we age." (Tucson senior)

2) Educating the general public/family/friends so they can be part of solution.

"Starting by educating people who are health conscious so they can share information and/or volunteer and help those in need." (Prescott senior)

3) Addressing social isolation (e.g., more peer support and intergenerational programming to alleviate loneliness).

"Getting in and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse." (Prescott senior)

4) Educating physicians about older adult substance use issues.

"I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else... I think it really is an issue of over-prescription that's happening today." (Tucson senior)

5) More focus on prevention of health problems and opportunities to receive alternative health (acupuncture, qigong, etc.)

"There is a growing group of many seniors who want to age well and be as healthy as possible for as long as possible… [Seniors are doing] essential oils…

qigong and all of those other things… I think those are the places that you reach people who are interested in their health. They are more apt to want this, and they are going to listen… but they also have friends from their volunteer jobs and everything else they're doing that they can share it with." (Prescott senior)

Additional primary prevention needs related to education that emerged for the senior community included:

- Targeted training for in-home caregivers;
- Older adult-specific education/training for professionals;
- Clear information about "How much is too much" alcohol for older adults;
- Providing education to people who "don't think it will happen to them"; and
- Professional videos or TV programs for seniors to watch at home in which peers share their first-hand experiences of using substances and becoming addicted.

Other primary prevention needs that emerged for the senior community included:

- Mailings from pharmacies notifying when medication has expired;
- Physical fitness programs at senior center for pain prevention;
- Music therapy;
- Articles about prevention in the local newspaper;
- More effective messaging (billboards, tv ads);
- TV shows on older adult prevention; and
- A local coalition for substance use prevention for older adults.

A few secondary prevention themes emerged for seniors, including the need for treatment services targeted to older adults generally and for older adult women (who experience greater shame and denial).

LGBTQ Populations

Individuals affiliated with LGBTQ communities shared ideas about prevention efforts that could benefit these communities. Some key themes that came forward for primary prevention were:

1) The need for more safe, non-judgmental spaces to hang out or to engage with other LGBTQ.

> "It is hard to have safe spaces for LGBT kids. You need to look for LGBT colors for a safe space and a safe zone so you can find the people that can help you, that are an ally…seeing physical reminders that you would be accepted." (Flagstaff youth)

2) Pro-social programs/community centers (with free activities and snacks).

> "It would help if there were events happening where people can hang out for free especially if there were snacks… just a place and something for free… I like to just read … and be around people who are sort of similar to me." (Tucson adult)

3) Better access to appropriate mental health services/LGBTQ-friendly behavioral health services (thereby avoiding self-medication via substances).

> "At NAU they have only 20 minute appointments with counselors at the mental health center because funding has been cut. Making those counselors have practices that are LGBT friendly, pronouns on intake forms, not assuming sexual practices, not being sensitive to gender, body parts. LGBT friendly practices are uncommon." (Flagstaff youth)

Additional primary prevention needs that emerged for the LGBTQ community included:

- Educating parents on how to talk openly with their children
- Education in K-8 schools
- A help line for LGBTQ
- Educating the community on how to be better LGBTQ allies
- Offering other coping mechanisms besides drugs or other outlets to express anger and concerns
- Less marketing for substances, and a lower availability of drugs.

A few secondary prevention themes emerged, the most common of which was:

1) Harm reduction/needle exchange.

Additional secondary prevention needs that emerged included learning from LGBTQ individuals what helps them stop using, and AA-like group for LGBTQ and community rehabilitation instead of incarceration for non-violent drug offenses.

Tribal Populations

Community members of two Arizona Tribes shared their ideas about what substance use prevention efforts are needed for their Tribal communities Some key themes that came forward were:

1) Doing prevention work grounded in the Tribal culture:

> "We have a cultural society, if they could inform the youth and teach them life skills… that's where I think they could do a lot of good." (Pascua Yaqui focus group participant)

> "The best approach for native communities is help people focus on the community and not just on the individual by "reintroducing our cultural ways, our stories, our prayers. And I think some of the Tribes are now looking at that and bringing that back into the community and you know that's what we use. A long time ago when we were going through tough times, that's what we would turn to …. our ceremonies and prayers." (Key Informant from the Inter-Tribal Council of Arizona)

A key informant from the Gila River Indian Community felt that the most successful substance use prevention efforts with this population would be culturally-based such as incorporating songs and stories to help younger people identify with the Tribe for both youth and adults.

The key informant from ITCA indicated that Tribes are relying on an indigenous approach framework rather than the Western framework to good effect. She described the mistrust of mainstream culture that lingers in native communities, in part due to the historical experiences such as American Indian children being adopted out to non-native families or adoption agencies after parents were told that the children were going to visit with these families and come home. The respondent noted the conflict between funding opportunities to support substance use prevention services and the best approaches for Tribes; funding for mainstream resources is available to Tribes but "a lot of time we push these evidence-based intervention models on them and say, 'You have to use this,' but you know a lot of times those models don't work for Tribes." She stated:

> "I think that's really important for funders to know that…. I think a lot of Tribes are trying to go that route …. trying to utilize what they have in their community now what they've always used before… but sometimes that can be hard when you're applying for a grant because we have all these lists of evidence-based models they want you to use."

A North RBHA key informant agreed that tailored programming for Tribes was appropriate:

> "Culturally, Tribal specific, responding to these community needs. Not being afraid to have a small program respond to an issue that affects a smaller portion of the community. It may not be attractive to the State though to say we reached 400 people this year instead of 4000. But if we respond to them in a culturally specific way I think that is more powerful than a pamphlet."

The most common suggestion from a focus group with members of the Pascua Yaqui community was having "someone to talk to." A participant also recommended making programming available to community members who were not members of the Tribe:

> "The Tribe is doing an excellent job in behavioral health… one unfortunate thing is most of the programming is only for Tribal members, what happens to rest of population who needs services? Town is not acknowledging there's a problem… you can see they are not here in this focus group… I think they are so busy… putting out fires… our youth are being hurt out there."

Other suggestions from the focus group with the Pascua Yaqui included:

- Law enforcement engagement;
- Pro-social programs;
- Community discussions/focus groups;
- Community engagement programs or events;
- Parents talking to and supporting their children;
- Teen events;
- Prevention messaging at church; and
- Trainings/workshops.

The key informant from the Gila River Indian Community suggested other prevention efforts needed:

- Outreach about resources provided by professionals and by peers regarding professional help (treatment), jobs, and economic development, including information about both local resources and resources in surrounding communities; and
- More communication by health initiatives about substance use and prevention.

He noted that there are some cultural taboos around the topic of substance use, and peer-to-peer efforts can get around the taboo. The respondent agrees that someone telling their own story at a health or coalition event would be an effective approach if done well (he has seen it done "kind of scattered"). This would require efforts to train speakers who have experienced substance use issues to be better speakers. He felt that the best approaches for secondary prevention with Tribal community member were one-on-one peer support.

The key informant from ITCA suggested other prevention efforts needed:

- Programming that addresses alcohol and meth use delivered by ITCA;
- Support or different services for families that address cultural losses that affect community health; and

- Better access to Tribal-specific data (not aggregated for all Tribes).

Refugee Populations

Interviews with three individuals who work with the refugee population in Southern Arizona (Eritrean, Congolese, Sudanese, Somali, Afghani, Pakistani, Burundi and Bhutanese) revealed some recommendations for substance use prevention. They described the best approaches to addressing prevention with the refugee populations as training in-group members similar to a promotora model. They said that approaches conducted in first (native) languages were most important and that refugees are more willing to listen to other refugees than service providers and are more likely to learn from people who have been in this country longer. A "trusted member of the community" needs to deliver the programming. "We've had the wrong facilitator in the past and it didn't work." It requires a community member with a "good reputation" to go out into the community and meet its members "where they are." Using one-on-one versus group strategies depends on the target population.

Similar to the Tribal community respondents, they recommended culture-based groups like a drumming circle they used to have. One respondent (a refugee herself) felt that having substance prevention addressed by a spiritual leader, especially in their own language, would be helpful as it is connecting it with their cultural beliefs.

The respondents reported that refugee youth do not seem to be particularly vulnerable to substance use and/or misuse, possibly because they tend to value education more than American youth, which is reiterated by parents. They reported that the best prevention strategies with youth were tangential efforts like sports and supporting their parents. "The more supported the parents are the better for the kids." The children suffer less from acculturative stress and the parents are less caught up in their own needs. One respondent (a refugee herself) stated that it is hard for parents to be fully involved in the education system due to language barriers, noting that youth take on a lot of this responsibility.

There was concern that the State is moving away from direct service to coalitions. While this may be more efficient (and direct service more expensive) there is a good reason to maintain direct services in the case of refugees because coalition programming is in English and Spanish only and doesn't take literacy level into account. The refugee population needs linguistically appropriate, translated education materials, but not all are literate in their own language so more visuals would also be helpful.

Refugees are often from community-oriented populations and secondary prevention efforts should help people understand that it affects more than themselves – it affects their family and the community. It might help to hear it from the community rather than the service providers. Once engaged, linguistically appropriate services are not as available as they should be,

including at the case management level (e.g., reminding them of an appointment in their own language).

All respondents noted the unique strengths of these communities for resisting substance use that can be built on, especially resiliency and learned coping strategies for dealing with extreme stress. "They have already experienced hardship. It's made them strong." These are "some of the most resilient people in the world - What they have been through to get here." "All they've been through before and once they get here." They are guided by hopes and dreams of a better future. The youth want to get an education and make a difference in their home countries. The communities are closely knit families and help each other a lot. They typically have strong religious and cultural beliefs. If they need treatment, refugees are adaptable and have the potential to learn how to adapt to a healthier lifestyle.

Promotores

Promotores reported a desire for more prevention workshops for children and youth. Respondents felt schools should provide prevention programs in health education, but currently this does not occur in their school district in Phoenix. Other ideas included:

- Mandatory guidance counseling sessions to assist youth with post high school options to address kids having few opportunities to lead them away to drug use;
- More educational materials related to prevention;
- Help for those who need treatment for substance use and/or misuse but can't afford it even if they have insurance;
- Parents networking and talking more to one another;
- Parents nurturing kids' self-esteem more;
- Parents having more conversations about dangers of substance use with kids; and
- More programs to keep kids busy such as leadership programs and resources to allow kids to participate in extracurricular activities which means sometimes parents need to be educated to enroll their kids in these activities.

Higher Education

Interviews with four key informant university staff who were engaged in prevention efforts identified some suggestions specific to the higher education population, where alcohol use is a major issue. The higher education respondents suggested making presentations more interactive and moving away from PowerPoints to be more flexible - "having a little more freedom to incorporate different activities and a little just different teaching styles". Other ways to improve on prevention included more broadly implementing SBIRT (Screening, Brief Intervention and Referral to Treatment) strategies, and expanding awareness of dangers related to mixing alcohol with other substances. The higher education respondents identified the best ways to reach their students with prevention. They recommended less high-handed strategies ("Don't do this because it's bad for you"; "This is going to kill you") in favor meeting them

"where they are and giving them tools to make some changes and some reasons for why they should consider those changes, without being prescriptive and mandating –'You have to do this kind of thing'…because they feel like they're invincible and they don't necessarily agree with that." Students seem to register the messaging around social norms, the statistics that reveal that not all students are drinking. University-age students "want to feel empowered, they want to be able to read that information and then have that knowledge themselves to make their own decisions, feel like they're making the decisions themselves and no one's telling them what to do…..they take all the information they learn from us, from the media, from different things and they kind of use that as a guide but it's not anyone telling them exactly what they can or can't do."

Workforce Survey

Responses from prevention workers across the State also shared ideas on resource needs, challenges in working in prevention, and other recommendations regarding future prevention efforts.

Needed Resources

Respondents were asked, "What are the main challenges that you experience as a substance use prevention 'specialist' in your community or at your agency/coalition/organization?" The most common responses relating to primary prevention are illustrated in Exhibit 85. See Appendix F for the full list of responses, including responses related to treatment.

> "Not having enough time or money to do our job effectively. We need more staff…"
>
> "Remember the Arizona campaign about tobacco in the 1990s that led to Arizona having the lowest tobacco use nationally today? That's what we need regarding opioids. Show little kids what their lives will look like if they use drugs. Scare them. Make them want a better life."
>
> "Parent involvement is a challenge. Parents frequently don't see the need to put the time and effort into gaining the knowledge and skills to help their children resist drugs. A large portion of parents don't acknowledge the need for it until their child has been caught using drugs."
>
> "[There are] not enough prevention "champions" at the state level to advocate for prevention in the State and coordinate prevention efforts."

"…The schools are hard-pressed to make time to both deliver academic curriculum and perform well on State tests and allow prevention specialists to work with youth during the school day."

Exhibit 85. The most common response themes to "What are the main challenges that you experience as a substance use prevention "specialist" in your community or at your agency/coalition/organization?"

Theme	n
Funding/consistent funding/flexible funding (e.g., for coalitions, for prevention staff committed to a single community, prevention programs, transportation, snacks/incentives, for an evaluator; for community outreach; to research what is effective; treatment)	34
Not enough time to do the job well/lack of staff (e.g., to cover the needed partners, to cover the territory)	7
Engaging the community to participate in prevention efforts	7
Finding volunteers (e.g., for coalitions, promotores)	5
Engaging parents to participate in prevention efforts	5
Educating the public/ Community does not recognize the risk from drugs	5
Engaging community institutions/authorities to support prevention efforts (e.g. schools, the State)	5
Collaborating with other area agencies (e.g., sharing space for prevention programs; cross referrals)	4
Lack of resources generally	4

The following quotes describe less common themes but in informative detail.

> "Prevention Specialists don't seem to be recognized as a profession in Arizona. …This work is underpaid, making it difficult to attract and retain educated, experienced, and motivated staff. Many of the people I have met in prevention didn't necessarily set out to have a career in this profession, so they must do a lot of the learning on their own, and yet there are not many in-person affordable and accessible learning opportunities to keep up with drug trends, terms, types, or uses."

> "A lot of the prevention material is too wordy."

> "That we don't have time to prevent substance use. We spend all of our time treating it."

> "The focus is chasing the overdose numbers. When prevention saves lives from the beginning it is hard to measure but it is easy to track how many people you have brought back from the brink of death- but why should we wait until that point? We know that prevention works. We need to invest in the front end to keep people from becoming addicted to begin with."

> "We cannot get our providers in this community (both within our organization and out) to stop prescribing medication with potential for addiction intelligently. That is, we can't

> get them to consider non-addictive medicines first (i.e. Strattera for AD/HD vs. Ritalin or Ibuprofen over opioids). Further, we also struggle with ensuring they're using our well-trained behaviorists, physical therapists, or acupuncturist or other pain-based specialists before just writing a prescription and wishing the patient luck."
>
> "Working with youth who are already using isn't prevention, it's intervention and it has be a struggle to cope with the changes prevention has seen in the last three years."

Some issues respondents raised about funding:

> "Funding is also always a challenge in prevention and health promotion."
>
> "Funding. And not having secured funding over multiple years. It's difficult to work in a community when funding ends and begins. You lose trust [from] the community."
>
> "Funding, Funding. Funding. Did I say funding? As a rural program funding provides the life line to cover the costs of programs, transportation and should cover the cost [of] food/snacks as incentives for attendance. Feed them and they will come."

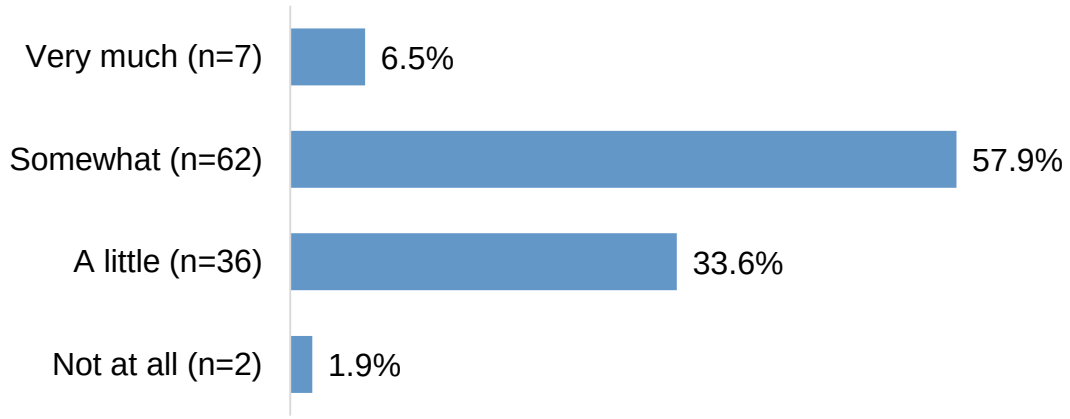
Respondents were asked to report on resources other than funding that would help the community be more effective in substance use and/or misuse prevention efforts. Respondents could report more than one type of resource. Exhibit 86 illustrates the number of individuals who reported that each resource was needed to help their community be more effective in substance use prevention efforts. The most common type of resource needed was help engaging the community. Respondents were also asked how engaged their community is in substance use prevention efforts. Almost all respondents (91.5%) reported that their community was a little to somewhat engaged in prevention efforts. Few reported that their community was very engaged. (See Exhibit 87).

Exhibit 86. Types of Resources Needed to Help their Community be More Effective in Substance Use Prevention Efforts (N=108)

	Number	Percentage
Help engaging the community	91	84.3%
Data on their community	71	65.7%
Prevention experts	64	59.3%
Facilities/building/space	59	54.6%
Help evaluating the impact of prevention programs	58	53.7%
Help with strategic planning	43	39.8%
Help running meetings	34	31.5%

*Respondents could report more than one type of substance use prevention resource needed.

Exhibit 87. How Engaged is the Community in Efforts (N=107)



Fourteen respondents reported one or more "other" resources that were needed besides those listed. Their responses fell into the following themes:

- Additional Staff (2)
- More Training Opportunities
    - Media Training
    - Free Trainings from Industry Experts
- Communicating the importance of collaboration to reduce duplication of efforts.
- Engaging professionals with authority.

    - Recruiting local government officials for education and awareness events and coalition participation to help them identify where they can be most effective.
    - More presence from "higher ups"
- Modeling best practices that are not criminalizing or stigmatizing.
- Recovery Meeting Materials
- Stronger Legal Interventions (e.g., for those arrested for dealing, using any drug legal or not legal, RX prescription drugs usage addiction).
- Annual Conference
- Housing Resources

Two respondents also noted that data, when it is provided, needs certain characteristics to be useful, specifying "up to date," "complete," and "timely."

Respondents were asked, "What resources for substance use prevention are sufficient in your community?" The most common responses relating to primary prevention are illustrated in Exhibit 88. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 88. The Most Common Response Themes to "What resources for substance use prevention are sufficient in your community?"

Theme	n
Public information (materials, dissemination opportunities)	6
Coalitions	5
Training and support for prevention professionals	4

Thirty-five respondents volunteered that there were not enough prevention resources. Examples of these responses included:

> "Naloxone trainings… Those are flooding all communities. But as for primary prevention, I don't think any communities have sufficient resources for substance abuse prevention. Prevention continues to be de-valued. More resources are being moved to treatment."

> "Prevention resources are drying up in Pinal County. Every non-profit and agency is going after the same pocket of funds. More funding is being put into treatment than prevention which in my opinion is not okay."

"There are currently none. The State Block Grant that funded coalitions was withdrawn at the RBHA level - hence no job."

"There are never enough resources. We need more prevention and early intervention, counseling not just for kids, but for families entirely. We need to incorporate this topic [into] the day to day school curricula and have parents involved and participating."

"Substance misuse is associated with a wide range of health and social problems including heart disease, stroke, HTN, various cancers, mental disorders, driving under the influence, sexual assault, rape, unintended pregnancy, sexually transmitted infections, intentional and unintentional injuries and property crimes. ……. More evidence-based prevention interventions…that could be carried out before the need for treatment, could delay early use and stop the progression from use to problematic use or to a substance use disorder all of which are associated with costly individual, social, and public health consequences."

"There is not enough money for more of a workforce to implement the strategies that we know work. Our State gives just enough to say they are doing something, but we are not able to do it in a meaningful way. Most dollars go to our big brother, Treatment… Do we really want to reduce costs and help people? Then we need to put more money, effort and time into prevention so that people will not need treatment."

One respondent wrote, "I believe there are sufficient resources for prevention, but inadequate knowledge of the resources available."

Evaluation of Efforts

Respondents were asked, "What methods are you using to evaluate whether your substance use prevention program or practice is effective?" The most common responses relating to primary prevention are illustrated in Exhibit 89. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 89. The Most Common Response Themes to "What methods are you using to evaluate whether your substance use prevention program or practice is effective?"

Theme	n
Pre/post or follow-up surveys or knowledge assessment with participants	29
Unspecified questionnaire/survey	16
Community surveys/feedback	8
Review results of external surveys (e.g. AYS)	7
Official records (e.g. overdose rates, police records)	5
Outcome evaluation generally	5
Process evaluation generally	4
Using an evidence-based program	4

While the most common responses (in pre/post/follow-up surveys or knowledge assessment with participants) related to potentially effective evaluation, responses also highlighted a lack of understanding for many respondents of what it means to evaluate a program *for effectiveness*. For example, strategies such as process evaluation generally; community surveys/feedback; or using an evidence-based program do not typically provide reliable evidence of effectiveness of a program (although using an evidence-based program may reduce the expectation that evaluating program effectiveness is needed). Further, seven respondents volunteered that there were *no efforts* to evaluate whether their program was effective.

Respondents were asked, "What kinds of evaluation needs does your community have that are not being met?" The most common responses relating to primary prevention are illustrated in Exhibit 90. There were few themes common across respondents, possibly due to the lack of understanding of evaluation, which was highlighted in their responses to the previous question. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 90. The Most Common Response Themes to "What kinds of evaluation needs does your community have that are not being met?"

Theme	n
AYS (e.g. more schools, quicker results, include LGBTQ data)	5
Formal evaluation strategies	5
Community Needs assessment	4

Conclusion

The 2018 Arizona Statewide Prevention Needs Assessment aimed to answer the following four key questions about substance use prevention in Arizona:

1. What are the current substance use issues in Arizona by region and subpopulation?
2. What substance use prevention programs are occurring in Arizona?
3. What are the causes for using and/or misusing substances in Arizona?
4. What are the recommendations for the future of substance use prevention in Arizona?

Critical Findings

The second and third steps in the Strategic Framework Process are capacity building and planning. The hope is that in conducting the first step (assessment) that findings can be generated that are specific, data-informed, and impactful in the subsequent strategic planning process that can lead to meaningful policy change. With these criteria in mind, the following key findings of the needs assessment have been identified:

1) **An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.** Barriers to treatment include the lack of appropriate/available treatment (long waiting lists or lack of services in underfunded regions), stigma associated with accessing treatment, the cost and complexity of receiving treatment, and the reduction of mental health services and supports in schools and universities across the State. Suicide rates in Arizona are significantly higher than the national average, which bolsters the finding, that the mental health needs of our State require enhanced support.

2) **LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.** This health disparity is one of the most prominent findings of this Statewide Needs Assessment. It is clear that there is work to do to reach this population more effectively with prevention efforts, resources and supports here in Arizona.

3) **Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.** This new substance use trend should be considered with future prevention programs.

4) **The counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.** Secondary data analyses indicate these three counties are experiencing more severe consequences of substance misuse (hospitalizations and deaths) than all other counties in Arizona. Prevention programs should target these high need/high risk regions.

5) **A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.** Increasing social isolation was a repeated theme across all regions and subpopulations. Future prevention efforts should consider prioritizing this key protective factor for their communities.

6) **The normalization of marijuana and other substances may be leading to increased substance use.** Due to the legalization of marijuana and the normalization of substance use in entertainment, social media, marketing/advertising and families/communities, individuals may not be adequately exposed to, or educated about, consequences of use and may also be less inclined to respond to these types of messages due to this normalization.

7) **Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.** Due to lack of funding and resources for some school districts (e.g. schools having to move to four-day school weeks), it is difficult to implement prevention programs due to schools needing to prioritize time and resources to focus on and meet the requirements for core competencies.

8) **Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.** Many efforts have been made in Arizona to reduce opioid use including RX take back days, educational efforts, and oversight and regulation of opioid prescribers. Some communities that are regulating the prescription of opioids more strictly are finding individuals are resorting to heroin and other street drugs once they are no longer able to procure opioids from their physicians.

9) **Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.** Across the State, and particularly among youth, many current prevention efforts are seeing limited engagement and results that may be due to an inability to grasp the attention of the target population. More modern and up to date prevention program strategies should be considered and developed to attract

and engage more effectively the populations being served. In addition, the cultural sensitivity of a prevention effort should always be considered before implementation in a community.

10) **If basic needs are not being met (e.g. shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.** Though there are a number of services available in communities to address these issues, many regions in Arizona still experience these difficulties. Prevention efforts should take into account the basic needs of the communities they serve, and offer, where possible, supports or referrals to address these basic needs parallel to prevention programming.

Strengths of Needs Assessment

A major strength of this needs assessment is the breadth and depth of data collected and analyzed. The four-pronged project approach (secondary data analysis, focus group and interview data collection, community inventory survey and workforce survey) helped to build a comprehensive understanding of the prevention needs and assets in Arizona. A cross section of communities, individuals and populations represented in this assessment paint a dynamic and detailed picture of the State. Relatively recent data was available for the majority of secondary data measures for both Arizona and national comparisons. In addition, response rates for both the Prevention Workforce Survey and the Community Prevention Inventory were healthy considering the short time frame for collection, and covered a wide cross section of regions, communities and populations.

Another strength of this needs assessment was the collaborative support and help received by so many individuals and organizations across the State to share data (or help locate data), coordinate and schedule focus groups (including offering spaces to conduct them and recruitment), and share information with helpful and informed individuals in focus groups and interviews. The excitement and appreciation expressed by the prevention community about the State's commitment to conducting this needs assessment was palpable.

Limitations

Secondary Data Analysis

There are a number of limitations to the secondary data analysis that should be considered when interpreting findings.

(1) Survey samples may not be representative of the target population, either because of chance, low response rates, or some error in survey methodology. Survey respondents may answer survey questions inaccurately, either because they cannot recall the event

correctly, did not understand the question, or because they want to provide a more socially desirable response. Social response bias can be especially problematic when survey questions ask about something illegal, like drug use. As a result, survey data may under-estimate the true prevalence of an event. Additionally, when sample sizes are small, it is more difficult to make accurate estimates or detect true differences between estimates. All data were also cross-sectional in nature, making it difficult to evaluate causality. Finally, administrative data sources are prone to error, especially due to mistakes or inconsistencies in mortality coding or disease classification. Errors in administrative data sources are difficult to identify and evaluate.

(2) Most indicator data were compiled from multiple data sources. Users are cautioned not to directly compare prevalence estimates from different data sources.

(3) Changes to national and statewide survey methodology or items overtime can compromise trend analyses attempting to compare data across baseline dates.

(4) Data were not available for several key indicators and priority populations; the most notable groups were American Indian/Alaska Native populations, especially at the Tribal level and LGBTQ adults.

(5) Online analytical tools, when available, were limited in the statistical analyses they could perform making it difficult to completely assess disparities and test hypotheses. Finally, due to lags in data collection and processing, the most recent data for many indicators were from 2016. These data may not accurately reflect current substance use patterns, risks and consequences in Arizona. In the future, targeted data collection and analytical efforts could help improve information about substance use in Arizona.

Focus Groups and Interviews

It is important to note that the time frame for the evaluation team to complete the entire Statewide Needs Assessment was very short, but despite this, primary data collection for focus groups and interviews were successfully conducted with groups and individuals that responded quickly to requests from the evaluation team. Although an enormous amount of support and requests were made, due to scheduling issues, travel coordination, resource availability, and willingness to participate, the reader should interpret qualitative findings as a **sampling** of perspectives in Arizona. There may be selection bias involved in the reporting on those groups and interviews because of the criteria mentioned above. In addition, it is important that the reflections of those members from the Pascua Yaqui and Gila River Indian Community focus groups and interviews not be generalized to each other or to other Tribes in Arizona. In future assessments, it will be a priority to include more Tribal communities in the data collection process.

Community Inventory and Workforce Survey

The community inventory and workforce survey were digital surveys sent to providers and workers across Arizona. Response rates for each survey were moderate, but only represent a

sampling of perspectives and programming. In addition, the level of detail provided by respondents in the community inventory varied widely, offering a range of detail on each program. Numerous follow up attempts were made to increase participation in both surveys, but due to time constraints, not all voices and viewpoints could be represented in these data summaries.

References

The Annie E. Casey Foundation. Kids count state ranking. Retrieved from https://datacenter.kidscount.org/rankings

Arizona Criminal Justice Commission. (December 20, 2018). Arizona youth survey 2016: State of Arizona. Retrieved from http://azcjc.gov/content/arizona-youth-survey

Arizona Criminal Justice Commission. (March 09, 2018). Arizona youth survey 2016: Selected trends, 2008-2016. Retrieved from http://azcjc.gov/sites/default/files/pubs/2016_AYS_Trends.pdf

Arizona Department of Health Services. (May 2018). Arizona medical marijuana program report: May 2018 monthly report. Retrieved from https://www.azdhs.gov/documents/licensing/medical-marijuana/reports/2018/2018-may-monthly-report.pdf

Arizona Department of Health Services. (2016) The 2016 Arizona opioid report. Retrieved from https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/arizona-opioid-report.pdf

Arizona Department of Health Services, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016). Death rates, vital statistics trends in Arizona. Retrieved from https://pub.azdhs.gov/health-stats/menu/info/trend/index.php?pg=deaths

Arizona Department of Health Services, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) Hospital inpatient discharges and emergency room visits statistics. Retrieved from https://pub.azdhs.gov/health-stats/hip/index.php?pg=drugs

Arizona Department of Health Services, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016). Intentional self-harm (suicide), Arizona, 2006-2016. Retrieved from https://pub.azdhs.gov/health-stats/hip/index.php?pg=drugs AZDHS intentional self-harm 2006-2016

Arizona Department of Health Services, Prevention Services. (2016). Suicide and self-inflicted related injuries, among Arizona residents. Retrieved from https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/injury-prevention/suicide-report-2016.pdf

Berning A., Compton R., Wochiner K. (2014). Results of the 2013-2014 National Roadside Survey of Alcohol and Drug Use by Drivers. National Highway Traffic Safety and Administration, 2014. Retrieved from https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/812118-roadside_survey_2014.pdf

Bureau of Labor Statistics, U.S. Department of Labor. (2018). Current Population Survey. Retrieved from https://www.bls.gov/cps/tables.htm

Centers for Disease Control and Prevention. (2015). Alcohol Poisoning Deaths: Vital Signs Retrieved from https://www.cdc.gov/vitalsigns/alcohol-poisoning-deaths/index.html

Centers for Disease Control and Prevention (2016). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016.

Centers for Disease Control and Prevention. (2016). U.S. county opioid prescribing rate aaps. Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

Centers for Disease Control and Prevention. (2017). High School Youth Risk Behavior Survey Data. Retrieved from http://nccd.cdc.gov/youthonline/.

Centers for Disease Control and Prevention. (2017). National Youth Tobacco Survey Data. Retrieved from https://www.cdc.gov/tobacco/data_statistics/surveys/nyts/index.htm

Center for Substance Abuse Treatment (2008). Substance Abuse and Suicide Prevention: Evidence and Implications – A White Paper. DHHS Pub No SMA-0804353. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (2009). Addressing Suicidal Behaviors in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 50. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Cicero, T. J., Ellis, M. S., Surratt, H. L., & Kurtz, S. P. (2014). The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA psychiatry*, 71(7), 821-826.

Community Anti-Drug Coalitions of America (2010). *The Coalition Impact: Environmental Prevention Strategies*. Alexandria, VA. Retrieved from https://www.cadca.org/sites/default/files/resource/files/environmentalstrategies.pdf

Compton, W.M., Han, B., Hughes, A., Jones, C.M., & Blanco C. (2017). Uses of marijuana for

medical purposes among adults in the United States. *JAMA*, 317(2).
Compton, R. (2017). Marijuana-Impaired Driving - A Report to Congress. (DOT HS 812 440). Washington, DC: National Highway Traffic Safety Administration.

Darke, S., Ross, J., Lynskey, M., & Teesson, M. (2004). Attempted suicide among entrants to three treatment modalities for heroin dependence in the Australian Treatment Outcome Study (ATOS): prevalence and risk factors. *Drug and Alcohol Dependence*. 73:1–10.

Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018. https://www.mentalhealth.va.gov/docs/datasheets/OMHSP_National_Suicide_Data_Report_2005-2016_508-compliant.pdf

Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., & Anda, R.F. (2003). Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. *Pediatrics*. 111: 564–72.

Grant, B.F., Stinson, F.S., & Harford, T.C. (2001). Age at onset of alcohol use and DSM-IV alcohol abuse and dependence: a 12-year follow-up. *J Subst Abuse*. 13: 493–504.

Grucza, R.A., Agrawal, A., Krauss, M.J., Cavazos-Rehg, P.A., & Bierut, L.J. (2016). Recent trends in the prevalence of marijuana use and associated disorders in the United States. JAMA Psychiatry. 73(3):300-301. doi:10.1001/jamapsychiatry.2015.3111.

Guy, P.H., Zhang, K., Bohm, M., et al. (2017). Changes in Opioid Prescribing in the United States, 2006–201. *Vital Signs*. 2017.

Hasin, D.S., Saha, T.D., Kerridge, B.T., et al. Prevalence of marijuana use disorders in the United States Between 2001–2002 and 2012–2013. JAMA Psychiatry. doi: 10.1001/jamapsychiatry.2015.1858

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychological bulletin, 112(1), 64.

Institute of Medicine. New directions in definitions. In: Mrazek, P.J., and Haggerty, R.J., eds. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington, DC: National Academy Press, 1994.

Kilpatrick, D., Acierno, G., Saunders R, et al (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology*, 68(1), 19-30.

Kuklinski, M. R., Fagan, A. A., Hawkins, J. D., Briney, J. S., & Catalano, R. F. (2015). Benefit–cost analysis of a randomized evaluation of Communities That Care: monetizing intervention effects on the initiation of delinquency and substance use through grade 12. *Journal of experimental criminology*, 11(2), 165-192.

Lipari, R.N., Ahrnsbrak, R.D., Pemberten, M.R., & Porter, J.D. (2017). Risk and protective factors and estimates of substance use results from the 2016 National Survey of Drug Use and Health. SAMHSA. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR3-2016/NSDUH-DR-FFR3-2016.html

Maloney, E., Degenhardt, L., Darke, S., et al. (2007). Suicidal behavior and associated risk factors among opioid-dependent individuals: a case-control study. *Addiction.* 102:1933–1941.

Mann, R.E., Smart, R.G., & Govoni, R. (2004). The epidemiology of alcoholic liver disease. National Institute of Alcohol Abuse and Alcoholism. https://pubs.niaaa.nih.gov/publications/arh27-3/209-219.htm

Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008. https://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf

Morbidity and Mortality Weekly Report (2017). Vital Signs: Changes in opioid prescribing in the United States. 66(26): 697–704. Retrieved from 10.15585/mmwr.mm6626a4

Nkansah-Amankra, S., & Minelli, M. (2016). "Gateway hypothesis" and early drug use: Additional findings from tracking a population-based sample of adolescents to adulthood. *Preventive Medicine Reports*. 4:134-141. doi:10.1016/j.pmedr.2016.05.003.

Office of the U.S. Surgeon General (2018). E-cigarettes: Know the risks. Retrieved from https://e-cigarettes.surgeongeneral.gov

Romano, E., Torres-Saavedra, P., Voas, R. B., & Lacey, J. H. (2014). Drugs and alcohol: their relative crash risk. *Journal of studies on alcohol and drugs*, 75(1), 56-64.

Rural Health Quarterly (2017). Arizona's Rural Health Report Card. Retrieved from http://ruralhealthquarterly.com/home/2017/12/15/u-s-rural-health-report-card-2017/

Spoth, R. L., Guyll, M., & Day, S. X. (2002). Universal family-focused interventions in alcohol-use disorder prevention: cost-effectiveness and cost-benefit analyses of two interventions. *Journal of Studies on Alcohol*, 63(2), 219-228.

Swendsen, J., Conway, K.P., Degenhardt, L., et al. (2009). Socio-demographic risk factors for alcohol and drug dependence: the 10-year follow-up of the national comorbidity survey. *Addiction* (Abingdon, England). 104(8):1346-1355. doi:10.1111/j.1360-0443.2009.02622.x.

Swendsen, J., Conway, K.P., Degenhardt, L., et al. (2010). Mental Disorders as Risk factors for Substance Use, Abuse and Dependence: Results from the 10-year Follow-up of the National Comorbidity Survey. *Addiction* (Abingdon, England). 105(6):1117-1128. doi:10.1111/j.1360-0443.2010.02902.x.

Substance Abuse and Mental Health Services Administration. (2017). 2015-2016 National Survey on Drug Use and Health: Other sources of state-level data. Centers for Behavioral Health Statistics and Quality. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUHsaeOtherSources2016/NSDUHsaeOtherSources2016.htm

Substance Abuse and Mental Health Services Administration. (2016). In Brief: Substance Use and Suicide: A Nexus Requiring a Public Health Approach (HHS Publication No. SMA-16-4935, NSDUH Series H-52). Rockville, MD Retrieved from https://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pdf

Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD Retrieved from https://www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration. (2018). Treatment Episode Data Sets (TEDS), Centers for Behavioral Health Statistics and Quality. Retrieved from https://wwwdasis.samhsa.gov/webt/information.htm.

Wilcox, H.C., Conner, K.R., & Caine, E.D. (2004). Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. *Drug Alcohol Depend*. 76(suppl): S11–S19.

Williams, A.R., Santaella-Tenorio, J., Mauro, C.M., Levin, F.R., & Martins, S.S. (2017). Loose regulation of medical marijuana programs associated with higher rates of adult marijuana use but not cannabis use disorder. *Addiction* (Abingdon, England). 2017;112(11):1985-1991. doi:10.1111/add.13904.

United States Census Bureau. (2017). American Community Survey 5-year estimates, 2012-2016. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml?src=bkmk

List of Figures

Exhibit 1. Overview of the Arizona Statewide Substance Use Prevention Needs Assessment ... 16

Exhibit 2. Location of Arizona's Counties and Tribal and Regional Behavioral Health Authorities (TRBHAs)* ... 27

Exhibit 3. Population Estimates by Arizona County, 5-Year Estimates from 2012-2016 ... 28

Exhibit 4. Median Age by Arizona County, 5-Year Estimates from 2012-2016 ... 29

Exhibit 5. Race/Ethnicity in Arizona, 5-Year Estimates from 2012-2016 ... 29

Exhibit 6. Race/Ethnicity by Arizona County, 5-Year Estimates from 2012-2016 ... 30

Exhibit 7. Percentage of Individuals Living Below 100% of the Federal Poverty Line by Arizona County, 5-Year Estimates from 2012-2016 ... 30

Exhibit 8. Annual Average Unemployment Rate (%) by Arizona County, 2017 ... 31

Exhibit 9. Percentage of Individuals 25 and Older who Did Not Graduate From High School by Arizona County, 5-Year Estimate 2012-2016 ... 32

Exhibit 10. Prevalence of Past Month Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016 ... 34

Exhibit 11. Prevalence of Past Year Drug Use Among those 12 and Older in the U.S. and Arizona, 2015-2016 ... 35

Exhibit 12. Prevalence of Past Month Alcohol Use and Binge Alcohol Use by Age Group in the U.S. and Arizona, 2015-2016 ... 36

Exhibit 13. Trends in Prevalence of Past Month Alcohol Use in Arizona by Age Group, 2008-2016 ... 38

Exhibit 14. Trends in Prevalence of Past Month Binge Drinking in Arizona by Age Group, 2008-2014 ... 38

Exhibit 15. Trends in Prevalence of Past Month Alcohol Use Among Arizona High School Students by Gender, 2009-2017 ... 39

Exhibit 16. Prevalence of Any Alcohol Use in the Past Month Among those 12 and Older by Arizona's RBHA, 2014 - 2016 ... 39

Exhibit 17. Prevalence of Past Month Alcohol Use among Individuals 18 and Older by Educational Attainment, 2016 ... 42

Exhibit 18. Prevalence of Past Month Tobacco and Cigarette Use by Age Group in the U.S. and Arizona, 2015-2016 ... 43

Exhibit 19. Trends in the Prevalence of Past Month Cigarette Use in Arizona by Age Group, 2008-2016 44

Exhibit 20. Prevalence of Past Month Cigarette Use Among those 12 and Older by Arizona's RBHA, 2014 - 2016 45

Exhibit 21. Prevalence of Past Year and Past Month Marijuana Use by Age Group for the U.S. and Arizona, 2015-2016 47

Exhibit 22. Trends in Prevalence of Past Year Marijuana Use in Arizona by Age Group, 2008-2016 48

Exhibit 23. Prevalence of Past Year Cocaine Use by Age Group for the U.S. and Arizona, 2015-2016 49

Exhibit 24. Trends in Prevalence of Past Year Cocaine Use in Arizona by Age Group, 2008-2016 50

Exhibit 25. Prevalence of Past Year Heroin Use by Age Group in the U.S. and Arizona, 2015-2016 51

Exhibit 26. Trends in the Prevalence of Past Year Heroin Use in Arizona by Age Group, 2013-2016 52

Exhibit 27. Prevalence of Past Year Pain Reliever Misuse by Age Group for the U.S. and Arizona, 2015-2016 54

Exhibit 28. Prevalence of Past Month Illicit Drug Use and Illicit Drug Use Other than Marijuana by Age Group for the U.S. and Arizona, 2015-2016 55

Exhibit 29. Prevalence of Past Year Alcohol, Illicit Drug Use and Substance Use Disorder by Age Group for the U.S. and Arizona, 2015-2016 56

Exhibit 30. Prevalence of Substance Use Indicators Available in the NSDUH, YRBS, and BRFSS 59

Exhibit 31. Hospital and ED Discharge Rates per 10,000 with Alcohol Abuse as First-Listed Diagnosis, by Age in Arizona, 2016 62

Exhibit 32. Hospital and ED Discharge Rates per 10,000 with Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Age in Arizona, 2016 63

Exhibit 33. Trends in Hospital Discharge Rates per 10,000 for Alcohol Abuse and Drug Dependence, Abuse and Misuse as First-Listed Diagnosis in Arizona, 2009-2015. 64

Exhibit 34. Trends in Hospital Discharge Rates per 10,000 for Specific Categories of Drugs in Arizona, 2009-2015. 65

Exhibit 35. Emegency Department Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016 66

Exhibit 36. Hospital Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016 66

Exhibit 37. Emegency Department Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016 67

Exhibit 38. Hospital Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016 67

Exhibit 39. Ratio of the Count of Drug-Related Deaths to Inpatient Discharges for Drug Abuse, Misuse or Dependence as First-Listed Dianosis by Arizona County, 2016 68

Exhibit 40. Hospital Discharge Counts and Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016 69

Exhibit 41. Inpatient Discharge and ED Discharge Counts and Rates per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016 70

Exhibit 42. Opioid Average 10-Year Death Rate per 100,000 Population in Arizona by Age Group, 2007-2017 71

Exhibit 43. Trends in Number of Opioid Deaths by Heroin and Prescription Opioids in Arizona, 2007-2017 72

Exhibit 44. Alcohol-Induced Death Rates per 100,000 by Arizona County, 2016 73

Exhibit 45. Drug-Induced Death Rates per 100,000 by Arizona County, 2016 73

Exhibit 46. Opioid-Induced Death Rates per 100,000 by Arizona County, 2016 74

Exhibit 47. Alcohol-Induced Death Rates per 100,000 by Gender and Race/Ethnicity in Arizona, 2016 75

Exhibit 48. Opioid and Drug-Induced Death Rates per 100,000 by Race/Ethnicity in Arizona, 2016 76

Exhibit 49. Percentage of Substance Use Admissions by Primary Substance of Misuse among Arizonans Aged 12 and Older, 2017 77

Exhibit 50. Age-Adjusted Suicide Mortality Rates per 100,000 by Age Group for U.S and Arizona, 2016 78

Exhibit 51. Arizona, Western Region, and National Veteran Suicide Deaths, by Age Group, 2016 79

Exhibit 52. Arizona Veteran and Overall Arizona, and National Suicide Deaths, by Age Group, 2016 79

Exhibit 53. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 for U.S. and Arizona, 2009-2016 80

Exhibit 54. Age-adjusted Suicide Mortality Rates per 100,000 by Arizona County, 2016 80

Exhibit 55. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Race/Ethnicity, 2006-2016 81

Exhibit 56. Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Gender and Race/Ethnicity, 2016 82

Exhibit 57. Drug-Related Arrests in Arizona in 2010 and 2016 86

Exhibit 58. Major Substance Issues* (N=109) 98

Exhibit 59. Distribution of Education Levels (N=140) 109

Exhibit 60. Distribution of Languages Spoken Fluently (N=141) 109

Exhibit 61. Length of Time Working in Substance Use Prevention (N=142) 110

Exhibit 62. Work Status of Respondents (N=142) 110

Exhibit 63. Counties where Respondents Engage in Substance Use Prevention (N=141) 111

Exhibit 64. Types of Communities Served (N=141) 112

Exhibit 65. Training related to substance use prevention that respondents reported they had received (N=97) 113

Exhibit 66. Where Respondents Reported Getting Substance Use Prevention-Related Trainings and Certifications (N=89) 114

Exhibit 67. Types of substance use prevention respondents engaged in. (N=140) 117

Exhibit 68. Types of Substance Use Prevention Happening in Respondents' Communities* (N=140) 118

Exhibit 69. The Most Common Response Themes to "What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?" 119

Exhibit 70. The Most Common Response Themes to "What substance use prevention activities have you seen that have been the most successful in engaging the community?" 120

Exhibit 71. The Most Common Response Themes to "Are there any types of substance use prevention efforts that you don't think help much or at all?" 121

Exhibit 72. All Themes to "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program?" 122

Exhibit 73. All Themes to "How does your agency/coalition/organization address underlying causes of addiction?" 124

Exhibit 74. Prevalence of Perceptions of Great Risk of Harm from Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016 127

Exhibit 75. Prevalence of Perceptions of Great Risk of Harm from Substance Use by Age Group for Arizona, 2015-2016 128

Exhibit 76. Prevalence of Serious Mental Illness and Major Depressive Episode in the U.S. and Arizona by Age Group, 2015-2016 130

Exhibit 77. Trends in the Prevalence of the Top Five Reasons for Using Substances Among Arizona Students in 8th, 10th and 12th Grades, 2012-2016 131

Exhibit 78. Trends in Prevalence of Past Year Major Depressive Episode in Arizona by Age Group, 2008-2016 132

Exhibit 79. Trends in Prevalence of Past Year Serious Mental Illness in Arizona by Age Group, 2008-2016 132

Exhibit 80. Prevalence of Early Age of Substance Use Initiation among High School Students for the U.S. and Arizona, 2017 134

Exhibit 81. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Substance Use 2016 137

Exhibit 82. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Disapproval of Substance Use by Grade, 2016 137

Exhibit 83. Percentage of High School Students Reporting Substance Use Risk Factors in the U.S. and Arizona and P-Values for Significant Difference Between Estimates, 2017 138

Exhibit 84. Opioid Prescribing Rates by Arizona County, 2016 141

Exhibit 85. The most common response themes to “What are the main challenges that you experience as a substance use prevention "specialist" in your community or at your agency/coalition/organization?” 177

Exhibit 86. Types of Resources Needed to Help their Community be More Effective in Substance Use Prevention Efforts (N=108) 179

Exhibit 87. How Engaged is the Community in Efforts (N=107) 179

Exhibit 88. The Most Common Response Themes to “What resources for substance use prevention are sufficient in your community?” 180

Exhibit 89. The Most Common Response Themes to “What methods are you using to evaluate whether your substance use prevention program or practice is effective?” 182

Exhibit 90. The Most Common Response Themes to “What kinds of evaluation needs does your community have that are not being met?” 183

Appendix A: Key Informant Interview Protocol

Date of Interview:_____ Start Time: _____ End Time: _____
Interviewee: _____
Special population if relevant: _____
…….I'm _____ from LeCroy & Milligan Associates. We are working with AHCCCS to conduct a Substance Abuse Prevention Needs Assessment for the State of Arizona. As part of this effort, we are interviewing people with expertise in substance abuse prevention in Arizona. Am I speaking with _____ [candidate's full name]_____?

I understand that you have been involved with substance abuse prevention and I'd like to ask you some questions about your experience [with *special population* as relevant]. The interview will take about 30 minutes. Is this a good time to talk?

I'll be tape recording our conversation so we can capture your ideas clearly. Is that ok?

I'd like to make sure you know that:

- There are no right or wrong answers;
- Your participation is voluntary; and
- You can choose to not answer any question or end the interview at any time.

Shall we get started?

---

1. What do you think are major substance use issues in [region/community/special population]?
2. What substances are causing the most harm in [region/community/special population]?
    a. What kinds of harm are they causing?
    b. Are you aware of any substances that are causing more harm for any specific groups compared to the community as a whole?
3. What causes people in [region/community/special population] to use these substances?
4. Are there any particular issues people in [region/community/special population] have that are contributing to using these substances? (Prompt as needed: mental health issues, financial challenges, physical health problems, etc.]
5. What does the community do to try to prevent use of these substances in [region/community/special population]?
6. How effective are these efforts?
    a. How could they be improved to be more effective?
7. What kinds of substance use prevention approaches would work the best for [region/community/special population]?

a. [As appropriate] Are the best prevention approaches different for youth and adults? How so?

8. What kind of prevention efforts does [region/community/special population] need more of?
9. What are some particular strengths of this [region/ community/special population] that prevent substance use?

Special Population Experts

10. [For special population experts] Are the substance use issues for [the subgroup] the same or different from the general population? How so?
11. [For special population expert] Are the substances that are causing harm in [the subgroup] the same or different from the general population? How so?
12. Are the causes of substance use the same for [the subgroup] the same or different from the general population?

Healthcare Experts

13. What changes have you seen recently to practices in the medical profession that reduce the risk for prescription drug misuse?
    a. Are there prescription practices or other practices that the medical field could change to enhance prevention efforts?

That was my last question. Thank you for your time and sharing your thoughts……

Appendix B: Focus Group Protocol

Introduction

a. Thank everyone for attending

b. Introduce facilitator, note taker and give a brief overview of LeCroy & Milligan Associates

c. Explain the purposes of the focus group:

- We are helping the State of Arizona learn more about alcohol and drug use and community prevention efforts. We'd would like to hear your ideas about these issues to help us understand how they affect the local community and how prevention efforts are working.
- Today's group discussion will take about 90 minutes. We will finish by ____.
- To show our appreciation for your participation, you will receive a gift card at the end of today's meeting.

d. Set Guidelines:
We have some guidelines that we find work well with focus groups and we'd like to suggest these:

- This is a brainstorming activity. There are no wrong answers. We're happy to hear a range of opinions and it's fine if people have different ones.
- We'd appreciate it if only one person talks at a time. Please do not interrupt or cut off other participants when they are sharing.
- Everyone should get an opportunity to speak to every question and no one should dominate the conversation; you are all experts and have something important to share.
- So that people can feel free to share their opinions, we ask that you not later share with anyone anything said by the other participants here today.
- Please turn off your cell phones or switch them to vibrate. Please go outside to take any calls that are urgent.
- Please feel free to quietly get up to use the rest room or get yourself something to drink at any time. The rest rooms are located _____.

Do you have any other grounds rules you'd like to suggest?

e. To help us document the information you share…….

- Please speak loud enough so everyone in the room can hear.
- We are going to be writing your ideas down so please try not to speak too fast.

- When we share your ideas with others, we will not say, "Charlie said this," or, "Beverly said that." Everything will be anonymous. We will identify people as Participant 1, Participant 2, etc.
- Here's how we'd like the focus group to go today: I will read a question. Then we would like you to discuss and respond to the question. It's not necessary to go around the room in order. Imagine you are sitting in your living room talking with each other about this subject, rather than talking to me as an interviewer. I will only add something if I have a follow-up question based on what people have been saying.

f. Ask permission to use tape recorder
   - Because it's hard to catch everything when we're writing and your opinions are important to us, we are going to record this discussion group. Only our research team will be able to listen to the recording.

g. Ask if there are any questions

h. Have participants introduce themselves

i. Turn on tape recorder and start the group discussion.

Questions

1. What do you think are major substance use issues in your student community?
2. What substances are causing the most harm in your student community?
3. What kind of harm is caused by these substances for your student community? What causes students in your community to use these substances?
4. Are there any particular issues your students have that are contributing to using these substances? (Prompt as needed: mental health issues, financial challenges, physical health problems, etc.)
5. How do students in your community get these substances?
6. What does the community or learning institution do to try to prevent use of these substances in your student community?
   a. How effective are these efforts?
   b. Are there ways they could be improved to be more effective?
   c. What kinds of prevention approaches would work the best in your student community?
7. What kind of prevention efforts does your student community need more of?
8. Is there anything else you would like to tell us?

Appendix C. Supplementary Demographic Data

County	Total Population	Hispanic or Latino (of any race)	White alone	Black or African American alone	American Indian/ Alaska Native alone	Asian alone	Other
Apache	72,346	5.9%	18.6%	0.5%	72.7%	0.4%	1.9%
Cochise	128,177	34.4%	56.3%	3.7%	0.8%	1.7%	3.0%
Coconino	138,064	13.7%	54.6%	1.3%	26.0%	1.7%	2.7%
Gila	53,179	18.5%	63.2%	0.6%	15.3%	0.8%	1.6%
Graham	37,529	32.1%	51.5%	1.8%	12.6%	0.7%	1.2%
Greenlee	9,224	46.5%	47.8%	1.8%	3.3%	0.6%	0.1%
La Paz	20,304	26.2%	58.9%	0.4%	12.1%	0.7%	1.8%
Maricopa	4,088,549	30.3%	56.9%	5.0%	1.5%	3.8%	2.5%
Mohave	203,629	15.7%	78.3%	1.0%	1.9%	1.1%	2.0%
Navajo	108,209	11.0%	41.9%	0.7%	43.2%	0.6%	2.6%
Pima	1,003,338	36.1%	53.3%	3.2%	2.4%	2.6%	2.4%
Pinal	397,604	29.2%	57.9%	4.3%	4.6%	1.7%	2.3%
Santa Cruz	46,547	83.2%	15.3%	0.2%	0.2%	0.8%	0.3%
Yavapai	218,586	14.1%	81.2%	0.5%	1.6%	0.8%	1.9%
Yuma	203,292	62.0%	32.7%	1.8%	0.9%	1.1%	1.5%

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Apache County Drug-Free Alliance (ACDFA)	Apache County RBHA: Steward Health Choice Arizona	youth and parents	Rx Drugs, Alcohol, Marijuana	Reality Tour (youth and parents do it together)	Little Colorado Behavioral Health; North Country Health Care	GOYFF -Parents Commission grant; SAMHSA (DFC grant
Be Awesome Youth Coalition	Santa Cruz RBHA: Arizona Complete Health	youth, parents, community members	Marijuana and alcohol	Too Good for Drugs (life skills) for 5th graders; Parent University, Rx-360	Maricopa Unified School District and Maricopa Police Department	Cenpatico for coalition; Governor's Office for mentoring; mini-grant from Casa Grande Alliance for Partnership for Success (PSS)
Way Out West (WOW) Coalition	Maricopa County RBHA: Mercy Care	youth, parents	Underage drinking, marijuana, Rx drugs	Currently reviewing programs, will soon decide what to implement. "Make Buckeye drug-free."	Buckeye Elementary School District; Buckeye Union H.S. District; Buckeye Police Dept.; Southwest Behavioral Health; Estrella Publishing	SAMHSA (DFC grant)
Santa Cruz County Drug Free Community Coalition	Santa Cruz RBHA: Arizona Complete Health	youth, parents	Marijuana, alcohol, and opiates	All Stars (EB). Parent workshops - Rx 260, 360 for Padres, opiates workshop, check points on prom night etc. in collaboration with Nogales Police Dept. - test youth coming back from Mexico; presentations in middle school assemblies	Santa Cruz County School Superintendent, Nogales Unified School District Superintendent, Mariposa Community	SAMHSA (DFC grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Clinic	
Urban Indian Coalition of Arizona (UICAZ)	Maricopa County RBHA: Mercy Care	American Indian youth and adults	Underage drinking, marijuana, Rx drug/opioid abuse, suicide prevention	The UICAZ is a community-driven coalition focused on educating and preventing substance use and abuse by adolescents; dedicated to discussing, advising and collectively working together to create awareness and address issues within the Native American community. UICAZ sponsors the Gathering of Native Americans (GONA) is a community event that provides culturally specific substance use prevention information eliciting community healing through topics of historical and cultural trauma experienced over generations. GONA is for the whole family, with age appropriate programming.		SABG
CARE Coalition (Community Alliance for Resources and Education)	Maricopa County RBHA: Mercy Care	youth, parents, community members	Alcohol, marijuana, prescription drugs	Rx-360 (youth, adults), Families in Action, community development (coalition, youth council), public awareness campaigns	Touchstone Health Services	Office of Adolescent Health- teen pregnancy prevention, SAMHSA (Project AWARE)- mental health, GOYFF –

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
						Parents Commission grant
Safe Out LGBTQ Youth Coalition	Maricopa County RBHA: Mercy Care	LGBTQ young adults aged 13-26	Alcohol, marijuana, prescription drugs and suicide	Education, collaboration, outreach & connection and community involvement	Terros Health	SABG
Mohave Substance Treatment, Education, and Prevention Partnership (MSTEPP)	Mohave County (Kingman) RBHA: Steward Health Choice Arizona	Youth (prevention), adults (recovery)	All	Arizona strategies "Tool Kit"	Kingman Police, Kingman Regional, Southwest Behavioral Health, Mohave Mental Health, Sonoran Prevention Works, Mohave County Department of Public Health, Probation, Drug court	Donations, Arizona Opioid State Targeted Response grant (STR) grants
Copper Basin Coalition	Gila County RBHA: Steward Health Choice Arizona	All ages	Opioids and all other substances, mental health wellness	Community Naloxone Distribution Project- community and peer-to-peer trainings Medication safety and proper sharps disposal- community and peer-to-peer trainings Rx-360, town halls, parent nights, various community events	Gila County Public Health Department, Gila County Sheriff's Office, Sonoran Prevention Works	We are 100% volunteer and operate by financial donations and in-kind donations.
Arizona Suicide Prevention Coalition	Statewide	All populations - i.e. youth, older adults,	The coalition addresses substance use as	The Coalition supports evidence-based programs, such as ASIST, safeTALK, QPR, Signs of Suicide, and another	The key partners are organizations who are invested in the	The Coalition doesn't receive specific funding,

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
		veterans, Native Americans, working-aged men; the focus is on these high-risk groups that are specifically affected by suicide.	part of suicide prevention.	suicide prevention media campaign called Man Therapy. The Coalition sponsors many trainings (ASIST, safeTALK) throughout the year. The Coalition supports evidence-based programming through our annual HOPE/Suicide Prevention conference and the Local Outreach to Suicide Survivors conference. Through a partner agency, Teen Lifeline, the Coalition supports Teen Suicide Prevention Awareness events in September, in conjunction with World Suicide Prevention Day. Also, the Coalition supports the efforts of EMPACT-SPC and their annual Survivors of Suicide Day Conference and the Jeremyah Memorial 5K Walk/Run to Support Survivors of Suicide.	mission of suicide prevention -i.e. behavioral health and crisis centers, hospitals, schools, state entities.	although is partnered with other suicide prevention agencies who receive funding from Mercy Care. The coalition receives funding through a state-wide conference that is sponsored/suppo rted by our community partners.
Help Enrich African American Lives Coalition (HEAAL)	Maricopa RBHA: Mercy Care	Youth and parents	Alcohol, Marijuana, Rx Drugs	Drug Prevention 4Teens - Evidence-based Rx 360 - Evidence-based, Community Forums, Basketball Camps, Youth leadership, Youth Peer education, adult community education, billboards, newspaper, Facebook, community health/resource fairs, youth media camp, legislative advocacy	South Mountain WORKS Coalition, Phoenix Police Dept., Maryvale YMCA, Urban Indian Coalition AZ, Tempe Coalition, Maricopa County Sheriff's Office, Maryvale Adolescent Prevention Partnership, South	Mercy Care, SAMHSA (Drug Free Communities Grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Mountain High School, Maryvale Community Center, Substance Abuse Coalition Leaders of Arizona	
Coolidge Youth Coalition	Maricopa County RBHA: Mercy Care	Youth K-12	Alcohol, Rx drugs, marijuana, tobacco, suicide	CYC collects core measurement data from Coolidge Unified Schools every 2 years by using the Arizona Youth Survey. CYC has for the past decade implemented environmental strategies such as SHO/URG, sticker shock, alcohol advertisement reduction (enforcing current signage code) and a permanent RX Drop Box location. CYC collaborates and implements sustainable prevention strategies in the Coolidge Community such as "The Green Zone" Anti-bullying curriculum; "Go Green – Don't Let Drugs Pollute Your Life" and the "Pinal County RX Pilot Program" among many others. They continue to deliver new & effective prevention strategies to Coolidge such as "Save a Life Stop Underage Drinking" campaign and "Just Drive" distracted driving campaign. CYC is collaborating with local treatment agencies to help Coolidge Schools	Youth, Parents, Law enforcement, Schools, Businesses, Media, Youth-serving organizations, Religious and fraternal organizations, Civic and volunteer groups, Healthcare professionals, State, local, and tribal agencies with expertise in substance use, Other organizations involved in reducing substance use	Drug Free Communities Support Program Private/Corporate Funding

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				update their current Drug and Alcohol Policy by offering counseling services. Starting August 2018, CYC will be going into 6th, 7th, 8th grades with Coolidge PD School Resource Officer to implement evidenced-based Marijuana Prevention Curriculum (NIDA) into the classroom.		
Healthy Pima	Pima County RBHA: Arizona Complete Health	All demographics affected by the opioid overdose epidemic.	All substances. However, action plans have been created for the prevention of Opioid overdoses through the year 2020	The Substance Misuse and Mental Health Alliance is comprised of six task forces dedicated to promoting mental health and addressing the misuse of over-the-counter and prescription medications, as well as the use of illicit drugs, that affect the health and wellbeing of Pima County youth, families, and the larger community.	Medicine Assisted Treatment Centers, Hospitals, Law Enforcement, Nonprofit organizations, faith-based communities, school administrators, community members, students, etc.	CDC, ADHS, and from whom ever can support the action plan initiatives.
(M.A.P.P.E.D.) Mohave Area Partnership Promoting Educated Decisions.	Mohave County (Bullhead City and the surrounding areas of Fort Mohave, Mohave Valley, Topock, Davis Camp, Katherine Heights, Fort Mohave Indian Reservation, Laughlin, NV and	The citizenship within the Colorado River Communities.	All types of substance use.	Currently hiring an education specialist to implement the Evidence-based Botvin Program (or an equivalent). Recovery in the Park, Walk Away from Drugs, Red Ribbon Week Events, Bike Safety Rodeo, Fire Prevention and Life Safety Fair, parades, Senior and Winter Visitors Expo, Community Health Fairs, Veterans Stand Down, Summer Library Programs, Town Halls and educational presentations to various community and	Bullhead City Police & Fire, many members of the medical community.	Donations and a small amount of grant funding

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
	Needles, CA)			religious groups. Each month the members brainstorm ways to reach all ages within the community.		
South Mountain Working to build Opportunities, Resources, Knowledge, and Skills (WORKS) Coalition	Maricopa County RBHA: Mercy Care	Youth (ages 12-17)	Alcohol, Marijuana, and Rx drugs	Above the Influence, Rx-360, PAC 360, Town Halls, door hangers, sticker shocks, community youth theater, Drug take back, education, youth leadership, youth council, movie screenings	South Mountain Community Library, HEAAL Coalition, First Pentecostal Church, South Mountain High School, Phoenix PD	Drug Free Communities Grant
MATFORCE, the Yavapai County Substance Abuse Coalition	Yavapai County RBHA: Steward Health Choice Arizona	Youth Recovery Community Parents/ Caregivers Elderly	All illegal and legal substances that are abused.	Substance Use Education in Schools - 15 different curricula Parenting Education Yavapai Reentry Project Professional Trainings such as Motivational Interviewing, Adolescent Brain Public Awareness on risks and harms of drugs and alcohol Strategies on Opioid Crisis Overdose Fatality Review Marijuana Harmless? Think Again! Campaign Youth Contests Youth Group Activities School Assemblies Red Ribbon Week Activities Stand with Me, Be Drug Free Week	We have over 300 committee members and partner with schools, the medical community, business community, faith-based community, recovery community, nonprofit organizations, government, etc.	GOYFF - Parents Commission grant; STOP Grant through SAMHSA Attorney General's Office PFS Grant Yavapai County
Casa Grande Alliance	Pinal County (Casa Grande) RBHA: Arizona Complete Health	Youth and adults	All substances	SADD, M.O.S.T. Campaign (Making Our Students Think): A social-norming model program implemented in partnership with local SADD Chapters and under the mentorship of University of Arizona's Campus Health Service. This campaign is youth-led and adult supervised, Anti-	CGA has over 50 organizations, agencies, and individuals from all of the 12 sectors.	GOYFF - Parents Commission Grant AHCCCS - Partnering For Success grant

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				drug Rally/SMART Moves Program, Play Healthy: A health-promotion program aimed at youth athletes, parents, and coaches. This unique program informs parents, coaches, and young athletes how players' health choices impact athletic performance and the success of their team. Strong Families, Prescription Drug Misuse Prevention Project, Prevention Poster Program		
Tempe Coalition	Maricopa County (Tempe) RBHA: Mercy Care	12-18 year old youth, parents, community members	Alcohol and marijuana	Town Halls, school assemblies, skill building workshops. As a coalition, we do not do programming. We support programs and services.	City gov't, local businesses, school districts, youth serving organizations, treatment organizations, ASU	Drug Free Communities Support Program
Cochise Health & Social Services Arizona Prescription Drug Overdose Prevention Program	Cochise County RBHA: Arizona Complete Health	Prescribers, Pharmacists, Law Enforcement, Community Members, Youth	Opioids/ Prescription Medications	Rx Drug Misuse & Abuse Initiative Community Toolkit which includes the following strategies: Strategy 1: Reduce Illicit Acquisitions and Diversion of Prescription Medications Strategy 2: Promote Responsible Prescribing and Dispensing Policies and Practices, Sign Up to Save Lives Campaign Strategy 3: Enhance Rx Drug Practices and Policies among Law Enforcement Strategy 4: Increase Public Awareness and Patient Education about the Risks of Rx Drug Misuse and Abuse Strategy 5: Enhance	Cochise Addiction Recovery Partnership Impact, Sierra Vista/Douglas Substance Abuse Coalition, Chiricahua Community Health Centers Inc., SEABHS Sonoran Prevention Works, Southern Arizona Opioid Consortium, Wellness Connections,	The Arizona Department of Health Services Office of Injury Prevention administers funds provided by the Centers for Disease Control Prevention for operation of the Prescription Drug Overdose (PDO)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				Assessment and Referral to Treatment. Outreach activities include health fairs, law enforcement events, Students Against Destructive Decisions (SADD)	Douglas/Bisbee Police Departments	Prevention for States grant.
Arizona SADD (Students Against Destructive Decisions)	Statewide	Middle and High School students	Drugs, alcohol	Various drug and alcohol awareness campaigns. Town Halls, Mock Crashes, Safe and Sober Prom nights, homecoming night, relay for life, various health and safety fairs, youth prevention conference.	Schools, parent groups, law enforcement, and firefighters	Governor's Office of Highway Safety, private donations
Chandler Coalition on Youth Substance Abuse	Maricopa County (Chandler, Gilbert) RBHA: Mercy Care	Teens, Adults	Opioids, Alcohol, Marijuana, ATOD	CCYSA created - Evidence Supported (we create the majority of our own presentations) Botvins Life Skills. Student presentations, Parent Presentations, Community Presentations, School Staff presentations, free Evaluations and Referrals into treatment, Tabling & Resource events, Shoulder Tapping, Advocacy, Take Backs, Compliance checks.	We have about 30 key partners from: Medical, Pharmaceutical, Prevention/ Intervention, Schools, City Government, Rehabilitation, Mental Health, and Faith based.	SAMHSA (DFC grant and STOP Act grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Copper Corridor Community Substance Abuse Coalition	Pinal County (Globe, Miami, and the Copper Corridor -Superior, Kearny, Hayden, Winkelman, Mammoth, San Manuel ,and Oracle) RBHA: Steward Health Choice Arizona	Youth, Young Adults, Parents	Rx drugs, opioids, marijuana	Community Naloxone Distribution Project- community and peer-to-peer trainings Medication safety and proper sharps disposal- community and peer-to-peer trainings Rx-360, town halls, parent nights, various community events		SAMHSA (DFC grant and STOP Act grant)
Development in Gila County for Young Adults (DIG YA)	Gila County RBHA: Steward Health Choice Arizona	Youth (under 21 years old)	Underage drinking			SAMHSA (STOP Act grant)
Fountain Hills Youth Substance Abuse Prevention Coalition	Maricopa County (Fountain Hills) RBHA: Mercy Care	Youth and their parents	Alcohol Prescription Drugs Marijuana	Text-A-Tip (environmental strategy) Evidence-based Safe Homes Network (environmental strategy) Rx-360 - Youth and parents - Evidence-based Rx Take Back programs Public Information campaigns. We partner on many of these activities with our coalition leaders taking most of the lead - Town Halls, parent nights, Falcon Fiesta (safe graduation party), Back to School Bash, sports nights	Drug Free Communities, CADCA, Town of Fountain Hills, Maricopa County Sheriff's Office, businesses, Fountain Hills Times, Fountain Hills Unified School District, Fountain Hills High School , Fountain Hills Elementary School, Fountain Hills Middle School, Fountain Hills PTO, Faith Community -	Drug Free Communities Grant - SAMHSA

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Church of the Ascension, Presbyterian Church, Shepherd of the Desert, Fort McDowell Yavapai Nation	
The Healthy People Coalition (HPC)	Tohono O'odham Nation (GuVo District)	Tohono O'odham, particularly youth	Underage drinking	Too Good For Drugs (Evidence-based), Safe and Sober Movie Nights Safe and Sober Arcade Nights Family Fun Nights Fun Runs Safe and Sober Holiday Parties After School Program Summer Adventure Program	Native American Advancement Foundation (NAAF), Healthy O'odham Promotion Program (HOPP), Cenpatico, Gu Vo District and Community Councils	Cenpatico Native American Advancement Foundation
Southern Arizona Opioid Consortium	Cochise County, Graham County, Pima County (rural) RBHA: Arizona Complete Health	Those affected by opioid use disorder inclusive of family and caregivers' Grades 6-9 students First responders & EMS	Opioids	Botvin Life Skills - Opioid Prevention education for grades 6-9 (Cochise County). Southern Arizona "Find Help & Treatment Close to Home" referral rack card Magnet with Cochise & Pima Co crisis line and Arizona Poison Control phone numbers - use by providers, first responders or general public Participation in community events primarily in Cochise County.	Northern Cochise Comm Hospital, TMC, Cenpatico, Wellness Connections, Community Bridges, Air Methods, Med Transport, Addiction Network, SAHBHS, Community Partners: Cochise Co Health Dept, Willcox School District, City of Douglas, City of Willcox, City of Bisbee,	HRSA grant funding an FTE only. Ends 6/30/18.

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Impact Sierra Vista	Cochise County (Sierra Vista, Fort Huachuca and Hereford) RBHA: Arizona Complete Health	Youth 12-19 and parents of youth 12-19	Alcohol-Underage Drinking and Marijuana Prevention	Project Alert: Middle School Evidence-based Program 8 sessions of 40 mins SADD Youth Leadership Program: 1 hr. Week or Biweekly sessions MADD Parent Workshop for the prevention of substance use in youth Marijuana Harmless: Think Again! Presentation for Cochise County NIDA Brain Power presentations for elementary schools. Annual Cochise County Youth Leadership and Empowerment Conference, Red Ribbon Week Brain Power Presentations for Elementary Schools, National Drugs and Alcohol facts week, International Overdose Awareness day.	Parents, Sierra Vista Schools, Youth, Cochise County Sheriff's Department, Cochise County Health Department, Lori's Place, Cochise County Youth Probation, Cochise County Superintendent.	Substance Abuse Block Grant
Young Adult Association of Havasu (YADAH)	Mohave County (rural areas-Lake Havasu City) RBHA: Steward Health Choice Arizona	10-17 year olds	alcohol, marijuana and opioids	Love Notes (Evidence-based), Rx-360, Alcohol 360, Meth 360, Marijuana 360, town halls, prom night, health fairs, teen maze (substance use related), monthly coalition meetings, assemblies at schools,	social service agencies	DFC
Nexus Coalition for Drug Prevention (NCDP)	Navajo County (Showlow, Pinetop-Lakeside) RBHA: Steward Health Choice Arizona	Target population is youth 10-18 but we educate K-12 We also educate parents/community	Alcohol, Marijuana, Rx drugs	Mpowrd, 2BMowrd - Evidence-based Mpact - Non Evidence-based. Parent-Teen University twice a year with parents and youth. Town Halls, Safety Village, Red Ribbon, Dump Your Drugs, Freshman University, Drug-Free Art Contest, Mid School Presentations, Prom Mailing, Senior Graduation Mailing, P/T Conference Parent Education, AZ Gives,	We have 12 Sector Representatives. Youth, Parents, Business Community, Media, Schools, Youth-serving organizations, Law enforcement, Religious, Civic &	Drug Free Communities Grant. We are in our 5th year. Just applied for 6th year. Will find out if we get to stay up and running in Oct

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				National Prevention Week, Junior Leadership Academy, Shoe Drive Project, Town Lighting, Appeal Letter Mailoffs etc.	volunteer, Healthcare professionals, Local govt. & others such as Recovery Program	2018.
BeMedSmart	Pima County RBHA: Arizona Complete Health	Older Adults 65 + and their caregivers	Misuse of prescription medication including opioids, OTC medication, and nutritional supplements, etc.	Evidence-based: Wellness Initiative for Senior Education (WISE) - English and Spanish versions. PowerPoint presentation: Prevention of Prescription Medication on Misuse in Older Adults adapted from Rx-360. Collect Sidewalk Surveys -Distribute safe disposal fliers such as Dispose A Med fliers.	Pima County Health Dept., Dispose A Med Partnership, Medication Abuse Prevention Coalition (MAPIC), Community Prevention Coalition (CPC), Arizona High Intensity Drug Trafficking Area (HIDTA / Counter Narcotics Alliance (CNA) / Tucson Police Dept. (TPD), Behavioral Health Refugee ....(RISPNET)	Substance Abuse Block Grant (SABG) funds - Arizona Complete Health
Marana Prevention Alliance	Pima County RBHA: Arizona Complete Health	Youth	Marijuana and Rx drugs	Dispose-A-Med, medication lockboxes, medication disposal, youth coalitions, information dissemination at community events, Marana Red Ribbon Week, "Teen Maze" events at local high schools.	Local government, law enforcement, school district.	DFC

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Substance Abuse and Prevention Education Coalition (SAPE)	Pima County (Ajo) RBHA: Arizona Complete Health	Middle and high school youth	Underage drinking, Rx drugs, and marijuana	Providing Botvin's Life Skills program in middle school, engaging behavioral health staff in schools to improve protocols related to substance use and dependency	Arizona Youth Partnership, Arizona Complete Health, Ajo Unified School District	AHCCCS (Partnership For Success grant), Arizona Complete Health, GOYFF (Health and Wellness grant)
Douglas Community Coalition	Cochise County (Douglas) RBHA: Arizona Complete Health		Underage drinking, Rx drugs,		Douglas Police Department, Portable Practical Educational Preparation (PPEP), University of Arizona, Mexican Consulate, ARIZONA@WORK	SABG
Coconino County (currently forming)	Coconino County RBHA: Steward Health Choice Arizona	Not yet decided	Not yet decided	Not yet decided	Coconino County Public Health Services District, Flagstaff Shelter Services, Catholic Charities, and the Coconino County Continuum of Care	None at this time
Liberty Partnership Kino Neighborhoods Coalition (LPKNC)	Pima County (Neighborhoods in the southern part of Tucson) RBHA: Arizona Complete Health	Youth and parents	Alcohol, Rx drugs, marijuana	Strategic Prevention Framework	Sunnyside Unified School District, Tucson Police Department, neighborhood associations	

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Pima County Community Prevention Coalition	Pima County RBHA: Arizona Complete Health	Youth, parents/caregivers, schools, community	Underage drinking, marijuana, opioids, synthetics	Power Parents, Marijuana 360, RX 360, youth coalitions, multiple strategies across multiple sectors	Over 100 members, over 35 organizations	GOYFF – Parents Commission grant; Local, state, county, federal
Amado DFC Coalition	Pima County and Santa Cruz County (Amado area) RBHA: Arizona Complete Health	Youth, parents, schools, community	Underage drinking, marijuana, opioids, synthetics, border issues, local medical marijuana grow sites	Power Parents, Marijuana 360, RX 360, youth coalitions, multiple strategies across multiple sectors	Rural community members (Amado area) and organizations	
Isaac Community in Action Coalition	Maricopa County (Maryvale) RBHA: Mercy Care	Youth, parents, churches, schools, community organizations	Tobacco, marijuana, alcohol, opioids, synthetics	Increase membership capacity and organizational partnership	Urban community organizations	Federal
Catalina Community Coalition	Pima County (Catalina) RBHA: Arizona Complete Health	Community-wide but focus on 18 to 20-year olds	Underage drinking, Rx drugs	Requested permission to implement Botvin Life Skills in middle and high school, planning to implement curriculum for 18-20-year-old youth	Arizona Youth Partnership	AHCCCS (Partnership For Success grant)
Sahuarita Community Coalition	Pima County (Sahuarita) RBHA: Arizona Complete Health	Community-wide but focus on 18 to 20-year olds	Underage drinking, Rx drugs	Requested permission to implement Botvin Life Skills in middle and high school, planning to implement curriculum for 18-20-year-old youth	Arizona Youth Partnership	AHCCCS (Partnership For Success grant)

Other Community Organizations and Programs

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Touchstone Health Services	Maricopa County RBHA: Mercy Care	youth, parents	Alcohol, controlled substance, Rx drug misuse	Substance use education for youth and caretakers (Rx 360), family-based substance use education (Families in Action), and community awareness (CARE Coalition & public awareness campaign).		GOYFF – Parents Commission grant
Area Agency on Aging, Region One	Maricopa County RBHA: Mercy Care	Older adults 55+	Alcohol, Prescription Drugs and Suicide		A member of MEBHAC (Maricopa Elder Behavioral Health Advocacy Coalition)	SABG; GOYFF STR Prevention Funding
Teen Lifeline	Maricopa County RBHA: Mercy Care	Schools in Maricopa County (youth, administrators, parents)	Youth suicide		A member of Arizona Suicide Prevention Coalition (AZSPC)	SABG
Sonoran Prevention Works	Statewide		Harm reduction	Provide community workshops, trainings, referrals, consultation, and risk reduction materials to individuals, families, and organizations in order to prevent HIV, Hepatitis C, overdose, and the perpetuation of stigma. Also facilitate the largest free naloxone distribution network in the state.		
Arizona Youth Partnership	Maricopa County RBHA: Mercy Care	Youth		Peer leadership programs such as SAD, YES, Sources of Strength, and University leadership programs		

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Pinal Gila Council for Senior Citizens - Arizona City Triad						
MSTEPP - STR Opioid Prescription Abuse Prevention	Mohave County RBHA: Steward Health Choice Arizona			Community Lunch and Learn Events		
RallyPoint	Major metropolitan areas	Veterans	Substance use and suicide prevention		An initiative of La Frontera Arizona in partnership with the Arizona Department of Veterans Services	
University of Arizona Center for Rural Health's Arizona First Responders Initiative (FR-CARA)	Statewide	First responders	OD prevention	Naxalone and OD prevention training	Arizona Department of Health Services, Sonoran Prevention Works,	SAMHSA
Youth4Youth program	Maricopa County RBHA: Mercy Care		N/A	Youth development (leadership skills development - public speaking, problem solving) - he conducts training sessions in school, youth decide how to move forward on activities in their school	Buckeye Elementary School District	
Arizona Department of Liquor Licenses	Statewide	Youth	Underage drinking	Arizona strategies "Tool Kit"		GOYFF – SABG Prevention Funding

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
and Control						

Universities

Arizona State University						
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, marijuana	Challenging collegiate alcohol and other drug social norms social marketing/ media (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU staff, student leaders, faculty	Alcohol, Other drugs, Opioids	C-3: Compassion, Communication, Connection - ASU's Screening, Brief Intervention and Referral to Treatment training program (EBP)		GOYFF – STR Prevention Funding
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other drugs	Recovery Rising Substance Free Socials (EBP)		GOYFF – Collegiate Recovery Program Funding
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Electronic Check-Up to Go for Alcohol (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Marijuana	Electronic Check-Up to Go for Marijuana (EBP)		Student fees and grants

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Alcohol Wise Online Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Under the Influence Online Sanctions Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Marijuana	Marijuana 101 Online Sanctions Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Marijuana, Prescription Drug abuse	Screen U online screening (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs	AOD Peer Education Program		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drug, Opioids	ASU Maroon and Gold Ribbon Week Awareness Event (in conjunction with Red Ribbon Week and ASU Homecoming)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs, Prescription Medicines, Opioids	One More Step Walk and Health Expo (Awareness Walk)		Student fees and grants

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Prescription Drugs	Safe Medication Disposal Campaign (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs	Step Up Bystander Skill Building Program		Student fees and grants
ASU Educational Outreach and Student Services	Maricopa County	ASU students	Primarily alcohol	Environmental strategies (EBP): Tail gate policies, Substance free residence halls, restrict alcohol sponsorship and advertising, alcohol-free programming, welcome to the neighborhood police and ASU rounds for fall semester		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, other drugs	Presentations for groups and classes (Evidence Informed Program): includes social norms correction, peer influence, values clarification.		Student fees and grants
Northern Arizona University						
SBIRT Expansion @ NAU	Coconino County	NAU students	Alcohol, marijuana, prescription drugs	SBIRT		GOYFF (State Targeted Opioid Response Grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Primary AOD Prevention @ NAU	Coconino County	NAU students	Alcohol, marijuana, prescription drugs	Personalized feedback intervention (eCheckUpToGo, ScreenU); skills training; normative re-education; educational presentations/tabling events; social norms campaigns; peer-to-peer education; training for clinical and campus staff		GOYFF (State Targeted Opioid Response Grant)
Collegiate Recovery Program	Coconino County	NAU students	n/a	Dedicated CRP lounge space; weekly recovery meetings; comprehensive referral network; sober social events; staff and faculty training around recovery support		GOYFF (Collegiate Recovery)
University of Arizona						
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	BASICS (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, Marijuana	Student Health Alcohol and Drug Education (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol primarily	The Buzz		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol primarily	Challenging Collegiate Alcohol Abuse Social Norms Media (EBP)		GOYFF – Collegiate Recovery Funding

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Cats After Dark alcohol/drug-free social programming (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Awareness events around campus		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Red Cup Q & A Columns		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Presentations in classes and to student groups		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	social media (Facebook, U Tube, Instagram, Twitter)		

Tribal Organizations and Programs

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Gila River Health Care BHS Prevention Program & The Gila River Prevention Coalition	Maricopa and Pinal Counties	Gila River tribal community	Alcohol, marijuana, prescription drugs	Botvin's Life Skills, Active Parenting, ASIST, QPR, SafeTALK, Reconnecting Youth/CSAT and Signs of Suicide	Gila River Tribe	AHCCCS SABG Block Grant and First Things First
Pascua Yaqui Behavioral Health Centered Spirt Program	Guadalupe	Pascua Yaqui Tribal members and immediate family	All	Youth life skills groups, individual, couples, family and group therapy, methadone/suboxone maintenance, psychiatric evaluation, and psychiatric medication follow-up. CSP also offers crisis evaluations for emergency situations.		Program generated funds
Guadalupe Community Partnership (GCP)	Guadalupe	Youth and adult community members		Prevention through education	Tribal departments, town government, community programs, and assorted health agencies that serve the town of Guadalupe	The Pascua Yaqui Tribe's Guadalupe Prevention Partnership program sponsors GCP
Meth Suicide Prevention Initiative	Guadalupe	PYT tribal members and Guadalupe community members	Meth	This initiative promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context.	Pascua Yaqui Tribe, Town of Guadalupe, Guadalupe Prevention Partnership, Guadalupe Community Partnership	Indian Health Services

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Inter-Tribal Council of Arizona - Methamphetamine and Suicide Prevention Initiative (MSPI)	Tribal areas in Arizona, Utah, and Nevada	Tribal members	Meth and suicide prevention	The Methamphetamine and Suicide Prevention Initiative (MSPI) promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. (1) Increase tribal, Urban Indian Organization (UIO), and federal capacity to operate successful methamphetamine prevention, treatment, and aftercare and suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans. (2) Develop and foster data sharing systems among tribal, UIO, and federal behavioral health service providers to demonstrate efficacy and impact. (3) Identify and address suicide ideations, attempts, and contagions among American Indian and Alaska Native (AI/AN) populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies. (4) Identify and address methamphetamine use among AI/AN		Indian Health Service 5-year grant (2015-2020)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies. (5) Increase provider and community education on suicide and methamphetamine use by offering appropriate trainings. (6) Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.		
Phoenix Indian Center - Urban Indian Coalition of Arizona (UICAZ)	Maricopa County	American Indian Youth, Adults, and Elders	Underage drinking, youth drug use, parent communication	To create a sustainable coalition that addresses prevention of suicide, underage drinking and use/abuse of marijuana and prescription drugs through the foundation of cultures to improve the overall well-being of Urban American Indian youth and families. This is accomplished through the services we provide: • Urban Indian Coalition of Arizona • Parenting in Two Worlds • Living in Two Worlds Middle School Curriculum • Gathering of Native Americans • Community Education and Awareness Presentations around Historical Trauma,	Native American Connections; Phoenix Indian Medical Center; Inter Tribal Council of Arizona; Native Health; Pasqua Yaqui Tribe; Phoenix Union High School District; Mesa Public School, Tempe Elementary School District; Help Enrich African American Lives (HEAAL) Coalition	Mercy Care; GOYFF – Parents Commission grant

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				Rx360, Marijuana, and Underage Drinking • SafeTalk trainings • ASIST trainings		

Appendix E: Workforce Training Topics Available by County

County	Topics
Apache	None
Cochise	Botkins Life Skills Marijuana 360 RX 360 MADD underage drinking presentation Substance Abuse Prevention Youth leadership QPR (2) SAPST
Coconino	Rx-360 Marijuana 360 Meth 360 Strengthening Families 10-14 Program Botvins Life Skills SAPT SPF Indian Country DEC ACEs Cultural Comp 101 Logic models Strategic planning Grant writing, Tribal Action Planning (TAP) SBIRT Motivational interviewing Alcohol, marijuana and prescription drugs Alcohol
Gila	Mental Health First AID Mental Health First Aid - Adult and Older Adult, ASIST (2) SafeTALK (2) Drug Trends Overdose awareness and Naloxone usage Rx-360 (4) Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life SkillsTalk Saves Lifes Underage Drinking

County	Topics
	Marijuana use SBIRT Wellness Initiative for Senior Education (WISE) Rx Matters
Graham	Rx-360 The Buzz Alcohol True stories Strengthening Families SAPST ASIST QPR
Greenlee	SAPST ASIST QPR
La Paz	Rx-360 Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life Skills SAPST ASIST QPR
Maricopa	SPF generally (4) SPF needs assessment (2) SPF coalition development/capacity building (2) Rx-360 (2) SAPST (2) Alcohol/Alcohol Prevention (2) Marijuana/Marijuana Prevention (2) Diversion for youth in schools Substance Abuse generally Mental Health First AID Drug Trends Risk Assessment Motivational Interviewing Building Resilience Active Parenting CDSMP Prevention basics Risk and protective factors SPF implementation Strengthening Families EBPs generally (2)

County	Topics
	SPF evaluation and sustainability Cultural competence Environmental strategies Best practices in suicide prevention and safe messaging guidelines and standards YMFA The science of prevention Cultural aspects of substance use ASIST (2) SafeTALK (3) suicideTALK
Mohave	Motivational Interviewing SBIRT, SAPST Rx-360 Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life Skills
Navajo	Rx-360 Marijuana 360 Meth 360 Alcohol/alcohol abuse (2) Strengthening Families 10-14 Program Botvin's Life Skills Mental Health First AID ASIST SafeTALK Drug Trends Substance abuse
Pima	Motivational Interviewing Naloxone Stages of Change History of 12 Step Understanding Homelessness Housing First Overdose Prevention Harm Reduction 101 QPR (4) Marijuana 360 SAPST (3) ASIST (2) Cultural Competency Botvin's Lifeskills, Botvin's LifeSkills Training TOT

County	Topics
	Rx-360 Mental Health First Aid (2) Youth Mental Health First Aid SPF coalition development (2) Volunteer management AZ Toolkit Training SPF generally (2) Strengthening Families Prevention basics Risk and protective factors SPF needs assessment Strengthening Families The older adult population and addiction EBPs generally
Pinal	Mental Health First AID Mental Health First Aid - Adult and Older Adult SAPST SBIRT ASIST (2) SafeTALK Drug Trends QPR (2) Rx 360 (3) Alcohol 360 Marijuana 360 (2) Meth 360, Strengthening Families 10-14 (2) Local drug trends based AYS data Adult substance abuse recognition Youth use of marijuana Alcohol Botvin's Life Skills Wellness Initiative for Senior Education (WISE) Rx Matters Community Assessment Environmental Strategies Fundraising Grant Writing
Santa Cruz	QPR SAPST (2) ASIST SPF coalition Development Volunteer management AZ Toolkit Training

County	Topics
Yavapai	Substance abuse generally
Yuma	SAPST ASIST QPR SBIRT

Appendix F: Workforce Survey Content Analysis

Prevention Workforce Survey Themes

Q10. What types of substance use prevention efforts are not currently available in your community that you think are needed?

Theme	n
Primary Prevention	
Meeting basic needs (e.g., jobs, housing/homeless shelters, financial assistance, transportation, mental health resources/crisis services, wellness programs)	11
Collaborative education/awareness efforts with local schools	10
Family-level education/skill-building approaches	9
Pro-social activities (e.g., for youth, free/inexpensive, substance-free	7
Early prevention efforts (e.g. elementary school)	5
Trauma-informed efforts/services/treatment	5
Education on marijuana/meth/heroin	5
More/accessible education/awareness/prevention efforts generally (e.g., North end of Navajo)	4
Teaching social/emotional skills/resilience	4
More environmental strategies (e.g. policy change/reduced access/limiting alcohol sales venues/limiting signage/enforcing social host)	3
Evidence-based prevention programs (e.g., generally, Prime for Life)	3
Teaching long term effects	3
Holistic approaches	3
Coalitions/funding for coalitions/adult coalitions	3
Teaching decision-making	2
Community-level education/awareness	2
Education/awareness for adults/older adults	2
Prevention efforts targeting adolescents (e.g. marijuana)	2
Age appropriate resources	1
Suicide prevention	1
Education on health literacy	1
Promoting leadership	1
Programming for children/families with emotional risk factors (e.g., who have experienced trauma) to prevent later SU	1
Evidence-based prevention programs for Latinos	1
Overdose prevention education	1
More long term/comprehensive prevention efforts	1
Educating the medical community	1
Mental health counselors in schools	1
Collaborate with schools to screen kids needing tx	1
Coalitions working in rural communities	1
Community mobilization/capacity-building	1
Positive mentors/leaders for teens in the community	1

Theme	n
Secondary Prevention: Harm reduction	
Harm reduction	9
Secondary Prevention: Treatment	
Access to treatment for low income	4
More RTCs/beds	4
More MAT centers/increased access to MAT	4
Detox centers (including for adolescents)	3
More treatment facilities	3
Quality rehab homes/housing/sober living for those coming out of tx	3
Family-level TX approaches	2
Better/more supportive hospitals and institutions	2
More access to referral/tx generally	2
More OP counseling	2
More services in rural areas	2
More treatment facilities for adolescents (e.g. Yuma)	2
Access to IOP treatment for adolescents (e.g. Yuma)	2
TX for seniors (affordable)	2
Stigma reduction	2
Bridges to tx provision (e.g. hospitals, juvenile detention)	1
Identifying treatment gaps	1
Treatment for veterans	1
RTC for women with children	1
More Tribal-focused services	1
Support groups	1
Insurance coverage for treatment	1
Secondary Prevention: Criminal justice-related	
Diversion strategies - implementation or improvement	3
More informed criminal justice system (e.g., trauma-informed policies/programs in the criminal justice system; law enforcement trained about addiction as a disease)	2
Intervention resources in jails	1
Collaboration with law enforcement/govt	1
Bridging juvenile probation with SU providers	1

Prevention Workforce Survey Themes

Q11. What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?

Theme	n
Primary Prevention	
Activities available (e.g., for youth, Low-cost/free after school care)	15
Meeting basic needs (e.g., Career training/jobs/economic mobility, Financial assistance, Housing, Education, Healthcare/mental healthcare, Transportation)	13
Education/training generally	13
Education/awareness efforts for the community	8
Education/awareness classes/efforts at the family level	7
Coalitions/community-driven efforts	6
Education/awareness classes address danger/ long term effects of SU	6
Family-level approaches	5
Programming for youth/adults with emotional risk factors (e.g. trauma, children of addicts/users)	5
Honest dialogue (e.g., with youth)	5
Education/awareness classes/efforts at the school level	5
Comprehensive/holistic strategies at multiple levels of the community with common messaging	5
Schoolchildren/youth	5
Teaching social/emotional/coping skills	5
Mentoring	4
Creating connectedness (e.g., with family, school, community	4
Parenting classes/support	3
Teach kids about resources	3
Teaching life skills	3
Teaching decision-making	3
Reaching older adults with prevention efforts (including companionship and activities)	3
Reduce access (e.g. drop boxes, alcohol)	3
Posters/PSAs/ads	3
Community/coalition collaboration	3
Serving high risk populations (LGBTQ, homeless/unaccompanied, low income areas, single parent households, etc).	3
Hearing from people who have lived addiction	3
Trauma-informed programs/approaches	3
Evidence-based programs (e.g., that increase knowledge, change attitudes)	2
Social norming campaigns	2
Reality-based/Not fear-based	2
Identify community need	2
Change community conditions that lead to SU	2
Develop leadership skills	2
Promote self esteem	2
Teach resistance/refusal skills	2
Peer to peer (e.g., students, youth groups)	2

Theme	n
Flexibility in funding so communities can tailor their efforts	2
Environmental strategies generally	2
Rx-360	1
Evaluation of effectiveness of prevention programs	1
Pilot demonstrations of prevention interventions	1
Engage the community/population	1
Medication management	1
Support groups for various community sectors	1
Skill building generally	1
Age appropriate resources	1
Age appropriate approaches	1
Culturally relevant approaches	1
Enforcement of codes (e.g. signage/alcohol placement in stores)	1
Community that focuses on safety	1
Policy changes generally	1
More law enforcement presence in neighborhoods	1
Neighborhood beautification	1
Group discussions	1
Education/awareness classes include law enforcement	1
Arts integration,	1
Prevention specialists	1
Training for parents/providers/caregivers in identifying risks	1
Education/awareness for the medical community	1
Address multiple substances	1
substance use education generally	1
Education/awareness classes address legal consequences	1
Cultural competence	1
Secondary Prevention: Harm Reduction	
Harm reduction	7
Secondary Prevention: Treatment	
Reach kids before they become at risk/before use starts	4
Recovery Coaches/peer support	4
Reducing stigma	4
MAT	3
Trained LE/medical staff (e.g. cultural competence, stigma)	2
Affordable treatment	2
Combination of individual and group therapeutic treatment	2
Reach users early	1
SBIRT	1
Standardized screening tools across systems	1
Immediate access to TX	1
Easily accessible treatment in the community (e.g. libraries)	1
IOP programs (for adolescents, adults)	1
12 Step programs	1

Theme	n
"Genuine" integrated care	1
TX programs with true incentives to maintain sobriety	1
Long term treatment	1
Well-trained law enforcement (e.g. mental health crisis response, naloxone/harm reduction)	1
Learn to handle cravings without MAT/MAT as a last resort	1
Secondary Prevention: Criminal justice-related	
Diversion/court-affiliated TX efforts	2
Not criminalizing mental illness/SA/Focus on TX	3

Prevention Workforce Survey Themes

Q12. What methods are you using to evaluate whether your substance use prevention program or practice is effective?

Theme	n
Primary Prevention	
Pre/post or Follow-up Surveys or knowledge assessment with participants	29
Unspecified Questionnaire/survey	16
Community surveys/feedback	8
Review results of external surveys (e.g. AYS)	7
Official records (e.g. overdose rates, police records)	5
Outcome evaluation generally	5
Process evaluation generally	4
Using an evidence-based program	4
Weight of RX drop off every six months	3
Casually with students/ clients who keep in touch/teachers	3
Focus groups	3
Satisfaction surveys	3
Number served	2
Track medical providers using prevention resources	2
Needs assessment surveys	2
Qualitative methods (unspecified)	2
Quantitative methods (unspecified)	2
System evaluation	2
Testing fidelity when using an evidence-based practice	1
Tracking program completion	1
Participant engagement (program records)	1
number of materials distributed,	1
School records	1
Stakeholder surveys	1
Using evidence-base screening tools	1
Tracking what kind of resources the client accesses	1
Surveys of non-participants (e.g., family)	1
Reviewing other studies of programs	1
Noting community trends	1
Evaluating achievement of grant goals	1
Secondary Prevention	
Treatment outcome evaluation generally	3
Relapse frequency/time to/positive lifestyle changes	3
Treatment utilization	2
Drug screens	2
Using a variety of treatment strategies	1
Successful Treatment completion	1
Number of individuals seeking treatment	1

Theme	n
Decrease in individuals going into treatment	1
Unspecified noting of Stability post treatment	1
Treatment goals met	1
"Hoping our patients don't die"	1
Patient surveys	1
Peer and family reports	1

Prevention Workforce Survey Themes

Q13. What kinds of evaluation needs does your community have that are not being met?

Theme	n
Primary Prevention	
AYS (e.g. more schools, quicker results, include LGBTQ data)	5
Formal evaluation strategies	5
Community Needs assessment	4
Community-specific data (narrower than county-level)	3
Follow-up data collection (e.g. knowledge change in perceptions of harm)	3
Demographics data on the community (including better gender ID and Latino/a/x id)	2
Community survey generally (e.g., for adults like the AYS)	2
Research: role of mental health in substance use	2
Local official record data across sources	2
Specific tools	2
One common evaluator (e.g., so findings are consistent across the community, so there is accessible TA consultation)	2
Using evidence-based curricula	2
Engaging the community to participate in community surveys	2
Baseline overdose data (e.g. rural, Tribal)	1
Track all substances	1
Baseline data for specific populations (e.g. rural, Tribal)	1
Regular surveys for community adolescents (e.g. when AYS is not collected)	1
Academic achievement	1
Research: Effects of legalization on drug use generally	1
Research: how at-risk populations cope with stress/trauma/adversity/ find meaning in life, would do to promote wellness (rather than resorting to self-medication with substances)	1
Data on who engages in poly-use	1
Substance use trends by age/ethnicity/gender	1
Geographic "hot spots"	1
Cost/benefit studies	1
Resource assessments	1
Short term follow-up (rather than long-term that involves the program)	1
Risk assessments	1
Dissemination of evaluation results in the community	1
Validated data collection tools (e.g., extent of use, history of use)	1
Evaluator to analyze community survey data	1
More tailored reporting for grant requirements	1
Volunteers to staff school surveying	1
Tracking support/knowledge for follow ups	1
Secondary Prevention	
Evaluation strategies that identify which programs are working best (e.g., Common data collection across local TX programs (e.g. AHCCCS and non-AHCCCS)	2
Demographics of needs	1
Follow up data collection (e.g. reentry success)	1

Theme	n
Follow-up screenings	1
Drug-testing	1
Treatment-related: screening of schoolchildren	1
How grant $$$ is being spent in the community (e.g., is opioid $$$ being spent on evidence-based programs, duplication)	1
Access to treatment (e.g. gaps in services; points of intercept)	1

Prevention Workforce Survey Themes

Q14. Are there any types of substance use prevention efforts that you don't think help much or at all?

Theme	n
Primary Prevention	
Scare tactics	11
General handouts/posters/marketing material/commercials/media campaigns	10
Just say no strategies	9
Programming that demonizes drug users/negative messaging	6
Single presentations/events not connected to a larger strategy (e.g. town halls)	4
Relying on untrained staff (e.g. at schools) to deliver the program unsupported (rather than partnering with prevention experts/coalitions)	4
Programming with older youth	3
Programs that do not give people the facts so they can make their own choices/tell them what to do	1
Programming of youth without their parents	1
Programs not evidence-based	1
Programs not tailored to the target population	1
Presentations with too many statistics/no case examples	1
Public Speakers	1
Outdated curricula (e.g., Botvin Life Skills)	1
Programming that does not teach refusal skills	1
Programming that fails to provide positive social/emotional development/autonomous decision-making	1
Programming that fails to identify alternatives to drug use	1
Programming that fails to acknowledge benefits to drug use	1
"Pledge campaigns" not connected to a larger strategy	1
Gateway drug information	1
Strategies not supported by the community (e.g., legal drinking age in local bars)	1
Putting the money into treatment instead of prevention	1
Disjointed efforts in the community	1
Coalitions	1
Youth involvement	1
Secondary Prevention	
Fear-based	4
Legal consequences	3
12-step programming	3
Rejection/Tough love	2
Tiered consequences without follow-through	1
Delaying treatment (i.e., access is not timely)	1
Being talked down to	1
Cold-turkey	1

Kicking people out for relapsing	1
Sober living communities that offer inadequate support/threats of losing housing	1
Tying recovery to religion	1
MAT as a first resort	1
MAT without long term counseling	1
Outpatient groups	1
TX Programs that are not evidence-based/trauma informed	1
Short-term residential (e.g. 28-days)	1
"Agreements"	1
Lack of holistic focus	1
Calling secondary prevention "prevention" (e.g., Naloxone)	1

Prevention Workforce Survey Themes

Q15. What substance use prevention activities have you seen that have been the most successful in engaging the community?

Theme	n
Primary Prevention	
Community-building/Social events (e.g., town halls, community fairs, programs with food, for the whole family)	13
Coalitions	10
Family/parent-oriented	9
Alternative activities (e.g., generally, after prom, after graduation)	7
Information-sharing (that lets people make their own decisions)	6
School-based	5
Promoting youth leadership	4
Enhance skills (e.g., Teaching critical thinking skills/life skills to schoolchildren)	4
Casual Face to face interactions/not "professional"	4
Community education (e.g., Symposiums that highlight educational warning signs of substance use.)	4
Fun/ Associated with a fun event	4
Age/culturally responsive (e.g. Language of materials)	3
Diverse community sector involvement	2
Specific prevention programs (e.g. Reality Tour, DARE)	2
Depends on the community and what is topical there	2
Universal anti-smoking campaigns are a model	2
Medication take-back events	2
Personal stories (e.g., Giving youth access to people who struggle with addiction)	2
Tabling	2
Interactive	2
Youth coalitions/youth involved in planning prevention efforts	2
collaboration between youth, school, parent/ and/or community	2
Mass media prevention messaging	2
Helping the community meet basic needs	2
Address perceptions of harm	2
Multi-agency	1
Local PSAs (with local kids)	1
Social media campaigns	1
Prescription inventories	1
Community connections for youth (e.g. mentoring)	1
Programs endorsed by word of mouth	1
When communities/schools trust the local prevention specialists	1
Supporting positive school social environments	1
Create awareness	1
Activities related to "hot button" topics/topics in the news	1
ACES-informed	1

Theme	n
Address refusal skills	1
Address community norms (e.g., with statistics)	1
Policy work	1
Mobile units (to address lack of transportation)	1
Secondary Prevention: Harm Reduction	
Harm reduction	5
Secondary Prevention: Treatment	
Counseling	4
Integrated care	1
Inpatient detox	1
Groups (e.g., AA, group therapy)	3
Longer term inpatient (i.e. more than 28 days)	1
IOPs	1
MAT	1
Mental health first aid	1
Meeting basic needs	1
Peer support/recovery coaches	3
Enhance access/reduce barriers (e.g., stigma)	3
Secondary Prevention: Law Enforcement	
Specialty drug courts/diversion	2

Prevention Workforce Survey Themes

Q16. What resources for substance use prevention are sufficient in your community?

Theme	n
Primary Prevention	
Public information (materials, dissemination opportunities)	6
Coalitions	5
Training and support for prevention professionals	4
Community efforts (e.g., health fairs)	2
Funding/grant funding	2
Funding for Life Skills education	1
Sufficient resources for prevention generally	1
Resources for youth and younger adults	1
School curriculum/activities for younger kids	1
Community support	1
Agency collaboration	1
Parenting education	1
Integrated healthcare	1
Resources for mental health providers for providers with $$$	1
Mental health homes	1
Primary Prevention: Harm Reduction	
Naloxone trainings.	2
Crisis response resources	1
Primary Prevention: Treatment	
12-steps	3
MAT	3
Outpatient	2
Inpatient Facilities	2
TX options for those who can afford it	1
Support groups/activities other than AA	1
Detox	1
TX for seniors	1
Referral system	1

Prevention Workforce Survey Themes

Q17. How does your agency/coalition/organization address underlying causes of addiction (e.g., poverty, historical trauma, systematic oppression, poverty)?

Theme	n
Primary Prevention	
Providing general resources and referrals to meet basic needs	9
Educating staff/ providers/coalition leaders (e.g. on ACES; systemic oppression; cultural awareness)	8
Youth-focused poverty-prevention strategies (e.g. teen pregnancy prevention, decision-making; social skills; general education)	4
Collaborating with the local community	3
Whole family education	2
Addressing social isolation for seniors	2
Tailoring programming for the population (e.g., Language awareness/using primary language)	2
Including underlying causes information shared (e.g., Using a curricula that recognized underlying risk issues	2
Educating community (e.g. on ACES; underlying causes of addiction)	2
Adult-focused poverty-prevention strategies (e.g. resume development; healthy relationships)	2
Teaching participants to advocate for themselves	2
Recognizing local historical trauma	2
Not ignoring the issue	2
Addressing mental health	2
Collaboration with other agencies (e.g. working with high risk youth)	1
Hiring from within the local community	1
Advocate for policies that address underlying causes	1
Providing positive alternate activities	1
Youth shelters	1
Utilizing available resources from the State, etc.	1
Diversion program	1
Providing access (e.g., Going to the community)	1
Primary Prevention: Treatment	
Trauma-informed programs/TX	7
TX for underlying causes	6
Assessing for underlying issues	4
Providing low/no cost TX	4
Comprehensive care	2
Meet people where they are	2
Stigma reduction/choose language of addiction	2
Serving populations that have suffered the underlying cause experiences	2
No wrong door policy/collaboration with first responders	1
"Resiliency Committee" advises TX team and programming	1
"Cultural competency advisors" advise TX team and programming	1

Prevention Workforce Survey Themes

Q18. How does your substance use prevention program take into consideration demographic characteristics of the participants of your program (race/ethnicity, urban/rural, veterans, LGBTQ, youth, seniors, foreign language users, etc.)?

Theme	n
Primary Prevention	
Primary language taken into consideration (e.g., interpretation provided; hire bilingual staff)	19
Be ready to serve everyone from any demographic/treat everyone with respect	17
Program tailored to/inclusive of the population (e.g., youth, seniors, LGBTQ)	17
Tailoring materials/evaluation tools (e.g. language, font, gender options)	8
Seek feedback from the target population (e.g., before or while implementing a strategy)	7
Training staff in subpopulation issues (e.g., cultural competency, LGBTQ, trauma-informed)	7
Recognize/Identify/understand the demographic characteristics/needs of the target population/community (e.g., needs assessment)	6
Collaborate with partners/agencies that work with the target population (e.g. LGBTQ)	5
Hire staff/recruit coalition members/volunteers from the community/demographic	5
Promote accessibility (e.g., Reach them in a common/convenient location/schedule at a convenient time)	3
Financial considerations (e.g. providing food, no cost services)	2
Aware of potential for prejudice by participants/try to address	2
Awareness in facility management (e.g., bathrooms not segregated by gender, disability-accessible bathrooms, microphones at trainings for seniors)	2
Outreach efforts to marginalized communities	1
Tailor referral options	1
Inclusive marketing materials	1
Adapt programs to be culturally relevant	1
Secondary Prevention	
Recognize/identify culture (e.g., to tailor intervention, meet language needs)	4
Understand how to tailor treatment according to subpopulation needs	2
Provide free/low cost treatment	2
Provide system navigation services	2
Recognize need for treatment for subpopulations/target historically disadvantaged populations	1

Prevention Workforce Survey Themes

Q19. What are the main challenges that you experience as a substance use prevention "specialist" in your community or at your agency/coalition/organization?

Theme	n
Primary Prevention	
Funding/consistent funding/flexible funding (e.g., for coalitions, for prevention staff committed to a single community, prevention programs, transportation, snacks/incentives, for an evaluator; for community outreach; to research what is effective; treatment)	34
Engaging the community to participate in prevention efforts	7
Not enough time to do the job well/lack of staff (e.g., to cover the needed partners, to cover the territory)	7
Finding volunteers (e.g., for coalitions, promotores)	5
Educating the public/ Community does not recognize the risk from drugs	5
Engaging community institutions/authorities to support prevention efforts (e.g. schools, the State)	5
Engaging parents to participate in prevention efforts	5
Lack of resources generally	4
Collaborating with other area agencies (e.g., sharing space for prevention programs; cross referrals)	4
Knowledge of what is effective/effective programs/culturally competent programs	3
Lack of trainings available	3
Lack of recognition of prevention specialist as a profession (e.g., lack of State credentialing for prevention specialists	2
Restrictive regulations (e.g., law enforcement data access, TX workforce regulations)	2
Finding a location for prevention programs (e.g., for youth groups/workshops)	2
Lack of knowledge about behavioral health	2
Lack of access to local data	2
Establishing community leadership in prevention efforts/sector representation in coalitions	2
Not prioritizing prevention relative to treatment	2
Engaging those most in need of the messaging (e.g., Intergenerational Users	2
Programs do not address underlying causes of substance use	1
Programming at the family level	1
Lack of understanding that fear-based presentations don't work/are harmful	1
Only interest in one-time presentations	1
Easy access to drugs in the community	1
Getting the medical community on board to reduce prescribing addictive medication	1
Promoting successful mentoring (e.g., bonding)	1
Sharing prevention-related information with target populations (e.g. seniors)	1
Less text-heavy/more language appropriate prevention materials	1
Lack of capacity	1
Overlooking target populations (e.g. seniors)	1
Considering treatment prevention	1
Demonstrating the cost effectiveness of prevention efforts	1
Able to afford professional evaluation assistance	1

Theme	n
Transportation (e.g. for youth)	1
Secondary Prevention: Treatment	
Treatment and support resources (e.g. for adolescents, in rural areas; detox; inpatient; MAT; post treatment housing)	10
Stigma	7
Criminalization of SU (e.g., Punitive drug court practices)	2
Understanding/Meeting the wraparound needs of clients (e.g., housing, those receiving MAT	2
Patient follow-through/Engaging people participating when they think it is voluntary"	2
Treatment participation requirements (e.g. attendance, abstinence)	2
Not requiring counseling of MAT clients	1
People being referred to a program they do not qualify for	1
Community awareness of services	1
Serving a population in a remote area	1
Affordable treatment and support resources (e.g. for people on Medicare)	1
Agencies not fully engaged in SA treatment (e.g. "dabbling")	1
Agencies not committed to long term Treatment	1
patient fear of having unmanaged pain	1
Insufficient workforce	1
Treatment retention	1
Admissions process to treatment (e.g., timely, collaborative, family-oriented)	1
Keeping kids in their school during Treatment	1
Care of treatment workforce/secondary trauma	1
Engaging adolescents in treatment	1

Appendix G: Short Reports (Youth, Veterans, Older Adults, LGBTQ)

Substance Use: *Youth in Arizona*

The 2017 Youth Behavioral Risk Factor Surveillance System* indicated a significantly higher percentage of Arizona high school students, compared to youth nationally, have ever tried an electronic vapor product .

1 in 5 Arizona high School Students used marijuana in the past month

1 in 7 Arizona high school students have at one time misused pain relievers

The prevalence of **illicit drug use disorder** was significantly higher for Arizona youth aged 12-17 (4.7%) that nationally (3.3%).

As part of the **2018 Arizona Statewide Substance Use Prevention Needs Assessment**, 3 focus groups were conducted with youth in Phoenix, the city of Maricopa and Prescott. Four focus groups were conducted with adults that serve youth (educators, parents, etc.) in sierra Vista, Phoenix, Kingman and Globe. Both groups were asked about what current and most harmful substance issues existed for youth, what they thought caused substance use/and or misuse for youth, and what would be effective prevention programming to combat these issues. A number of key informant interviews were also conducted with adults that work with youth.

* Centers for Disease Control and Prevention. (2017). High School Youth Risk Behavior Survey Data.

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

Causes of Substance Use and/or Misuse:
Thoughts from Youth and Those Serving Youth

1. **Youth are self-medicating with substances due to mental health issues/trauma and a lack of or inability to access mental health services.**
2. **Due to a lack of healthy, affordable, fun activities for youth, they engage in substance use and/or misuse.**
3. **Youth today currently lack coping skills or the social/emotional tools to deal with life's challenges which leads them to substance use and/or misuse.**
4. **Peer pressure leads to substance use and/or misuse.**
5. **The use of substances has been normalized by popular culture, social media, marketing, peers and the legalization of marijuana which is leading to substance use and/or misuse.**
6. **A lack of family values and lack of family supervision of youth (or a stable adult for youth) to turn to leads to substance use and/or misuse.**
7. **Due to inadequate funding and resources given to schools, and the demands of Arizona's core competencies, there is not enough time or resources for effective prevention programming in schools which leads to substance use and/or misuse.**

Substance Use Prevention Recommendations from Youth & Those Serving Youth:

Make sure youth have someone to talk to, someone to turn to for support and help

Start programming in lower grades

Teach children healthy coping skills so they don't turn to drugs

Give schools enough support so they can go beyond the core curricula and spend time on prevention and community-school partnerships

Involve parents in prevention efforts and offer meaningful incentives to promote parent engagement

Don't use scare tactics. Don't say, "Don't do drugs". Just provide the facts and build positive relationships

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

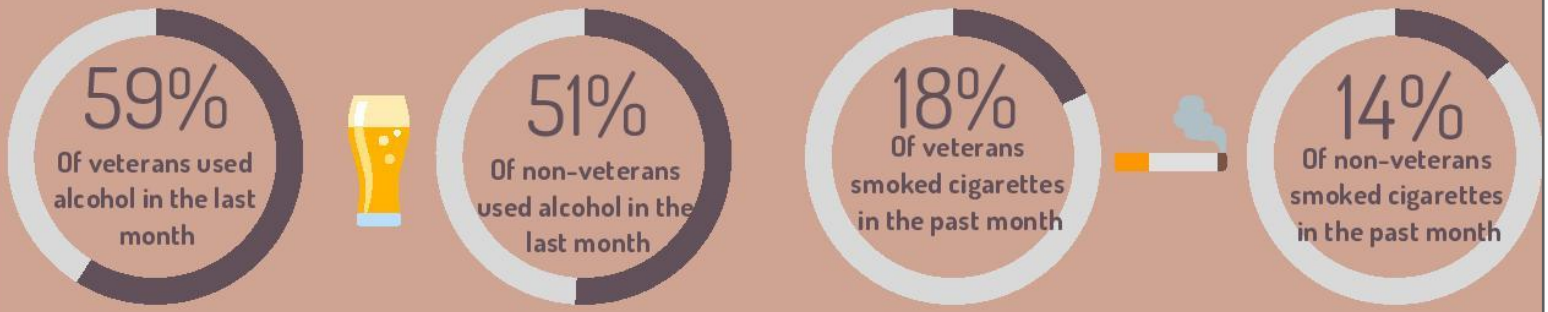
AHCCCS Arizona Health Care Cost Containment System

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

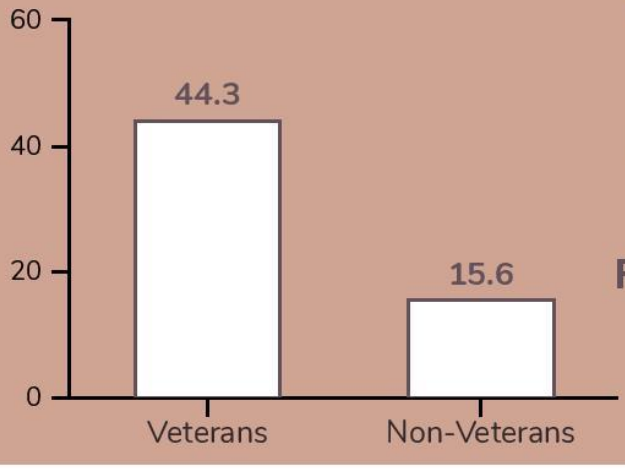
LeCroy & Milligan ASSOCIATES, INC.

Substance Use & Suicide: *Veterans in Arizona*

The 2016 Behavioral Risk Factor Surveillance System* indicated that veterans report significantly more alcohol and tobacco use in the past month than non-veterans:



Arizona Suicide Rates per 100,000 (2017)



The suicide rate among veterans are 3X higher than non- veterans in Arizona.**

For male veterans, suicide rates are 2X higher than for non-veterans.

For female veterans suicide rates are 5X higher, compared to non-veteran females.

As part of the 2018 Arizona Statewide Substance Use Prevention Needs Assessment, 3 focus groups were conducted with veterans in Flagstaff, Phoenix and Yuma. Veterans were asked about what current and most harmful substance issues existed in their community, what they thought caused substance use/and or misuse, and what would be effective prevention programming to combat these issues. In addition, one phone interview was conducted with a veteran Key Informant in Pima County.

* Centers for Disease Control and Prevention (2016). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016.
** ASU Center for Violence Prevention and Community Safety. Arizona Violent Death Reporting System. Data-At-A-Glance, Violent Deaths Involving Veteran Victims. January 1, 2017 to August 31, 2017.

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

Causes of Substance Use and/or Misuse: *Thoughts from Veterans*

1. **Veterans use substances to self-medicate for untreated mental health issues related to military service including PTSD and other trauma.**
   In the military you can't bring up mental health issues because you would be kicked out and now you're trying to figure out navigating the V.A. system on your own when you're suffering from depression and you have financial strain. (Interview with Pima County Key Informant)

2. **Untreated chronic pain and dental pain leads to street drug use**
   We have a lot of people who have chronic pain. Up here in rural AZ, we don't have the level of care other areas have. If you think of a vet in a rural area, where are those people with chronic pain going to get treatment? If they don't have the eligibility to get treatment, where are they going to go? (Flagstaff veteran focus group)

3. **Veterans miss the adrenaline rush they got in the service; that's why many turn to drugs.**
   When you are in the military, you have your good time boys to have fun together. You may be drinking excessively but are in good shape. When you are out, it's a downer without your buddies and new stresses... and you don't have the adrenaline rush from when in the service. There is nothing comparable to that which you did in the military, that can give you that kind of rush. (Yuma veteran focus group)

4. **Substance use is normalized and encouraged in the military which leads to substance misuse.**
   When I was in the NAVY, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work. (Flagstaff veteran focus group)

5. **The difficulty in reintegrating into society once out of the military leads to substance use and/or misuse.**
   … So I get out service, I run around, I get a job at Target or whatever… it's not enough… Those barriers of life start to become an issue…because I've been somewhere being catered to… I could go get a chow, I don't pay for anything when I'm in the service, and when I come out, now I need a job. And for a lot of us, it's our first time [trying to find a job]. (Phoenix veteran focus group)

Substance Use Prevention Recommendations from Veterans

Help vets get involved with something meaningful

Educate VA Doctors about opioid issues and how to approach patients individually

More education and peer support before discharge and right after to let vets know the resources available for them

Improve access and reduce stigma of mental health services for vets

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

AHCCCS Arizona Health Care Cost Containment System

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

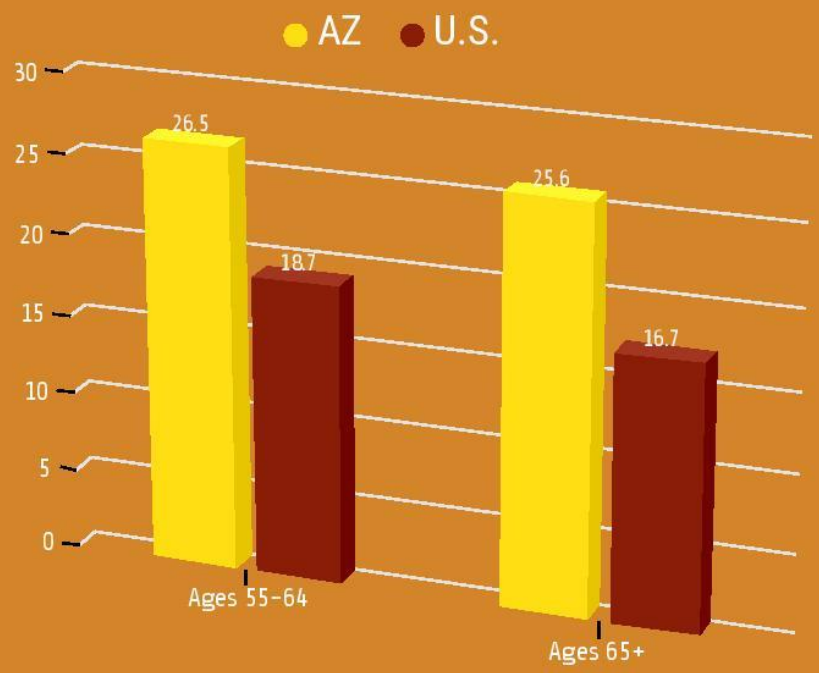
LeCroy & Milligan ASSOCIATES, INC.

Substance Use & Suicide: Older Adults in Arizona

The suicide mortality rate for older adults in Arizona is significantly higher than the average suicide mortality rate for older adults in the U.S.

The greatest absolute difference in suicide rates between Arizona and the United States occurred for those aged 65 or older (25.6 versus 16.7 per 100,000).

Age-Adjusted Suicide Mortality Rates per 100,000 for U.S. and Arizona, 2016



FOR FEMALES IN ARIZONA, THE SUICIDE MORTALITY RATE PEAKED FOR THOSE AGED 55-64 (13.3 PER 100,000).

FOR MALES IN ARIZONA, THE SUICIDE MORTALITY RATE PEAKED FOR THOSE AGED 65 AND OLDER (46.6 PER 100,000).

SUICIDE RISK CONTINUES TO INCREASE WITH INCREASING AGE FOR MALES OVER AGE 65.

The rate among males aged 75-84 was 55.3 per 100,000, and rose to 75.6 per 100,000 among those aged 85 and older.

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) Intentional self-harm (suicide), Arizona, 2006-2016.

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment, September 2018

Substance Use in the Arizona Older Adult Population

As part of the 2018 Arizona Statewide Substance Use Prevention Needs Assessment, 3 focus groups were conducted with older adults in Tucson, Prescott and Phoenix. Older adults were asked about what current and most harmful substance issues existed in their community, what they thought caused substance use/and or misuse, and what would be effective prevention programming to combat these issues.

Causes of Substance Use and/or Misuse for Older Adults

1. **Loneliness and isolation lead to substance use and/or misuse.**
   Getting into and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse. (Prescott older adult)

2. **Loss of role after retirement leads to substance use and/or misuse.**
   As a culture we identify so much with our role… [Once people retire], there's a loss of role, whether it's from an office, as a parent or as a grandparent… Role is what determines worth in this culture… and when you lose that there's of course the dependence on something else to alleviate that… (Tucson older adult)

3. **Prevention activities are not geared towards older adults, often only youth.**
   One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that if we get them younger, then that's prevention… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. (Prescott older adult)

4. **Over-prescription of pain medications which can sometimes lead to street drug use when prescription of pain medication becomes more regulated.**
   I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else… I think it really is an issue of over-prescription that's happening today. (Tucson older adult)

Substance Use Prevention Recommendations from Older Adults

Focus more on prevention of health problems and opportunities to receive alternative health (i.e., qigong, acupuncture, etc.)

Educate the general public/family/friends so they can be part of the solution

Address social isolation (e.g. more peer support and intergenerational programming)

Educate physicians about older adult substance use issues

Provide older adult-specific education and support that meet older adults' unique needs

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

AHCCCS

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment,
September 2018

LeCroy & Milligan ASSOCIATES, INC.

Substance Use Risks among LGBTQ Youth in Arizona

The 2017 Youth Risk Behavior Survey reveals troubling substance use patterns among Arizona high school students identifying as gay, lesbian and bisexual (unfortunately the 2017 YRBS did not include transgender students). Compared to their non-LGB peers, Arizona's LGB students report a higher prevalence of alcohol, tobacco and illicit drug use, suffer more consequences associated with substance use, and report a higher prevalence of substance use risk factors. These risks were supported through focus group research as well. The findings highlight an urgent need for more effective substance use prevention interventions targeted towards LGB youth.

Alcohol Use

Alcohol use is significantly higher among LGB students than their non-LGB peers.

53%
of LGB students currently drink

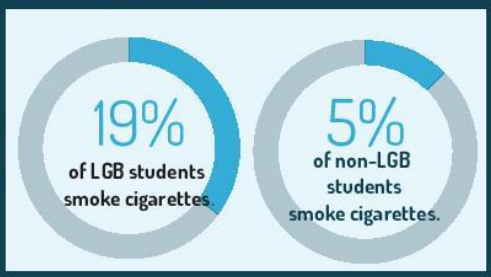
More than half of LGB students report drinking alcohol in the past month, compared to only 31% of non-LGB students.

32%
of LGB students currently binge drink

1 in 3 LGB students report binge drinking compared to 17% of non-LGB students. Binge drinking is defined as 4 or more drinks for females and 5 or more drinks for males in a few hours.

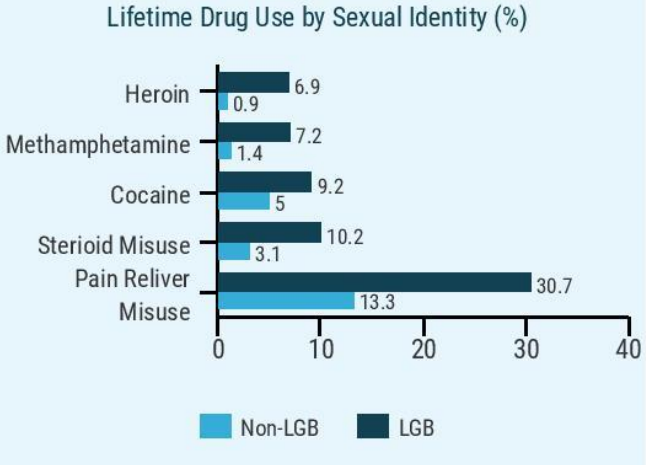
Cigarette Use

Nearly 1 in 5 LGB high school students report that they currently smoke cigarettes, which is 4 times higher than the prevalence of cigarette smoking among non-LGB students



Drug Use

LGB students are over twice as likely to report past month marijuana use than their non-LGB peers (38% vs 17%). Reports of lifetime drug use are also higher for LGB students. Lifetime misuse of pain relievers is the most commonly used substance, with 31% of LGB students reporting misuse, compared to only 13% of non-LGB students. Heroin use is 7 times more common among LGB high school students (6.9% vs 0.9%), mostly due to a much higher lifetime prevalence of heroin use among male gay and bisexual students (18%).



Notes: Pain reliever misuse is defined as taking medicine without a prescription or differently than as instructed by a doctor. Steroid misuse is defined as ever taking steroid without a prescription. All differences are at least marginally significantly at p<0.10, expect for differences in lifetime cocaine use which had a p-value of 0.13.

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

Substance Use: Risk Factors and Consequences

First Substance Use Before 13

Early age of substance use initiation is an important predictor of later substance use, dependence and abuse. LGB students are significantly more likely to report that they tried alcohol, cigarettes and marijuana before the age of 13 than non-LGB students.

First Substance Use Before Age 13 (%)

All differences are statistically significant at p<.05

Victimization and Distress

Psychological distress and victimization are associated with higher rates of substance use (Newcomb, 2012). Compared to non-LGB students, LGB students report more past year :

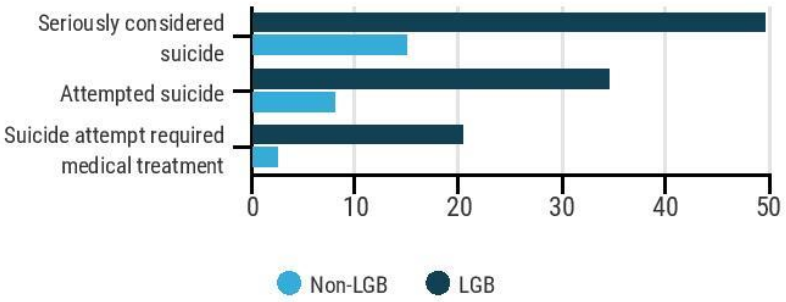
- bullying at school (41% vs 15%),
- electronic bullying (32% vs 13%),
- physical fighting (31% vis 18%), and
- ever been forced to have sexual intercourse(23% vs 6%).

70% of LGB students reported **persistent feelings of sadness or hopelessness in the past year** compared to 32% of their non-LGB peers

All differences are statistically significant at p<.001

Suicide is a leading cause of death among those who abuse alcohol and drugs (SAMHSA, 2016). LGBTQ youth are already at an elevated risk for suicide and suicide attempts. Substance use may compound these risks.

Report of Suicidal Thoughts and Behaviors (%)



All differences are statistically significant at p<.001

Focus groups conducted with the LGBTQ community across Arizona identified two major causal factors leading to substance use:
(1) Minority stress and
(2) A lack of appropriate, affordable, accessible, LGBTQ friendly mental health services

Suggestions for improved prevention efforts included:
1) Safe, substance free, non-judgmental LGBTQ spaces to connect and engage with others
2) Better access to appropriate LGBTQ friendly mental health services
3) Educating the community on how to be better LGBTQ allies including physicians, parents and teachers

- Centers for Disease Control and Prevention. (2017). High School Youth Risk Behavior Survey Data. Retrieved from http://nccd.cdc.gov/youthonline/
- Newcomb, M. E., Heinz, A. J., & Mustanski, B. (2012). Examining Risk and Protective Factors for Alcohol Use in Lesbian, Gay, Bisexual, and Transgender Youth: A Longitudinal Multilevel Analysis. Journal of Studies on Alcohol and Drugs, 73(5), 783-793.
- Substance Abuse and Mental Health Services Administration. (2016). In Brief: Substance Use and Suicide: A Nexus Requiring a Public Health Approach (HHS Publication No. SMA 16-4935, NSDUH Series H-52). Rockville, MD Retrieved from https://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pd

AHCCCS

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment, September 2018

LeCroy & Milligan ASSOCIATES, INC.