



## Arizona Substance Abuse Task Force

April 13, 2016  
Governor's Executive Tower  
2<sup>nd</sup> Floor Conference Room  
1700 West Washington Street  
Phoenix, Arizona 85007

A general meeting of the Arizona Substance Abuse Task Force was convened on April 13, 2016 at 1700 West Washington Street, Phoenix Arizona 85007, notice having been duly given. Present and absent were the following members of the Commission.

### Members Present (26)

<b>Debbie Moak</b> , Governor's Office of Youth, Faith and Family
<b>Sara Salek</b> , Arizona Health Care Cost Containment System (AHCCCS)
<b>Cindy Beckett</b> , Flagstaff Medical Center
<b>Eddy Broadway</b> , Mercy Maricopa Integrated Care
<b>Kate Brophy-McGee</b> , State House Representative
<b>Michael Carr</b> , Department of Child Safety
<b>Reuben Howard</b> , Pascua Yaqui Tribe
<b>Peggy Chase</b> , Terros
<b>Haley Coles</b> , Community Member
<b>Denise Dain</b> , St. Luke Behavioral Health Center
<b>Doray Elkins</b> , Community Member
<b>Elaine Ellis</b> , Phoenix Children's Hospital
<b>Deb Gullett</b> , Arizona Association of Health Plans
<b>Mary Hunt</b> , Maricopa Integrated Health System
<b>Robert Johnson</b> , Arizona Perinatal Care Center
<b>Susan Junck</b> , Arizona Health Care Cost Containment System (AHCCCS)
<b>Lee Pioske</b> , Cross Roads
<b>Dennis Regnier</b> , CODAC Health, Recovery and Wellness Inc.
<b>Thelma Ross</b> , National Council on Alcohol and Drug Dependency
<b>Dawn Scanlon</b> , Community Member
<b>Frank Scarpati</b> , Community Bridges
<b>Claire Scheuren</b> , Pima Prevention Partnership
<b>Gagan Singh</b> , Banner Health
<b>Jeff Taylor</b> , Salvation Army
<b>Glenn Waterkotte</b> , Retired Medical Director, Banner Desert Medical Center
<b>Michael White</b> , Community Medical Services

Staff/Guests Present (13)	Members Absent (3)
<b>Alexandra O'Hannon</b> , Governor's Office of Youth, Faith and Family	<b>Sherry Candelaria</b> , Mentally Ill Kids In Distress (MIKID)
<b>Christina Corieri</b> , Governor's Administration	<b>Jennifer Carussetta</b> , Health System Alliance of Arizona
<b>Sharon Flanagan-Hyde</b> , Flanagan-Hyde Associates	<b>Jonathan Maitem</b> , Honor Health
<b>Deborrah Miller</b> , Governor's Office of Youth, Faith and Family	
<b>John Raeder</b> , Governor's Office of Youth, Faith and Family	
<b>Sam Burba</b> , Governor's Office of Youth, Faith and Family	
<b>Steve Selover</b> , Governor's Office of Youth, Faith and Family	
<b>Sara Rumann</b> , Arizona Department of Health Services	
<b>Eddie Sissons</b> , Guest	
<b>Monica Coury</b> , Arizona Health Care Cost Containment System	
<b>Danny McKone</b> , Guest	
<b>Sarah Esperanza</b> , Guest	
<b>Ivan Pembarlan</b> , Guest	

**A. CALL TO ORDER**

**Sara Salek, Co-Chair**, called the Arizona Substance Abuse Task Force (Task Force) meeting to order at 3:09 p.m. with a quorum of twenty-six (26) members and thirteen (13) staff and guests present.

**B. WELCOME AND INTRODUCTIONS**

**Sara Salek** welcomed the commissioners and asked them to introduce themselves.

**C. APPROVAL OF MINUTES**

Members reviewed the meeting minutes for the Task Force meeting that occurred on March 23, 2016. The minutes were approved as is, without needed modification or corrections.

**D. OVERVIEW OF AGENDA AND GROUP NORMS**

**Sharon Flanagan-Hyde** provided an overview of the agenda and reminded members about the group norms; specifically, she noted:

- As a courtesy to others, only one person should speak at a time;
- Be respectful and speak concisely; and,
- Keep an open mind and remember the overall goal is to reach consensus.

**E. REPORT: PREVENTION AND EARLY INTERVENTION (PEI) WORK GROUP**

**Dawn Scanlon** provided an update on the Prevention and Early Intervention Work Group's activities. The PEI Work Group:

- Reviewed the definition of Evidence-Based Practices (EBPs) and concluded that for the purpose of developing Task Force recommendations, the National Registry of EBPs definition should be expanded to include emerging and promising practices. This is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Will be focus on addressing and reversing the growing epidemic of drug abuse and addiction in Arizona communities, by finding the best treatments and reducing barriers to care.

- After brainstorming about what comes to mind when they think of prevention and early intervention, the six (6) essential elements/topic categories identified were:
  - Education and awareness that is inclusive of culturally appropriate messaging that is impactful for various Arizona populations
  - Service Delivery
  - Parent/Caregiver Engagement
  - Environmental Strategies
  - Collaborative Communication
  - Targeted Strategies for Prevention and Interventions
- Further Discussion on each of the essential topics resulted in the following strategies:
  - Education and Awareness
    - Work on prevention as a whole.
    - Educate on how to identify early substance use in youth. Encourage frequent drug testing and intervene according to the substance used.
    - Utilize young messengers because youth can relate to them.
    - Utilize well-trained youth peers to engage youth.
    - When a fetus is exposed to alcohol or drugs they are at risk of becoming addicted to that substance as they progress through life. They are frequently born with conditions such as Attention Deficit Hyperactivity Disorder.
    - Having individuals and their families share their stories has historically proven to be impactful.
    - Keep the message simple and to the point; example- "If you brush your teeth you can avoid pain and expensive dental work."
    - Put more effort into educating kids and their families so they understand that prescription medications can be addictive.
  - Service Delivery
    - Evaluate for basic needs. Support the needs of the family and the individual.
    - Pay attention to return on investment and simple interventions that are inexpensive, but still impactful.
    - Pay attention to the individual's signs and symptoms of use.
    - Instead of schools suspending kids for seven (7) days, reduce the number of days suspended and replace them with intensive treatment for half of those days. This practice is consistent with a popular treatment program, "Teen Intervene."
    - Address Vaping.
    - Ensure there are services available to send the patient to after he/she has screened positive for substances.
    - Utilizes EBPs that have had positive outcomes with this population.
  - Parental/Caregiver Engagement
    - Do not focus solely on or single out the user; instead, incorporate the family.
    - Be mindful that the Health Information Portability and Accountability Act (HIPAA) prevents medical staff from speaking to a youth's parents.
    - Address why kids are looking to use substances and eliminate easy access to prescription medications.

- Family Strengthening has proven to work and it is cost effective. The cost averages \$400-\$500 per family and the program has a 90+ percent participation rating. Utilizing extremely well trained adolescents is imperative.
- Monitor kids and have them drug tested. Do not use test results as a reason to kick them out of school; instead, use this as an opportunity to help them.
- Because problems are deeply rooted (family, genetic pre-dispositioning, etc.) it is recommended that addressing substance abuse occur comprehensively and include relational supports outside of the individual.
- Utilize motivational interviewing when assessing/interacting with youth and their families.
- Environmental Strategies
  - Integrate services that are free, such as charity and faith-based services.
  - Address substance abuse as a health issue and work to eliminate shame associated with addiction. When a child is addicted to substances, they are not happy about it and shaming causes them to hide it.
  - Take a multi-layered approach to educating the community; beginning with prescribers so they understand the impact of prescribing practices.
- Collaborative Communication
  - Continue to support Governor Ducey's messaging and find other champions who are willing to speak out in support.
  - Agencies and programs should stop working in silos; instead, they should collaborate with all system stakeholders. Consider taking a public safety or financial savings position to gain the public's support.
- Targeted Strategies for Prevention and Intervention
  - Intervene early using appropriate supportive strategies; avoid being punitive.
  - Increase the use of EBPs and early intervention services.
  - Interventions must be very specific and cross-functional.
  - Because 90 percent of substance abuse begins in the teen years, it is recommended that this population be targeted.
  - Shift dollars to support substance abuse prevention programs.

The PEI Work Group identified the following barriers to creating change:

- Agency reluctance to spend money on prevention and intervention programs.
- Prevention is a relatively invisible process, which can make rolling out programs challenging.

When considering currently available data that could prove helpful in the progression of the Work Group's process it was recommended the PEI Work Group:

- Request a consultation from someone who is employed in the probation field.
- Invite someone from the Juvenile Detention Alternatives Initiative to provide technical assistance for the Work Group.
- Request data on prevention and intervention from Dr. Rene Bartos.

#### **F. REPORT: NEONATAL ABSTINENCE (NAS) SYNDROME**

**Cindy Beckett** provided an update on the Neonatal Abstinence Syndrome Work Group's activities. In regards to EBPs the NAS Work Group:

- Agreed to acknowledge both “emerging” and “promising” practices in their definition of EBPs.
- Recommended the standards identified in the document titled, “Report of the Autism Spectrum Disorder Advisory Committee,” which included a statement from the Substance Abuse and Mental Health Services Administration (SAMHSA), and web links and definitions provided by Task Force member Claire Scheuren, be adopted by all four (4) Work Groups.
- Acknowledged the importance of how EBPs are defined for the Work Group’s final submission to the Substance Abuse Task Force.

The NAS Work Group members were asked to inform the group of one to two things they believe need to be represented and addressed in the final report to the Task Force. The following elements were identified:

- Early intervention for both the mother and child are crucial, as are having a formalized best practice for the treatment of NAS.
- Increase education on how to interact with Department of Child Safety.
- Provide nurses and doctors with a standardized approach for treating NAS.
- Eliminate stigma associated with NAS.
- Understand that NAS cases require long-term care for both the mother and the baby.
  - Recognize that the hospital is often the starting place for the continuum of care for NAS cases.
  - Work to collectively to ensure the mother and baby’s needs are being met.
  - Have a clear understanding that once a NAS baby is born, this is where the work begins.
- At birth, women are more open to treatment, which presents an opportunity to get the mother substance abuse treatment.
- The Healthy Families program is designed for mothers with children birth to five-years-old. It would be beneficial to see a provider network where providers can give direct, timely and meaningful resources to the mother.
- Be mindful that the earlier a practitioner is able to intervene in the mother’s prenatal care, the better for both the mother and the baby. There are different treatments for the baby in utero that could be considered, but a Task Force member believed this group’s time would be better served focusing on training opportunities for obstetricians, along with a clear standard network of resources. It is critical to train and educate obstetricians.
- When a woman is using opiates, the obstetricians keep the mother on a regulated and stable dosage of the medication to help mitigate further harm to the child.
- Increased education for prescribers is needed. Some doctors do not consider alternative treatment options for pregnant women.
- The Work Group should not forget to address other drugs such as stimulants, alcohol, etc.
- Currently, legislation is being considered that mandates physicians use of the Arizona’s Controlled Substance Prescription Monitoring Program (CSPMP); how have other states addressed this?
  
- The NAS Work Group categorized their needs-based discussion to include:
  - Awareness
    - Education of women regarding consequences of NAS.
    - Resources to services.
    - Education for prescribers.
  - Intervention during pregnancy.

- Continuum of services.
  - Early involvement of Department of Child Safety (DCS) programs such as the Arizona Families First program.
- Standardization across hospitals and the DCS.
- Elaboration on the categories resulted in the following discussion:
  - Continuum of services.
    - A Task Force member said DCS' medical director would be more than happy to consider extending the scope of the AZ Families First program to include pregnant women.
    - It is important to garner DCS involvement as it will help change the perception of what DCS does, how it offers resources, and how it serves the State of Arizona.
  - Awareness
    - There are two initiatives currently being considered by the Governor's Commission on Child Safety and Family Empowerment that allow for strong and meaningful collaboration between state agencies and faith communities.
    - Care Portal – the pilot in Tucson has been able to keep more than one hundred kids out of DCS custody.
      - Angel Initiative – Commission is interested in targeting this potential initiative to engage women in high-risk areas.
      - These initiatives allow for strong and meaningful collaboration between state agencies and faith communities.
    - Increased awareness for people and agencies that interact with pregnant women. People need to understand what the mother is going through and offer positive interventions to best support the mother and child.
    - Reduce stigma.
    - Focus on women who are dually diagnosed (seriously mentally ill and substance abuse) in the final report.
- Intervention during pregnancy.
  - Providers will often use DCS as a threat. This group should help change the way that providers talk about DCS. Mothers should see DCS as a tool rather than a “stick” or punitive entity.
  - Develop a resource toolkit for providers to use early in pregnancy, and to better identify at-risk women.
  - Early intervention is not just about engaging the obstetrician but health providers as a whole. Health providers need to be trained to identify at-risk women before pregnancy.
- Standardization across hospitals and the DCS.
  - Encouraging DCS to be more involved in NAS cases will help with the standardization of care and resources for the mother and child.
  - Ensure every family has access to the necessary tools and resources to succeed. This may lead to changing the culture of DCS.
  - Identify use/abuse early in pregnancy; this is as important as identifying venereal disease.
  - Requiring mothers to be drug screened. Some debate on this intervention occurred with members having different perspectives regarding mandating providers screen pregnant women. Members noted:
    - Such action is best accepted as “best practice” after being adopted by a medical community, rather than top down through governmental regulation.

- A recommendation that requiring mothers be screened be included in the final report to the Substance Abuse Task Force.
- Sometimes exposing or forcing treatment can have positive outcomes.
- The largest hurdle in the advancement of standardized practices will not be the Arizona Health Care Cost Containment System (AHCCCS), but private/commercial medical providers.
- Utilize private and commercial relationships to get private insurance companies to use the same standardized practices.

When considering currently available data that could prove helpful in the progression of the NAS Work Group's process, it was recommended the NAS Work Group:

- Consider beginning by identifying what is currently available, what is working and not working, and then build upon that information to create a list of available resources.
- The "Statewide Task Force on Prenatal Exposure to Alcohol and Other Drugs" report will be sent to the facilitator for group dissemination and consideration.
- Some said the group should provide hospital social workers with a standard referral process for reporting. It is unclear to Task Force members what the hospital's actual legal responsibilities are.

#### **G: REPORT: ACCESS TO TREATMENT WORK GROUP**

**Doray Elkins** provided an update on the Access to Treatment Work Group's activities. Like the aforementioned Work Groups, the Access to Treatment Work Group:

- Reviewed the definition of Evidence-Based Practices (EBPs) and concluded that for the purpose of developing Task Force recommendations, the National Registry of EBPs definition should be expanded to include emerging and promising practices. This is supported by SAMHSA.
- Members were asked to keep language clear and concise when talking about EBPs, and distinct from evidence-based programs. Also, be mindful that the overall goal of EBPs is to improve program and treatment outcomes.

The Work Group was asked to discuss access to treatment, to which the group thought it beneficial to first define what "access" means, because the word is tied to various criteria. The members were asked what comes to mind when they think of access to treatment, to which the Work Group reported:

- Availability of detox services.
- Education on the type of services available.
- Emergency and outpatient services, delineating emergent and chronic needs.
- Collaboration and coordination of care, as well as readiness to provide them.
- Process for accessing services (appointments referrals, approvals, etc.).
- Diversity in treatment options.
- Insurance barriers. Having to present with unrelated conditions in order to receive treatment.
- Age-appropriate services (example- adult services versus services for teens).
- Ongoing community supports after treatment is completed.
- Coordination of care; providers communicating with one another, especially individuals with dual diagnoses. Also, parity and how services are provided for individuals who are privately insured.
- Capacity, capability; workforce that is capable of treating conditions. Also, barriers faced by individuals with private insurance; limited network- particularly when compared to individuals who receive services through Medicaid.
- Availability of resources and quality assessments, and the ability to treat pregnant women.

- Financial means and transitional programs that help treat and sustain sober living.

The Work Group categorized their responses, which lead to the following categories:

- Awareness
- Financial
- Capacity/Capability
- Accessibility
- Criminal Justice

The members were then separated into five (5) groups and tasked with exploring the five (5) essential topic categories. The results were as follow:

- Awareness
  - A centralized “depot” of resources.
  - Diverse and culturally competent services that are available to all populations (adults, kids, pregnant women, etc.).
  - Fulltime staff that can actively update a resource website that stores information for all community providers.
  - Use of Motivational Interviewing for all assessments.
  - Stigma-free environment.
  - Easy access to comprehensive services.
  - Coordination of care and consideration of potential barriers (example- in order for an individual who is homeless to come in for their appointment, they may need assistance with storing their possessions/cart).
  - Consider individuals who may not be ready for treatment yet, but may be ready in the future.
- Financial
  - Insurance-related issues
  - Parity
  - Funding source
  - Limited beds/ patients clogging emergency rooms.
  - Compare and contrast the Medicaid system with commercial insurance.
    - High premiums and co-pays imposed by private insurance companies.
- Capacity/capability
  - Right treatment for each individual or condition.
  - Increase the number of providers who produce quality, comprehensive assessments.
  - Develop a resource portal/website that hosts a current and well-maintained list of treatment providers.
  - Employ the use of “warm handoffs” so recipients are not being handed off to a wait list.
  - Service availability on demand.
  - Workforce development is needed to ensure competent staff are readily available to help patients.
- Accessibility
  - Removal of barriers that prevent recipients from getting into treatment (example- transportation, childcare, etc.).

- Availability of services in rural areas.
- Immediate availability of beds.
- Rural and Tribal areas.
- Centralized resources.
- No “wrong door” for accessing services.
- A network of behavioral health professionals who conduct quality assessments.
- Utilize support groups to identify and aid recipients with getting into the right level of care.
- Education, information production and dissemination.
- Having numerous “touch-points” to guide the recipients.
- Recognizing signs and symptoms that indicate the recipient is not doing well.
- Criminal Justice System
  - It is important to factor criminal justice into the equation. If people receive good treatment in jail, the system may prevent them from going to prison.
  - One Task Force member said there are five (5) critical components that contribute to an individual’s ability to get/maintain sobriety, they are: therapy, transportation, vocational services, faith, and safe sober living.
  - 20,000 people are released from criminal institutions every year; 70 percent of these individuals have a substance abuse problem.
  - Target those who would not be in jail if it were not for substance use.
  - Change the culture of over-institutionalization.
  - Create a safe environment for assessment and recovery in prisons.
  - Release inmates to the care of comprehensive treatment programs.
  - Promote the use of conditional treatment in lieu of jail.

The Work Group discussed the availability of Prevention Block Grant and other funding to support a systemic shift in culture.

- AHCCCS recognizes substance use and abuse is a problem in Arizona.
- Veterans are experiencing difficulty transitioning from military to civilian life.
- The system may need to transfer funds to prevention programs until the shift in Arizona’s culture catches up.

The Work Group discussed additional questions/comments to be considered, such as:

- Where are substance abusers encountered? The number of places could be increased, for example, HIV programs.
- What does Arizona have budgeted for treatment?
- What ROI data do we have on long-term sobriety?
- How many treatment beds are available in Arizona?
- What is the workforce situation?
- Why is it expensive/difficult to invest in recovery upon incarceration?

Sharon asked the group to think ahead to the report they will be submitting to the Task Force. What essential elements do they need to address in the report?

- Beds and services available on demand to meet needs.
- Decrease in the number of people arrested and incarcerated.
- Decrease in the number of accidental and preventable deaths.

- Crosswalk: who provides what services – a description of the web of supports in the community, different options, targeted supports for different ages and populations, navigation tool.
- One stop comprehensive programs along the continuum of care.
- Providing services to people not yet willing to get treatment; keeping them alive until they will access treatment.
- Good assessments at the diverse points of encounter.
- More engagement of people through schools and other organizations.
- More supports for parents because healthy parents are more likely to produce healthy kids.

This Work Group, too, was asked to consider available data as well as information the Work Group feels would be helpful in the progression of its process, the following information was discussed:

- Terros' data indicates the cost of substance abuse treatment is relatively cheap; \$1,800 for a 90-120 day program. The Terros CEO further stated that patients who have successfully completed their program are often hired by Terros; she described them as highly involved and productive staff.
- There is a positive return on investment because healthy recipients get jobs and pay taxes.
- Members were asked to email data to Sharon, and she will use the information provided to create the agenda for the next Access to Treatment Work Group meeting.

#### **H. REPORT: MEDICATION-ASSISTED TREATMENT (MAT)**

**Peggy Chase** provided an update on the MAT's Work Group's activities.

- The MAT Work Group also reviewed the definition of EBPs and concluded that for the purpose of developing Task Force recommendations, the National Registry of EBPs definition should be expanded to include emerging and promising practices.
- The reality is that there is not much published literature in this field yet. As the program moves forward it will be important to better understand how we can best collect data and inform future practice.
- EBPs are defined by the practice. We are more concerned that we are including EBPs, emerging trends and promising practices in how practitioners employ MAT.
- EBPs must incorporate cultural diversity. Data collection and sharing on tribal lands has traditionally been difficult. Collecting and sharing tribal-collected data is not an easy task.
- Even though EBPs are discussed, programs are not funded to employ models to 100 percent fidelity.
- When looking for outcomes, fidelity must be taken into consideration.
- An emerging trend in Mat is integrating behavioral health into the medical health field. It is important that addiction is also seen as a chronic medical disease.

Work Group members were then asked to list one or two things they believe should be represented in the final report from the Task Force in regards to MAT; the following were identified:

- Education on MAT and cultural changes in the community.
- Access to care.
- Educating medical providers on how and why to adopt MAT, while addressing the shortage of behavioral health medical providers.

- Coordination of care. Providing medication, treatment, prevention, case management and caring for families.
- Access (defined as limited workforce and how to reach the most people possible).
- Greater use of non-opiate blockers in MAT (specifically Naltrexone). Utilizing EBP models.
- MAT for pregnant women, as well as the use of Naloxone to prevent death as a result of overdose.
- Come up with a wide range of solutions and scale those opportunities for the state.
- Use of MAT in prison, as well as prescribing Vivitrol to mitigate relapse.
- Expansion of programs that attract medical providers and students to serve this population, such as loan repayment program for providers that serve patients in rural communities.
- Lift the cap on the number of patients a provider can treat on specific MAT drugs, such as Buprenorphine.
- Substance and population specific (example- adolescence, co-occurring with a SMI, LGBT, etc.
- Data and reports coming from the CSPMP.

Work Group members were next asked to categorize their responses; the results were:

- Access to MAT
  - Increasing the number of providers trained on MAT.
  - Scope of practice.
  - Increased impact per provider.
  - List MAT drugs- authorization requirements.
- Provide education for system partners.
- Targeted strategies for special populations.
  - MAT and pregnant women.
  - Department of Corrections (DOC) populations.
- Coordination of care.
- Detox
- Awareness of MAT and decreased stigma.

Conversation occurred about each category, resulting in the following breakdown:

- Access to MAT.
  - Think from the perspective of how medical providers can become more comfortable with MAT. It is important that providers are able to choose whether they participate in MAT programs.
  - There are online training opportunities for MAT.
  - Eight (8) hours of training is insufficient when educating on substance abuse. Combine MAT with cognitive therapy.
  - MAT is only one component of a biopsychosocial issue.
  - There are too many barriers in mental health. If it is too difficult to get care, people are just not going to do it.
  - New Mexico has a program, Project ECHO, which has someone that knows how to prescribe and can assist medical providers.
  - Many providers are risk averse; these are individuals at high risk from morbidity so there is little incentive for providers to serve them.
  - Treating pregnant women is an important consideration from the perspective of risk versus benefit.

- Educating and supporting additional providers.
- New Jersey has stopped prescribing opiates in the emergency rooms (ER).
- Increase the number of MAT providers so people in need are not required to wait.
- Funding for medical colleges could/should be linked to mandated training on MAT in the medical institutions.
- The State can tie dollars to training; however, there are a lot of requirements on medical institutions so (understandably) we might get push back.
- Rather than making a top down mandate, it may make more sense for training requirements to come from medical agencies and boards.
- Many providers were trained many years ago. When you are brought up in different disciplines it can be difficult to accept new and innovative practices.
- Education for System Partners.
  - Re-evaluate the amount of Block Grant dollars Tribes receive for prevention programs.
  - Educate and re-culture the profession for ICD-10. Providers need to diagnose and refer appropriately.
  - Add MAT training to Relias trainings.
  - It would be beneficial to mandate training on MAT.
  - Opiate prescribing may become a mandated training.
  - Trainings should be diverse and not only target prescribers.
- Targeted Strategies for Special Populations.
  - Prevention and early intervention strategies.
  - A bill is being considered that mandates providers use the CSPMP and limit ER doctors to prescribing a maximum of a five-day dose of pain management pills.
  - Provide MAT in a timely and appropriate manner similar to someone who is diagnosed with chronic heart failure.
  - Giving MAT the prominence that it requires.
  - Strengthen early identification and intervention strategies.
  - Patients often have abused substances for years and mental health agencies wait until the patient asks for help to get care. This requires a shift in culture because today, "hitting bottom" often means death.
  - MAT is not necessarily the "magic bullet" and is not the only treatment for substance abuse.
  - MAT for pregnant women is a huge issue. There is no approved Vivitrol medication.
  - In addressing access to care, telemedicine is a resource that would be an effective platform for MAT.
- Coordination of Care.
  - Pregnant women
  - Relapse prevention for DOC populations.
  - Coordination of care is in the patients' best interests.
  - Historically, treatment has been provided in silos. All the changes in Washington for the 42-Code of Federal Regulations have proven to be challenging for doctors.
  - For some people MAT is a pathway to recovery. We all agree that MAT must be attached to therapy.
- Detox
  - Not specifically mentioned in this discussion.

- Awareness of MAT and Decreased Stigma.
  - Work to alter the public's perspective of MAT so it becomes a healthy approach to care when it is professionally done and shame and stigma are eliminated.
  - Stigma within and outside the treatment arena tend to make it difficult to accept MAT.

This Work Group was also asked to consider available data as well as information the Work Group feels would be helpful in the progression of the process. The following information was discussed:

- Outcomes and data are slowly coming in. The Work Group should have the opportunity to tap into the research institutions and the State agencies.
- There are research students who would be willing to work on gathering data for the Work Group or State agency.
- Data (particularly raw data) will need to be evaluated and analyzed, possibly by a graduate student.
- Comparative data with other states should be consistent.
- A current and comprehensive inventory of MAT programs in Arizona was requested.
- The Work Group requires data on how many people need MAT. One way to look at this could be through prevalence of people who are using the needle exchange program.
- A literature review on recent MAT, especially on special populations, was requested. Consider looking into what SAMHSA believes are the most promising options.
- A Work Group member reported having many resources on MAT. She is willing to share them with the group.
- Another Work Group member volunteered to conduct a literature review. He also suggested reaching out to the American Society of Addiction Medicine.
- An inquiry was made about whether strengthening the language in contracts and deliverables would solve some of the access to care problems.
- Cultural competency, when thinking and planning about access to care is critical. They have to think about how and why people access care as well as other ethnic factors. Consider looking at the number of Latinos that are accessing treatment and the number of Latinos who need care, and the numbers do not add up.
- An inquiry was made about whether Indian Health Services would be interested in participating in a discussion regarding access to care.

Task Force members were asked whether they had any questions or wished to add anything to the reports that were given; they responded:

- **Jeff Taylor-** Stated that substance abuse education must occur "all the way through." Also, level of use should be considered when responding to adolescents who are using substances, "You do not want to overkill our kids because they will react."
- **Michael Carr-** How we identify women who are using substances is a question that is answered by the Substance Services Block Grant Program.
- **Cindy Beckett-** Make universal screening a standard of care. Develop a tool that does not alienate anyone.
- **Claire Scheuren-** New York has a video about shaken baby syndrome that all new parents are required to watch.
- **Cindy Beckett-** Standard of care comes with education. If moms are educated, they are less likely to engage in substance use while pregnant.

- **Jeff Taylor-** Salvation Army is working on creating an outpatient detox facility in West Phoenix. Their goal is to fill a void in the continuum by allowing parents to bring their children with them to detox at the facility on an outpatient basis. Intensive Outpatient Programs are becoming good at creating outcomes. “Funding should be shifted from treating the wreckage of addiction to developing prevention programs that ultimately can impact adverse outcomes.”
- **Eddy Broadway-**The Task Force needs to address frontier and Tribal populations where members are located in vast locations and transportation/travel times are extensive.
- **Doray Elkins-** There are drugs that can prevent deaths due to overdose. Narcan and Naloxone are available in injectable and nasal spray forms. The medications are saving lives and other states allow parents and other non-medical providers access to these medications.
- **Christina Corieri-** Amending House Bill 2489 to include third party prescriptions is currently under review.
- **Reuben Howard-** Prescription abuse is being addressed on a national level. He requested a briefing on national efforts.
- **Claire Scheuren-** Congress has increased the number of people a prescriber is permitted to treat with medications like Suboxone.

## I: FACILITATED DISCUSSION

**Sharon Flanagan-Hyde** explained the reason each Work Group is required to report into the Task Force is so members can internally integrate the information. Members were asked to identify consistent themes among the different Work Groups; Claire Scheuren identified reducing stigma, creation of a toolkit, culturally diversity, and employing a comprehensive approach to intervention and training.

Sharon then asked what it will take to address stigma; and the members stated:

- **Michael White-** Shift the culture from consequences to support.
- Providers must cease threatening pregnant mothers with DCS involvement.
- **Peggy Chase-** Readiness and an understanding that harm reduction occurs along the way. Terros wants people who relapse to continue to come back to outpatient treatment instead of using ERs. Also, use nice facilities where a patient can feel respected and treated with dignity.
- **Doray Elkins-** Educate ground level staff: doctors, nurses, social workers, etc., so they can employ a welcoming and non-judgmental approach to treating patients.
- **Sara Salek-** Train not only the workforce, but also institutions of higher learning.
- **Reuben Howard-** Vocational rehabilitation should also be addressed because the services help the person to become a functional member of society.
- **Dawn Scanlon-** People have a hard time getting apartments and jobs when they have experienced setbacks often incurred as a result of substance abuse. Eliminating stigma can assist with this also.
- **Jeff Taylor-** Recommended inviting Steve Grams, President and CEO of Sage Counseling to present on Prison Transition for non-violent drug offenders, and Frantz Beastley, President of Common Ground, to present on Employment and Housing for Drug Felons.
- **Haley Coles-** Shift substance abuse from a criminal issue to a health issue. Support law enforcement diversion programs and “Ban the Box,” which eliminates questions about arrests from the employment application. Businesses are still permitted to ask questions pertaining to criminal history during the interview; however, they are prohibited from excluding someone because of a single question on an application.
- **Eddy Broadway-** Use progressive public health campaigns because, “This is an everybody issue,” that transcends prevention.

- **Christina Corieri-** Expects to receive the first set of predictive analysis data within the next twelve (12) weeks. She is willing to have the data presented to the Task Force.
- **Cindy Beckett-** A substance abuse campaign should mirror the Zika virus campaign. Do not forget families because patients will ultimately return home to them. Treat both the patient and the family.
- **Susan Junck-** Collaborate and coordinate care to avoid lack of clarity. Remember that the Health Insurance Portability and Accountability Act may create barriers to doing so.
- **Cindy Beckett-** Coordinate and collaborate to eliminate replication.

Sharon mentioned the use of a web or information portal as a central repository.

- **Peggy Chase-** Real time data and service availability would be a plus.
- **Dennis Regnier-** Service providers are needed. If the system does not have enough providers available, then it risks referring willing patients to waitlists. There should always be a warm handoff.
- **Jeff Taylor-** Arizona had a great anti-smoking campaign that made smoking “uncool.” He recommended creating a similar marketing strategy for substance use.
- **Michael Carr-** Recommended utilizing the SAMHSA website as a vehicle for locating providers.
- **Eddy Broadway-** Provide financial support to 2-1-1 Arizona, as the site contains community resource information.
- **Jeff Taylor-** Utilize well educated teens.
- **Haley Coles-** 2-1-1 Arizona can be very useful if readily updated.
- **Debbie Moak-** Asked each member to log into the Governor’s Office of Youth, Faith and Family’s treatment locator to evaluate if this tool is useful, or requires enhancements. She requested the locator be placed on the next agenda for discussion.

Sharon asked the group to continue to discuss themes; members responded:

- **Eddy Broadway-** Urban, rural, and Tribal issues.
- **Cindy Beckett-** Awareness and education campaigns.

Sharon asked the members to suggest expert presentations that could address gaps in knowledge that need to be filled:

- **Michael White-** Recommended inviting Dr. Sue Stevens to present on DCS issues and needs.
- **Michael Carr-** It would be beneficial to know which providers receive SABG dollars for youth services.
- **Jeff Taylor-** Homelessness. Arizona has become a magnet for young substance addicted and mentally ill people.
- **Kate Brophy-McGee-** Consider adopting a housing model that is similar to the one being implemented in Utah.
- **Eddy Broadway-** Would like to get more information on how commercial programs are addressing Parity. At this time, once a privately insured patient leaves the hospital, there is nothing for them in the way of outpatient treatment. Christina Corieri offered to forward information to him.
- **Haley Coals-** Would like for someone to speak on harm reduction.
- **Dr. Singh-** Training programs and incentives for providers to practice MAT.

## J. WRAP UP

**Sharon Flanagan-Hyde** informed the members the next meeting is scheduled to occur on May 25, 2016 at 3:00 p.m. at the Governor’s Executive Tower, 2<sup>nd</sup> Floor Conference Room at 1700 W. Washington Street.

**K. CALL TO THE PUBLIC**

No public members submitted a request to speak.

**L. ADJOURN**

**Sara Salek** adjourned the meeting at 4:46 p.m.

Dated the 13th of April, 2016

**Arizona Substance Abuse Task Force**

Respectfully Submitted By:

Alexandra M. O'Hannon

Governor's Office of Youth, Faith and Family Program Administrator