

# Maricopa County Department of Public Health

## Opioid and Substance Use Needs Assessment

### **Final Report**

July 2023



# MCDPH Opioid and Substance Use Needs Assessment: Final Report

July 2023

## Submitted to:

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Founded in 1991, LeCroy & Milligan Associates, Inc. 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, LeCroy & Milligan Associates has worked at the local, state, and national levels with a broad spectrum of social services, criminal justice, education, and behavioral health programs.

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# EXECUTIVE SUMMARY

This needs assessment report presents findings from existing and new data collection about the response to opioid and other substance use in Maricopa County, Arizona. It includes background data and literature, a situational analysis, key informant interviews, an electronic survey, a focus group session with regional youth coalitions, and listening sessions with over 300 provider organizations representing all five regions of the county. Findings and recommendations can be used to inform and implement how community, healthcare, and governmental organizations address gaps and improvements in the system of prevention and care for opioid and other substance use.

Opioid-related harms and deaths were declared a public health emergency in 2017, and in 2021 a national \$26 billion legal settlement agreement was reached with the three largest pharmaceutical distributors, McKesson, Cardinal Health, and AmerisourceBergen, and manufacturer Janssen Pharmaceuticals, Inc. As part of these settlements, Maricopa County will receive an estimated \$80 million over 18 years with additional funds expected as other settlements are finalized.

Drug overdose deaths have increased in Maricopa County for the last decade. In 2021, 1,963 people died of an overdose in Maricopa County, and there were also 12,167 non-fatal overdose hospital visits. In recent years, fentanyl has been involved in a majority of overdoses. In fact, from 2012-2021, the overdose death rate for synthetic opioids (e.g., fentanyl) increased by over 6,000%.

Primary sources of public funding for opioid use disorder (OUD) and substance use disorder (SUD) are federal Medicaid funds, the Arizona State General Fund, and other federal grants. While they are critical components to the overall system, these funds are often uncoordinated and do not fully support a care continuum, incorporate harm reduction services, ensure access to services, stabilize organizational services, or support evaluation and tracking of OUD/SUD responses.

## Key Findings

Findings from this needs assessment highlight common structural factors that affect the effectiveness and coordination of OUD/SUD interventions, along with dynamics unique to the different OUD/SUD interventions. Maricopa County's rising death toll from substance use is driven by the potency and prevalence of fentanyl in illicit drugs. Community and government agencies such as but not limited to substance use providers, recovery homes, first responders, and law enforcement are involved in responding to the crisis, but face challenges in coordinating with other institutions for timely access to appropriate services, identifying trends and outcomes to guide service provision, and adequately addressing social determinants of

health to facilitate care engagement. Thus, organizations' capacities to respond to OUD/SUD is blunted by a fragmented system of payers, care coordination, and varying institutional policies.

Analysis across all needs assessment components led to 10 major findings:

- 1 High and varied potency of illicit drugs necessitate a rapid, coordinated, and multi-pronged response.
- 2 Timely service access and coordination of care is hindered by inadequate resource and referral information, fragmented funding, and limited partnerships for crisis and care transitions.
- 3 Greater support for housing, transportation, justice-system transitions, and populations with health disparities is needed for positive care outcomes.
- 4 Common metrics for substance-related harms, service utilization, and outcomes would support organizational partnerships and activities, and facilitate public health monitoring of the response.
- 5 Stigma associated with people who use drugs hinders organizations providing OUD/SUD interventions, as well as individuals' access to care.
- 6 Primary prevention and early intervention to reduce harms to youth are limited by funding restrictions and state/local education policy.
- 7 Providing safer substance use services only became legal in Arizona within the past 3 years, and organizations providing them need infrastructure support and development to meet harm reduction demands.
- 8 Health insurance authorization and coverage restrictions cause delays and limitations for treatment and recovery services.
- 9 Social support is essential for maintaining recovery from opioid and other substance use.
- 10 The interplay between harm reduction, abstinence from substances, treatment, relapse, and recovery is important for many people's substance use journeys, and coordination for simultaneous services from different interventions is needed.



## Recommendations

These findings led to 30 recommendations that are outlined in a comprehensive table organized by population health factors in the Conclusions section of this report. They point to structural and intervention level changes, some of which are within the purview of community providers, cities and counties to impact, while others suggest areas to pursue with state and national policy leaders.

Overall, these recommendations suggest leveraging various payer and funding streams to support housing, transportation, and other wrap-around services for people accessing OUD/SUD services, and investing in services that support populations disproportionately affected by substance-related harms such as those involved in the justice system, people of color, and those with low incomes. They also identify potential system and policy improvements to enable access to existing OUD/SUD intervention programs, such as school-based prevention and early intervention, harm reduction outreach, and clarity about insurance coverage for treatment and recovery services. The importance of care coordination during times of crisis and transition, as well as access to simultaneous care services, led to recommendations for improving the capacity of rapid response systems, and resources to enable providers to coordinate with one another. Finally, the ability to identify substance use trends and priorities that inform intervention efforts is a key part of a coordinated response system, which rests on centralized and shared data about OUD/SUD.

## Key Recommendations for Improving the Continuum of Care Response

### Social Determinants and Equity

- Improve access to longer-term housing through existing funding and policies.
- Improve transportation support for people engaging in OUD/SUD services.
- Address stigma associated with people who use drugs through educational and media campaigns.
- Increase naloxone access points by limiting administrative, financial, and legal barriers to access, with particular focus on geographic areas with lower access and/or higher overdose rates.
- Support specialty treatment and recovery services for individuals and families disproportionately affected by OUD/SUD harms, including people of color, people with low income, LGBTQ+, and justice-involved individuals.

### Systems and Policies

- When creating grant funding opportunities, make the application process accessible to smaller organizations, incentivize connections to other levels of care services, and include planning, evaluation, and resources/support in the funding.
- Incorporate early intervention for youth at high risk for OUD/SUD in settings such as schools, behavioral health programs, foster care, street outreach, and the juvenile justice system.
- Bolster harm reduction street outreach efforts through capacity funding to increase services that reach people experiencing homelessness. Increase dialogue between community-based harm reduction providers and jurisdictions to support street- and park-based efforts.
- Support policies that reduce legal and administrative barriers to accessing and using naloxone, fentanyl test strips, and other harm reduction services.
- Support justice system diversion and deflection for drug-related charges that do not pose a threat to others.
- Work with the Arizona Health Care Cost Containment System (AHCCCS) to explore issues of prior authorization, covered service limits, and health care parity. Encourage clarifications regarding coverage while larger policy issues are explored.

### Provider Partnerships and Capacity

- Establish centralized care navigators to facilitate transitions between service providers and levels of care.
- Identify a system, such as a centralized database of OUD/SUD providers and services, to facilitate visibility and coordination of care across providers.
- Create opportunities for providers to convene to share information and strengthen partnerships.
- Improve crisis and post-overdose response team coordination to immediately connect people in distress to the most relevant care services.
- Integrate harm reduction education and services into treatment and recovery interventions to reduce fatal overdoses.
- Continue providing MAT/MOUD in correctional settings, and ensure continuity of medication during re-entry.

### Data and Evidence

- Continue substance overdose surveillance through County Medical Examiner's Office to have real-time data about drug trends and harms to share with providers.
- Establish a process for sharing data with community partners, such as a dashboard about opioid and other substance use trends by region and updated regularly to facilitate shared knowledge, priorities, and partnerships among providers.
- Establish high-level metrics for success in the OUD/SUD response, so that provider-level planning, funding, and reporting can connect to common goals.

# INTRODUCTION

The Maricopa County Department of Public Health (MCDPH) is the third largest public health jurisdiction in the United States, serving about 4.5 million residents. The County encompasses urban cities, suburban areas, and rural towns, along with tribal and unincorporated communities. The overall drug-related death rate has increased in Maricopa County for the past 10 years. In 2019-2021, more than two-thirds of all drug overdose deaths in the county involved opioids. Opioid-related harms and deaths were declared a public health emergency in 2017, and national opioid settlement payments began in 2022.

All 15 Arizona counties as well as 90 cities and towns in the state will receive opioid settlement funds. In the interest of maximizing funds for community benefit, Maricopa County sought a needs assessment to identify key barriers, concerns, and priorities among organizations responding to opioid and other substance use. The findings will be used to develop a countywide strategic plan for response interventions and inform funding priorities, as well as coordinate and minimize duplication of efforts with local jurisdictions.

The purpose of this needs assessment is to bring together existing and newly collected data related to the substance use response in Maricopa County. The assessment's primary goals are:

- 1 Improve understanding of **underlying causes of and experiences** with substance use in Maricopa County, especially among high-risk and underserved populations.
- 2 Provide a **summary of the current state** involving opioid/substance use overdose deaths and opioid/substance use prevalence, identifying trends by geographic regions and subpopulations.
- 3 Present a range of **evidence-based strategies and prioritized needs** relevant to Maricopa County.

This needs assessment builds upon existing state and local substance use data and assessments including the 2018 Arizona Statewide Prevention Needs Assessment<sup>1</sup>, the 2020 Arizona Health Care Cost Containment System (AHCCCS) Statewide Substance Abuse Prevention Strategic

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<sup>1</sup> LeCroy & Milligan Associates, Inc. (2018). Arizona Statewide Prevention Needs Assessment. Tucson, AZ. <https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf>

Plan<sup>2</sup>, the 2019-2021 Arizona Opioid Action Plan<sup>3</sup>, and the 2021 AHCCCS Pregnant and Post-Partum Women with Substance Use Disorder Needs Assessment<sup>4</sup>.

Throughout the needs assessment, an Advisory Committee comprised of 18 leaders from community provider organizations guided data collection participation and vetted findings. Their expertise in the substance use field ensured the assessment and interpretation process was rooted in the experiences of OUD/SUD in Maricopa County. See Appendix C for organizations involved in situational analysis and interviews.

## Assessment Framework

A *population health approach* is one that aims to improve health outcomes for entire populations, and incorporates social, economic, and environmental determinants of health into understanding and addressing the issues<sup>5</sup>. For opioid and substance use disorders (OUD/SUD), the U.S. Department of Health and Human Services (HHS) outlines a comprehensive strategic framework<sup>6</sup> for addressing the overdose crisis. MCDPH has aligned this assessment with the framework's four areas of focus: primary prevention, treatment, harm reduction, and recovery. Cross-cutting factors that affect OUD/SUD response interventions were also explored in the assessment: social determinants and health equity; systems and policies; data and evidence, and provider capacity and partnerships. Shown in Exhibit 1, this framework was used to guide this assessment's data collection and organize data analysis.

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<sup>2</sup> LeCroy & Milligan Associates, Inc. (2020). AHCCCS Statewide Substance Abuse Prevention Strategic Plan. Tucson, AZ. [https://www.azahcccs.gov/Resources/Downloads/Grants/SABG/AHCCCS\\_StatewideSubstanceAbuseStrategicPlan.pdf](https://www.azahcccs.gov/Resources/Downloads/Grants/SABG/AHCCCS_StatewideSubstanceAbuseStrategicPlan.pdf)

<sup>3</sup> ADHS, AHCCCS, GOYFF. (2019). Arizona Opioid Action Plan Version 2.0. <https://www.azdhs.gov/documents/prevention/health-systems-development/epidemic/opioid-action-plan-2019-2021.pdf>

<sup>4</sup> LeCroy & Milligan Associates, Inc. (2021). AHCCCS Pregnant and Post-Partum Women with SUD Needs Assessment. Tucson, AZ. [https://www.azahcccs.gov/Resources/Downloads/Grants/PPWPLT/AHCCCSPPWNAReport\\_LMA.pdf](https://www.azahcccs.gov/Resources/Downloads/Grants/PPWPLT/AHCCCSPPWNAReport_LMA.pdf)

<sup>5</sup> World Health Organization, Commission on Social Determinants of Health. (2008.) *Closing the gap in a generation: Health equity through action on the social determinants of health*. <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>

## Exhibit 1. Assessment Framework



Following are definitions used for the four intervention areas included in the assessment:

- **Primary prevention:** practices to prevent the initiation of substance use or the onset of substance misuse;
- **Harm reduction:** practices for reducing negative consequences of substance use, including overdose and infectious diseases;
- **Treatment:** intervening through medication, counseling, and other supportive services; and
- **Recovery:** activities to support the process of change through which individuals improve their health and live self-directed lives.

Each of these intervention areas contains multiple evidence-based practices that can be leveraged on their own but are also part of a *continuum of services* that people who use drugs access simultaneously and sequentially.

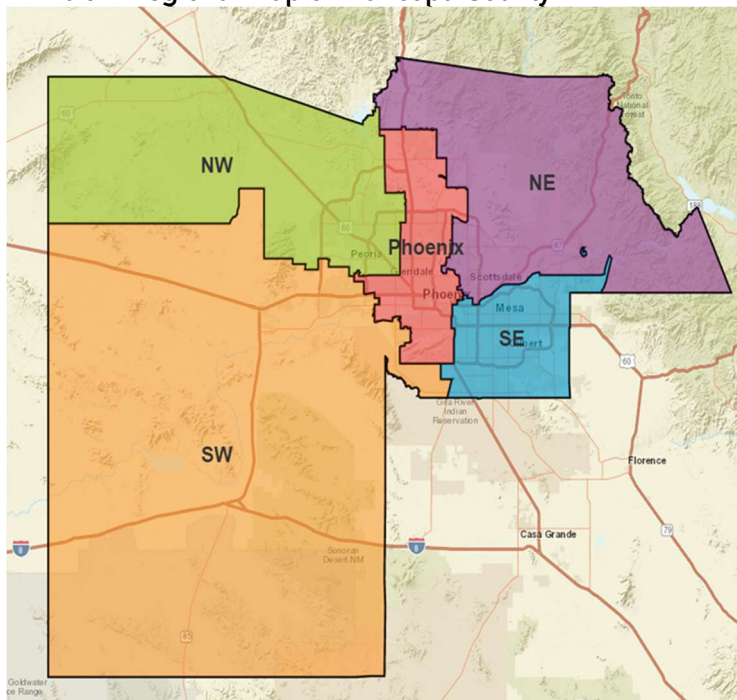
Cross-cutting factors that affect interventions for opioid and other substance use are:

- **Social determinants and health equity:** disparities in access to services, housing, and other structural resources needed for health are associated with racial, gender identity, sexual orientation, geographic, and other socio-economic inequalities; this also includes stigma;

- **Systems and policies:** organizational, governmental, and health care regulations;
- **Data and evidence:** information about OUD/SUD trends, resources, and intervention effectiveness; and
- **Provider partnerships and capacity:** workforce capacity for responding to OUD/SUD, and interorganizational capacity to coordinate care.

Maricopa County encompasses over 9,200 square miles, roughly the size of the state of Vermont, and is composed of a mix of urban, suburban, and rural areas. About 62% of Arizona’s population resides in Maricopa County. As a large county, regionality also was incorporated into the assessment to better understand provider needs and barriers in the communities they serve. Regional areas are shown in Exhibit 2.

**Exhibit 2. Regional Map of Maricopa County**



Northwest: Aguila, El Mirage, Glendale, Peoria, Surprise, Wickenburg, Youngtown

Northeast: Carefree, Cave Creek, Fountain Hills, Paradise Valley, Scottsdale

Central: Phoenix metro area

Southwest: Avondale, Buckeye, Gila Bend, Goodyear, Litchfield Park, Tolleson

Southeast: Apache Junction, Chandler, Gilbert, Guadalupe, Mesa, Tempe, Queen Creek

Throughout this report, findings and conclusions are organized within this framework, highlighting the intersections of cross-cutting factors and different OUD/SUD interventions.

# METHODOLOGY

MCDPH contracted LeCroy & Milligan Associates, Inc. (LMA) to conduct the needs assessment with a focus on the ecosystem of response strategies in the County, health equity, and regionality. Data collection took place from January through May 2023, and centered around provider organizations' experiences with people who use drugs, care coordination, and regulations affecting OUD/SUD services. A summary of the methodology is included here with additional details provided in Appendix B.

LMA reviewed existing data and best practices related to interventions and structural factors affecting OUD/SUD response and outcomes. To align with the current harms of synthetic opioids and polysubstance use, efforts were made to concentrate on literature published after 2017 when laws for prescription opioid monitoring were put into place.

A situational analysis, key informant interviews, online survey, and listening sessions gathered qualitative data from over 300 community-based agencies, healthcare organizations, and governmental departments that are part of the opioid/substance use response in the County.

Qualitative data focused on the intersection of OUD/SUD interventions and the cross-cutting factors of social determinants, policies, data, and provider capacity. Appendix C includes a list of all the organizations participating in qualitative data collection.

An online survey gathered structured and quantitative data from 493 individuals working in grassroots, coalitions, public, private, and non-profit organizations across the County. As shown in Exhibit 3, about 55% of respondents represented community-based agencies, and

## Assessment Methodology

**Trend and Funding Analysis:** Review of existing data and literature about OUD/SUD.

### Direct Data Collection:

- **Structured situational analysis** assessment and prioritization for OUD/SUD strategies by the Advisory Committee.
- **17 key informant interviews** conducted over Zoom lasting 30-60 minutes.
- **Electronic survey** completed by **493 provider** staff and volunteers in the County.
- **10 listening sessions** across the County's 5 regions. **1 listening session with prevention coalitions**; total of 131 providers representing 88 different organizations.

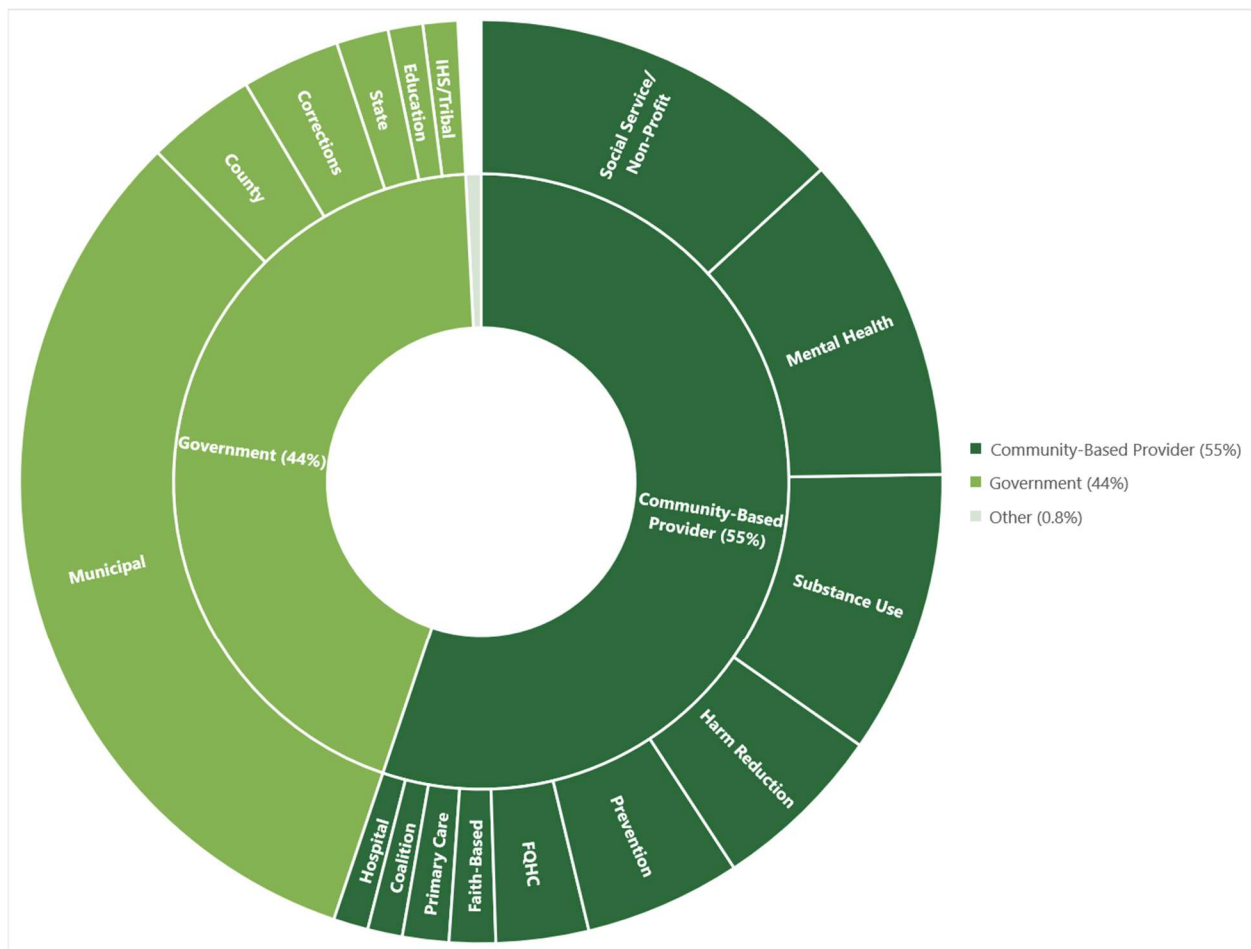
### Participants:

- **About 500 community-based and governmental staff** working in OUD/SUD prevention, treatment, harm reduction, and recovery.
- Participants represented **approximately 300 organizations** in the public, private, and non-profit sectors.



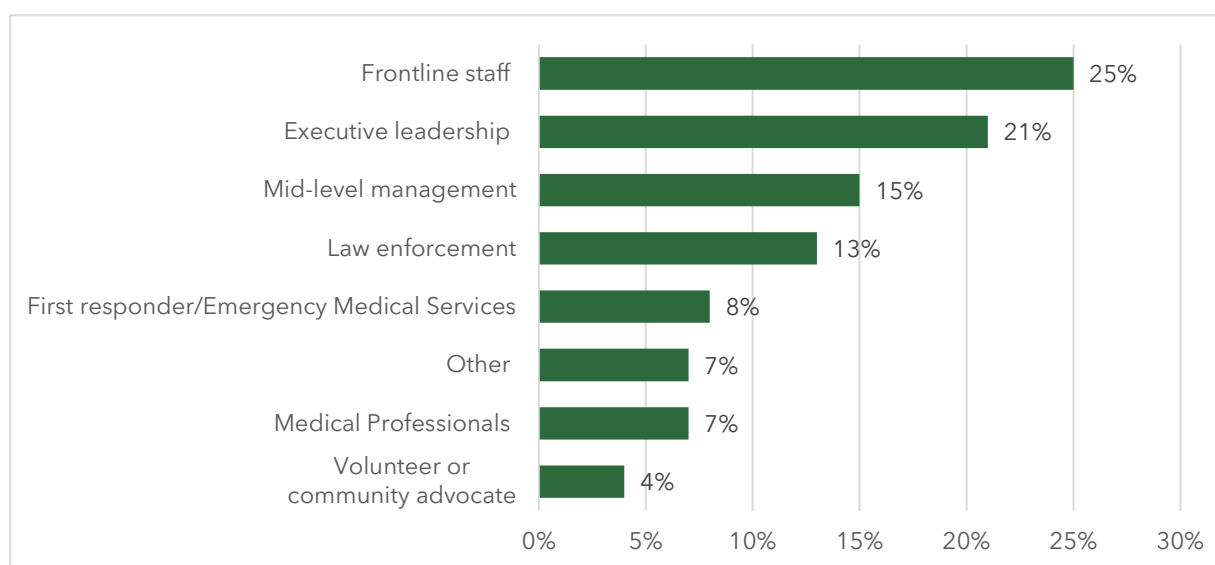
about 44% represented governmental agencies. Exhibit 4 shows the range of roles held by those participating in the online survey, including front-line staff, management staff, law enforcement, first responders, medical personnel, and volunteers.

**Exhibit 3. Organizational Representation among Survey Respondents**





#### Exhibit 4. Organizational Roles among Survey Respondents



Survey questions focused on key barriers, concerns, important settings, and strategies important to fund for that intervention. Several survey questions allowed respondents to choose more than one response. Aggregate findings, rather than findings for any individual organizations, are included in this report.

### Limitations

Limitations of this needs assessment methodology include a short window for data collection and, while there was strong engagement from across the county, those who participated still represent a limited cross-section of county providers. For example, across all data collection methods, few staff or providers from schools, faith-based organizations, agencies focused on Neonatal Abstinence Syndrome (NAS) babies and their families, or those providing specialty services to marginalized subpopulations participated. Regional listening sessions occurred within a four-week window, and some providers expressed wanting to attend but not being able to within the timeframe available. Less representation from these groups may have decreased recommendations specific to their respective populations and settings.

Participation in the survey and listening sessions was diverse, but included more representation from larger organizations with multiple staff. Grassroots and smaller organizations participated, but not in the same numbers. This assessment focused on the provider and organizational level of response. It did not directly seek out those with personal lived experience in OUD/SUD, though some participants disclosed their own substance use journeys. Thus, the data collected centers around provider perspectives, which may not fully align with the perspectives of people who use drugs, those who used OUD/SUD services or other sectors that interact with this population. In addition to this provider assessment, MCDPH concurrently contracted with LeCroy and Milligan Associates to conduct surveys and

individual interviews with People Who Use Drugs (PWUD) populations in Maricopa County to learn about this community's experiences/barriers in accessing services such as treatment, harm reduction supplies, and housing. Findings from this study (anticipated to be completed in late summer 2023) also will be used to inform County substance use strategic planning.

Secondary data included in the assessment was limited to the timeframes and data publicly available or collected by MCDPH. Funding landscape includes streams available, but does not likely reflect all funding in Arizona related to substance use.

Despite the limitations noted, this needs assessment provides the first comprehensive analysis about the response to opioids and other substance use in Maricopa County.

# SUBSTANCE USE AND ABATEMENT TRENDS

This section contains a summary of substance use trends, abatement efforts, and funding for responding to OUD/SUD at the national, state, and County levels.

## National and State Trends

Public health literature identifies three phases of the opioid crisis, with the first phase emerging in the 1990's from an increase in medically prescribed opioids for pain management, the second phase driven by heroin in the mid-2010s, which was followed by the third and current phase of fentanyl-involved overdoses<sup>6</sup>. The U.S.

Department of Health and Human Services recognized opioid misuse as a public health emergency in 2017, and opioid-involved deaths have risen each year since then. The estimated combined economic cost of opioid use disorder and fatal overdose is about \$22 billion in Arizona<sup>7</sup>.

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*In Arizona, over two-thirds of drug overdoses involve fentanyl, and opioid misuse has an economic cost of \$22 billion per year.*

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Statewide, opioids are involved in 74.1% of overdose deaths<sup>8</sup>, which is attributed to fentanyl's high potency and presence in other illicit drugs. National reports show that in Western states injection of drugs may be less prevalent than Eastern states. For example, in 2020, 57.1% of fentanyl-involved overdose deaths in Western states had evidence of snorting, smoking, or ingestion, while 11.7% involved injection<sup>9</sup>. Route of drug use has implications for harm reduction strategies and supplies.

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<sup>6</sup> Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid crisis: No easy fix to its social and economic determinants. *American Journal of Public Health*, 108(2), 182–186.

<https://doi.org/10.2105/AJPH.2017.304187>. Jalali, M.S., Botticelli, M., Hwang, R.C. et al. (2020). The opioid crisis: A contextual, social-ecological framework. *Health Research Policy and Systems* 18(87). <https://doi.org/10.1186/s12961-020-00596-8>.

<sup>7</sup> Luo, F., Li, M., & Florence, C. (2017). State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose - United States, 2017. *MMWR Morbidity and Mortality Weekly Rep* 70:541-546. <https://doi.org/10.15585/mmwr.mm7015a1>.

<sup>8</sup> CDC (2022). *State unintentional drug overdose reporting system: Fatal overdose data*. <http://www.cdc.gov/drugoverdose/fatal/dashboard/index.html>

<sup>9</sup> CDC. (2021). Trends in and characteristics of drug overdose deaths involving illicitly manufactured fentanyl – United States, 2019-2020. *MMWR: Morbidity and Mortality Weekly Report*. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7050e3.htm>

In November 2022, the U.S. Food and Drug Administration (FDA) issued an alert to health care professionals about increasing rates of xylazine contamination in fentanyl and other illicit drugs<sup>10</sup>. Xylazine is a non-opioid animal sedative that increases the risk of drug poisoning and can cause dangerous skin ulcers when injected. The U.S. Drug Enforcement Agency (DEA) reported that about 23% of fentanyl powder seized in 2022 contained xylazine<sup>11</sup>. While xylazine has been involved in few overdose deaths in Maricopa County to-date, this highlights the changing nature of illicit drug contamination and associated risks.

The Centers for Disease Control and Prevention (CDC) estimated that in 2021, nearly 81% of Arizona's drug overdose fatalities had at least one potential opportunity for intervention<sup>12</sup>. About two-thirds of overdose fatalities took place when someone else was present<sup>13</sup>. In addition, one-third of individuals overdosing had a mental health diagnosis, about 12% were recently released from an institutional setting, and nearly 11% had a prior overdose<sup>14</sup>. Almost one-in-five overdose deaths in the state involved someone experiencing homelessness or housing instability<sup>15</sup>. Rates of opioid overdoses rise with poor economic conditions<sup>16</sup>, which disproportionately affect marginalized populations<sup>17</sup>, and are higher in counties with lower levels of social capital<sup>18</sup>.

Recognizing the harms caused by opioid misuse, federal, state, and local jurisdictions have enacted policies to expand access to medication for opioid use disorder (MOUD), de-criminalize overdoses, and legalize harm reduction supplies such as naloxone, fentanyl test strips, and clean syringes. For example, from 2015-2018, Arizona Department of Health Services (ADHS) issued various standing orders for naloxone, allowing it to be obtained and used by emergency medical personnel, school personnel, pharmacists, and county health departments without a prescription<sup>19</sup> to reduce overdose deaths. In addition, in April 2018, a Good Samaritan law in

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<sup>10</sup> <https://www.fda.gov/drugs/drug-safety-and-availability/fda-alerts-health-care-professionals-risks-patients-exposed-xylazine-illicit-drugs>

<sup>11</sup> <https://www.dea.gov/alert/dea-reports-widespread-threat-fentanyl-mixed-xylazine>

<sup>12</sup> CDC (2022). *State unintentional drug overdose reporting system: Fatal overdose data*. <http://www.cdc.gov/drugoverdose/fatal/dashboard/index.html>

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> National Academies of Sciences Engineering and Medicine. (2017). *Pain management and the opioid epidemic: Balancing societal and individual benefits and risks of prescription opioid use*. Washington, DC: National Academies Press.

<sup>17</sup> Ghose, R., Forati, A. M., & Mantsch, J. R. (2022). Impact of the COVID-19 pandemic on opioid overdose deaths: A spatiotemporal analysis. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 99(2), 316–327. <https://doi.org/10.1007/s11524-022-00610-0>.

<sup>18</sup> Zoorob, M. J., & Salemi, J. L. (2017). Bowling alone, dying together: The role of social capital in mitigating the drug overdose epidemic in the United States. *Drug and alcohol dependence*, 173, 1–9. <https://doi.org/10.1016/j.drugalcdep.2016.12.011>.

<sup>19</sup> Legislative Analysis and Public Policy Association. (2023). *Naloxone Access: Summary of State Laws*. <https://legislativeanalysis.org/naloxone-summary-of-state-laws/>

Arizona was passed (ARS 13-3423), which de-criminalized providing medical assistance or intervention in a drug overdose.

As overdose deaths continued to rise during the first year of the COVID-19 pandemic<sup>20</sup>, in Arizona, state legislation was passed in May 2021 legalizing fentanyl test strips (SB 1486) and syringe services (SB 1250), which had previously been classified as drug paraphernalia and carried risk of arrest and criminal charges. Prior to this, these harm reduction supplies and services could not be legally provided, and the organizations and groups that did so were operating outside of official law. In March 2023, the FDA approved nasal naloxone (Narcan) for over-the-counter access and use without a prescription. This highlights a dramatic shift in harm reduction supplies and overdose prevention services that occurred over just the past few years at federal and state levels, in the interest of “reducing disease, increasing access to addiction treatment, improving public safety, and reducing costs.”<sup>21</sup>

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*The full suite of services provided by harm reduction organizations were only fully legalized in Arizona in mid-2021.*

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## Substance Use Response Strategies and Reducing Barriers

Medications for treating opioid addiction and withdrawal are available, as is overdose-reversing medication. Barriers to accessing substance use services also occur at individual, social, and structural levels. Individual barriers include self-stigma, fears of incarceration or loss of parental rights, and co-occurring mental health problems<sup>22</sup>. Social barriers include stigma, lack of family/peer support, and lack of role models successfully in recovery<sup>23</sup>. Structural obstacles to substance use services include provider accessibility and availability, lack of focus on marginalized communities, restrictive prescription practices,

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*A recent study found that the following three strategies may save the most lives over the next 10 years: reduce fentanyl overdose risk through harm reduction, increase naloxone distribution to people who use opioids, and provide recovery support to people in remission<sup>24</sup>.*

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<sup>20</sup> CDC National Center for Health Statistics. (2023). *National Vital Statistics System: Provisional Drug Overdose Death Counts*. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

<sup>21</sup> The White House Office of National Drug Control Policy. (2021). White House releases Model Law to help states ensure access to “safe, effective, and cost-saving syringe service programs.” <https://www.whitehouse.gov/ondcp/briefing-room/2021/12/08/white-house-releases-model-law-to-help-states-ensure-access-to-safe-effective-and-cost-saving-syringe-services-programs/>

<sup>22</sup> Farhoudian, A., Razaghi, E., Hooshyari, Z., Noroozi, A., Pilevari, A., Mokri, A., Mohammadi, M. R., & Malekinejad, M. (2022). Barriers and facilitators to substance use disorder treatment: An overview of systematic reviews. *Substance Abuse: Research and Treatment*, 16, 11782218221118462. <https://doi.org/10.1177/11782218221118462>.

<sup>23</sup> Ibid.

policies that favor enforcement over harm reduction, failure to address social determinants of health like transportation and childcare, and lack of linkages between care providers<sup>24</sup>. These barriers function synergistically; for example, restrictive provider policies can reinforce self- and social stigma about substance use.

Overall, using national overdose trend data, a recent modeling study found that the following three strategies would save the most lives over the next 10 years: reduce fentanyl overdose risk through harm reduction, increase naloxone distribution to people who use opioids, and provide recovery support to people in remission<sup>25</sup>. When MAT/MOUD providers can adequately meet the treatment demand, harm reduction and recovery activities feature strongly in preventing opioid-related deaths<sup>26</sup>.

## Maricopa County Trends

Countywide, the rate of fatal overdoses among residents increased by 35% from 2019-2021<sup>27</sup>. Mirroring national trends, 2021 was a historic high, with 1,963 fatal overdoses occurring in the county, a majority of which (59%) were among decedents under the age of 45<sup>28</sup>. Nearly half of all fatal overdoses in Maricopa County occurred in the central region each year from 2019-2021<sup>29</sup>. The southeast region accounted for the second-highest number of fatal overdoses during this time period, with an average of 23% of the county's fatal overdoses<sup>30</sup>.

In 2021, just under two-thirds (64%) of drug overdose deaths in Maricopa County involved fentanyl, and from 2019-2021 about 82% involved more than one drug<sup>31</sup>. The proportion of overdose deaths involving methamphetamines has also been rising, from 42% in 2019 to nearly 52% in 2021<sup>32</sup>. In that same time period, respective rates of fatal overdoses increased by 100% for American Indian/Alaska Native (AI/AN) populations and 53% for Black populations<sup>33</sup>.

MCDPH applies a standard case definition to identify trends in nonfatal overdoses using hospital discharge data. While this approach depends on the quality of hospital coding and

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<sup>24</sup> Ibid.

<sup>25</sup> Stringfellow, E. J., Lim, T. Y., Humphreys, K., DiGennaro, C., Stafford, C., Beaulieu, E., Homer, J., Wakeland, W., Bearnot, B., McHugh, R. K., Kelly, J., Glos, L., Eggers, S. L., Kazemi, R., & Jalali, M. S. (2022). Reducing opioid use disorder and overdose deaths in the United States: A dynamic modeling analysis. *Science Advances*, 8(25), eabm8147. <https://doi.org/10.1126/sciadv.abm8147>.

<sup>26</sup> Ibid.

<sup>27</sup> Maricopa County Department of Public Health (2022). Mental health and substance use data. <https://www.maricopa.gov/5079/Mental-Health-and-Substance-Use#fataloverdose>

<sup>28</sup> Ibid.

<sup>29</sup> Maricopa County Department of Public Health. (2023). Epidemiology data.

<sup>30</sup> Ibid.

<sup>31</sup> Maricopa County Department of Public Health (2022). Mental health and substance use data. <https://www.maricopa.gov/5079/Mental-Health-and-Substance-Use#fataloverdose>

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

only accounts for overdoses where an individual was transported to an emergency department or hospital, there were 12,167 hospital visits for nonfatal drug overdoses in Maricopa County in 2021, translating to a rate of 278.6 nonfatal overdose hospital visits per 100,000 residents<sup>34</sup>. Similar to patterns with fatal overdoses, most nonfatal overdoses (72.6%) were among those under the age of 45<sup>35</sup>.

Density maps can be used to understand areas of high concentration of fatal overdoses, regardless of geographic boundaries such as zip codes and cities. Understanding where there are high density areas can help direct outreach and limited resources. As shown in Exhibit 5, a comparison of density maps for overdose deaths in 2019 vs. 2021 reveals an expansion of highly concentrated areas<sup>36</sup>. A few trends from 2021 that are worth noting include:

- Higher concentration across central and northern Phoenix, especially downtown and northbound along I-17.
- Higher concentration of fatal overdoses to the west of I-17, north of I-10, particularly along Grand Ave.
- Higher concentration of fatal overdoses in Tempe, specifically from University to Baseline, west of McClintock.

Social vulnerability factors — such as socioeconomic status, racial minority status, households with vulnerable populations, and housing and transportation access<sup>37</sup> — are shown in Exhibit 6, and largely correspond to overdose death densities. CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) created a Social Vulnerability Index (SVI) that uses 16 variables from the U.S. census to calculate the potential negative effects of human health stressors on communities<sup>38</sup>. Higher social vulnerability is correlated with greater human suffering and economic loss during disasters or disease<sup>39</sup>.

A 2022 spatial analysis in Milwaukee County, Wisconsin found that opioid-involved overdose deaths were higher in census tracts with concentrated vulnerabilities of poverty and health inequalities, with limited access to health care and other resources to address substance use<sup>40</sup>. Since overdose deaths are often correlated with social vulnerability factors, this CDC data can be used to inform and geographically focus abatement efforts.

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<sup>34</sup> Maricopa County Department of Public Health. (2023). Epidemiology data.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

<sup>37</sup> CDC. (2020). SVI (Social Vulnerability Index) Documentation.

[https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI\\_documentation\\_2020.html](https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2020.html)

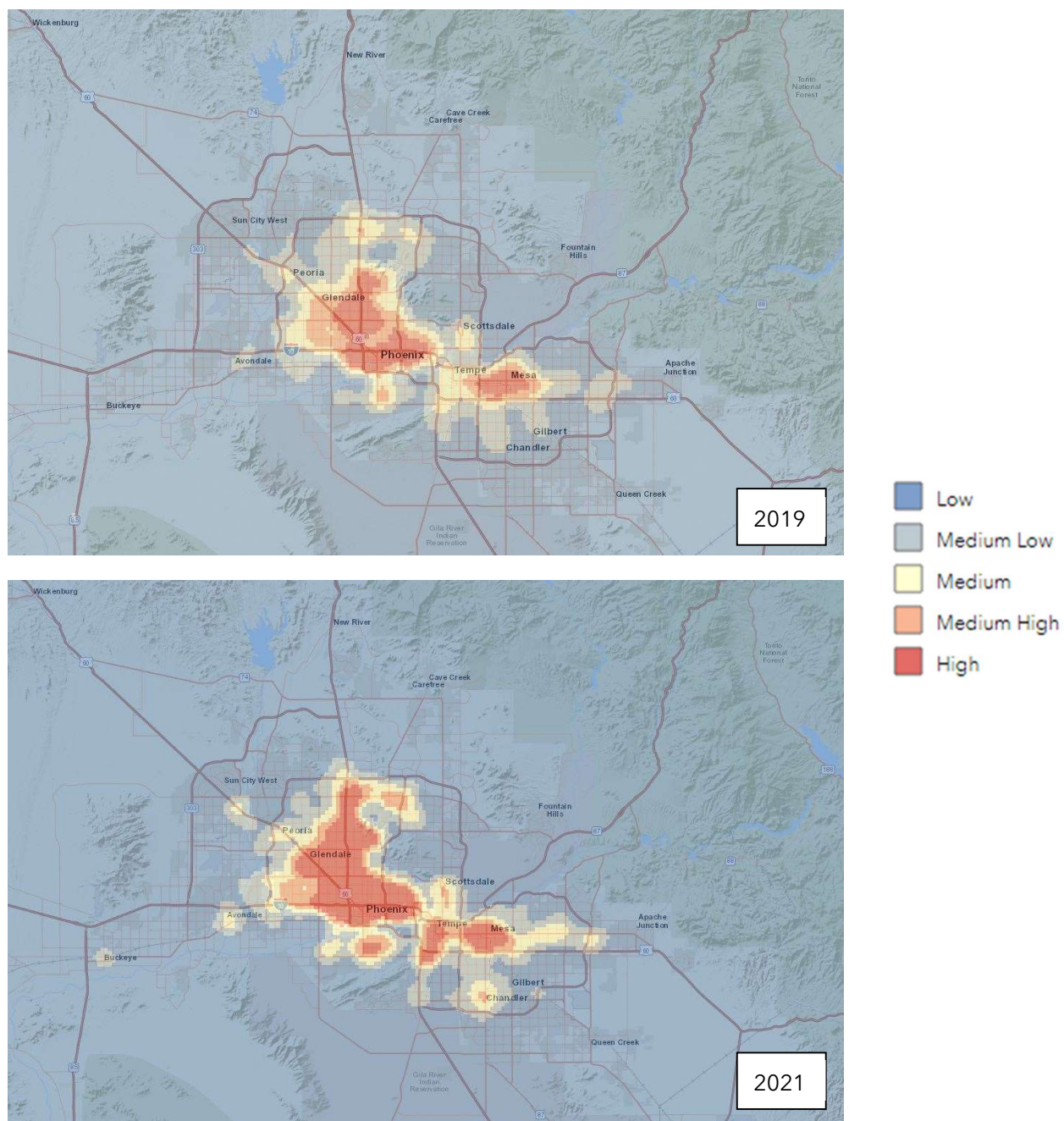
<sup>38</sup> ATSDR. (2023). Place and Health. <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>

<sup>39</sup> Ibid.

<sup>40</sup> Ghose, R., Forati, A. M., & Mantsch, J. R. (2022). Impact of the COVID-19 pandemic on opioid overdose deaths: a Spatiotemporal analysis. *Journal of Urban Health : Bulletin of the New York Academy of Medicine*, 99(2), 316–327. <https://doi.org/10.1007/s11524-022-00610-0>

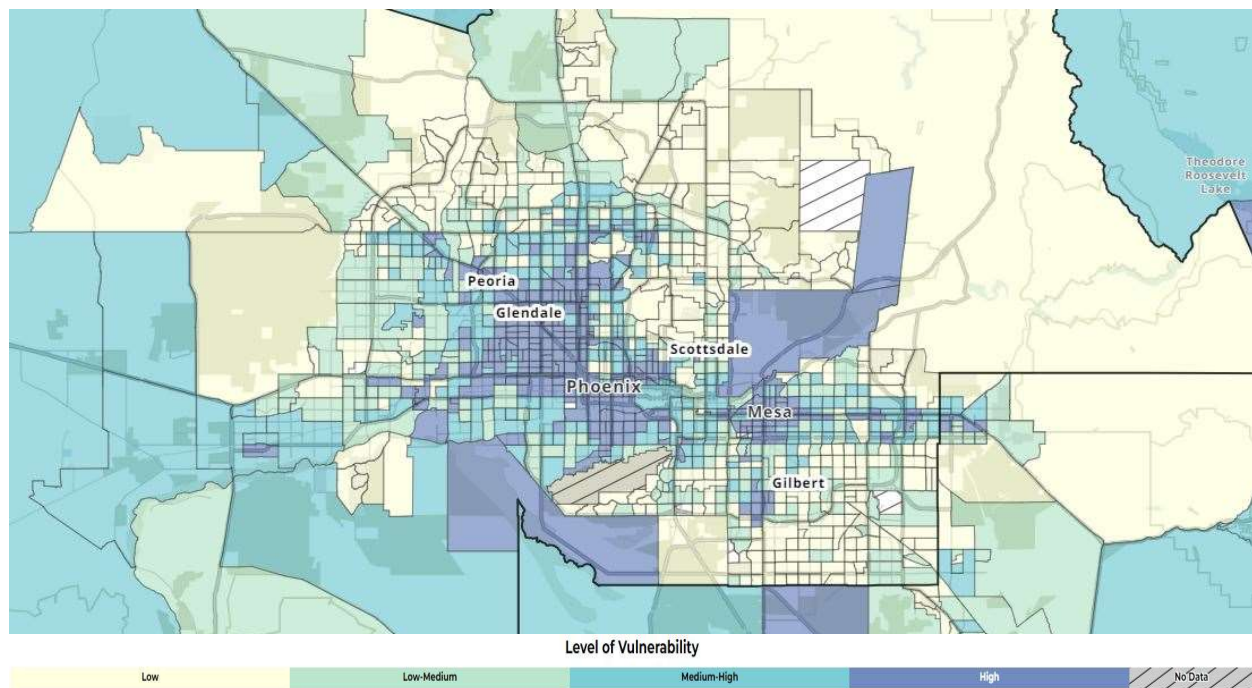


**Exhibit 5. Density Maps of Fatal Drug Overdoses in Maricopa County, 2019 and 2021**





**Exhibit 6. 2020 Social Vulnerability Index Scores in Maricopa County Census Tracts<sup>41</sup>**



In 2021-2022, the County conducted telephone interviews with nearly 200 people taken to a hospital after a non-fatal overdose. Among those with documentation of naloxone revival prior to being transported to the hospital (N=103), the majority were administered it by first responders. About half of all respondents reported that they did *not* have access to naloxone<sup>42</sup>. Among those that did have naloxone, the majority (70.4%) received it from a doctor, community organization, or hospital. For about half of all respondents (50.3%), it was *not* their first overdose<sup>43</sup>. About one-third of those interviewed who experienced an overdose indicated they were currently receiving treatment or had a treatment appointment scheduled, and one-tenth said they had used MAT/MOUD within the past 3 months<sup>44</sup>. This data underscores the non-linearity of people's substance use journeys, and the importance of concurrent harm reduction and treatment strategies.

In 2021, Maricopa County conducted a countywide Community Health Survey, where 29% of over 14,000 respondents reported that alcohol/substance use had the greatest impact on their

<sup>41</sup> CDC/ATSDR Social Vulnerability Index. (2020).

[https://www.atsdr.cdc.gov/placeandhealth/svi/interactive\\_map.html](https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html)

<sup>42</sup> Maricopa County Department of Public Health. (2022.) *Findings from nonfatal opioid overdose case investigations*. <https://www.maricopa.gov/DocumentCenter/View/79333/MCDPH-Nonfatal-Overdose-Report?bidId=>

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

community<sup>45</sup>. Alcohol/substance use ranked in the top three health concerns in every county region except for the Northwest<sup>46</sup>.

## Populations Disproportionately Affected by OUD/SUD

Substance use prevalence has increased statewide with some populations experiencing disproportionate rates of use and negative impacts.

**Race/Ethnicity.** In Arizona, American Indian/Alaskan Native (AI/AN) persons had the highest rate of nonfatal opioid overdose in 2019-2021 while persons who are Black or African American had the highest rate of opioid deaths<sup>47</sup>. In Maricopa County, from 2019 to 2021, the rate of AI/ANs who died due to drug overdose doubled while the rate of Black individuals who died from overdose increased from a rate of 42.2 to 64.6 per 100,000 people<sup>48</sup>. Strengthening surveillance and data collection may provide more insight into disparities experienced by people of color in Maricopa County.

### Homelessness and Incarceration.

Substance use, homelessness, and incarceration are intricately related. The 2022 Enhanced Drug and Gang Enforcement (EDGE) report, produced by the Arizona Criminal Justice Commission (ACJC), reports on

statewide prosecutions and convictions related to drug and gang activity<sup>49</sup>. In 2022, the Maricopa

### Disproportionate Impacts

#### Race/Ethnicity:

- In Arizona, AI/ANs had the highest rate of nonfatal opioid overdose in 2019-2021.
- Black/African American Arizonans had the highest rate of opioid deaths in 2019-2021.

#### Homelessness and Incarceration:

- In a Maricopa County sample of nonfatal overdoses, 21% had been incarcerated within 6 months prior to the overdose event and 15.6% were experiencing homelessness or unstable housing.

#### SUD and Other Infectious Diseases:

- Women with a congenital syphilis pregnancy were 6 times more likely to report illicit opioid use.

<sup>45</sup> Maricopa County Department of Public Health. (2021). *Regional, City, Zone Profiles*.

<https://www.maricopa.gov/5614/Regional-Profiles>

<sup>46</sup> Ibid.

<sup>47</sup> Reamer, M., Davidson, S., Tasnim, L., Gallaway, S. (2022). *ADHS Update on Opioid Monitoring, Surveillance, and Data for Action*. Tribal Opioid and Substance Use Conference.

<sup>48</sup> Maricopa County Department of Public Health. (2023). *Mental Health and Substance Use Data*.

<https://www.maricopa.gov/5079/Mental-Health-and-Substance-Use#nonfatal>

<sup>49</sup> Arizona Criminal Justice Commission. (2023.) Arizona Criminal Justice Commission EDGE Report 2022. [https://www.azcjc.gov/Portals/0/Documents/pubs/2022\\_EDGE\\_Report\\_FINAL.pdf](https://www.azcjc.gov/Portals/0/Documents/pubs/2022_EDGE_Report_FINAL.pdf)

County Attorney's Office (MCAO) recorded 11,547 drug-related prosecutions. Of those, 7,032 prosecutions resulted in a conviction. Out of the 11,547 drug-related prosecutions recorded in 2022, a total of 2,632 (23%) involved fentanyl. National data indicate that risk of fatal overdose is greatest in the two weeks following release from jail/prison<sup>50, 51</sup>. A 2018 North Carolina study of former North Carolina inmates concluded that formerly incarcerated people were 40 times more likely to die of an opioid overdose in the two weeks following their release than general residents<sup>52</sup>. This can be explained by tolerance loss during incarceration as well as limited access to harm reduction tools such as naloxone.

From September 2021 to August 2022, MCDPH conducted investigations of nonfatal opioid overdose cases reported by hospitals<sup>53</sup>. Among those who were successfully interviewed following their nonfatal overdose, 21% reported being incarcerated within 6 months prior to the overdose event and 15.6% were experiencing homelessness or unstable housing at the time of the interview<sup>54</sup>. The repeating patterns and connections between substance use, incarceration, and homelessness indicates a need for stronger intervention in multi-sector spaces, including local jails.

Finding: High and varied potency of illicit drugs necessitate a rapid, coordinated, and multi-pronged response.

**SUD and Other Infectious Diseases.** SUD, including OUD, often leads to engagement in other risky behaviors and development of comorbidities, including infectious diseases. Sex with multiple partners, which is common in the setting of SUD, can lead to sexually transmitted infections like syphilis, which can be passed vertically from a pregnant mother to a baby. For example, congenital syphilis in Maricopa County has increased 838% from 2016 to 2022 and a study of Arizona and Georgia women with a congenital syphilis pregnancy were 6 times more

<sup>50</sup> O'Connor, A. W., Sears, J. M., & Fulton-Kehoe, D. (2022). Overdose and substance-related mortality after release from prison in Washington State: 2014–2019. *Drug and alcohol dependence*, 241, 109655.

<https://doi.org/10.1016/j.drugalcdep.2022.109655>

<sup>51</sup> Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of internal medicine*, 159(9), 592-600. <https://doi.org/10.7326%2F0003-4819-159-9-201311050-00005>

<sup>52</sup> Shabbar I. Ranapurwala et al. "Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015", *American Journal of Public Health* 108, no. 9 (September 1, 2018): pp. 1207-1213.

<https://doi.org/10.2105/AJPH.2018.304514>

<sup>53</sup> Maricopa County Department of Public Health. (2022). *Findings from nonfatal opioid overdose case investigations*. <https://www.maricopa.gov/DocumentCenter/View/79333/MCDPH-Nonfatal-Overdose-Report?bidId=>

<sup>54</sup> Ibid.

likely to report illicit opioid use<sup>55,56,57</sup>. Additionally, in 2017 Maricopa County reported 349 cases of Neonatal Abstinence Syndrome (NAS) with a rate of 6.8 per 1,000 newborn hospitalizations; this increased to 554 NAS cases in 2021, at a rate of 11.5 per 1,000 newborn hospitalizations<sup>58</sup>. Of the populations impacted, in Arizona, NAS cases are highest among AI/ ANs at a rate of 11.8 per 1,000 newborn hospitalizations and White non-Hispanics at a rate of 10.9 compared to Arizona's average rate of 8.9<sup>59</sup>. Gaps in available data on the possible disparities faced by birthing individuals and other communities including the LGBTQ+ community continue to hinder analysis and development of appropriate interventions.

## County Response Efforts

To address harms from opioids and other substances, Maricopa County has engaged in epidemiological surveillance, assessments of those affected, jurisdictional partnerships, and contracts with community-based providers for services. Since 2019, with CDC Overdose Data to Action funding, Maricopa County has collaborated with state and local organizations to provide overdose tracking data, develop provider resources and educational webinars, and enhance linkages to care for justice-involved populations<sup>60</sup>. The County also established the SHIFT (Safe, Healthy Infants and Families Thrive) Coalition to connect pregnant and postpartum women providers to providers specializing in substance use and pregnancy<sup>61</sup>.

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<sup>55</sup> Maricopa County Department of Public Health. (2022). *Congenital Syphilis Case Count*. Patient Reporting Investigation Surveillance Manager.

<sup>56</sup> Carlson J.M., Tannis, A., Woodworth, K.R., et al. (2023). *Substance Use Among Persons with Syphilis During Pregnancy – Arizona and Georgia, 2018–2021*. MMWR Morbidity and Mortality Weekly Rep 72:63–67. DOI: <http://dx.doi.org/10.15585/mmwr.mm7203a3>

<sup>57</sup> Arizona Department of Health Services. (2023.) *Sexually Transmitted Infection (STI) Control*. <https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/std-control/index.php#reports>

<sup>58</sup> Davidson S, Lalani K, Griffin A, and Gallaway MS. (2022.) *Neonatal Abstinence Syndrome Surveillance Report, 2017-2021*. Phoenix, AZ. Arizona Department of Health Services. <https://www.azdhs.gov/opioid/documents/nas/5year-nas-report.pdf>

<sup>59</sup> Ibid.

<sup>60</sup> Maricopa County Department of Public Health. (2023). OD2A Initiatives. <https://www.maricopa.gov/5833/Substance-Use#OD2A>

<sup>61</sup> Maricopa SHIFT. (2023). <https://maricopashift.com/>

## Funding Landscape

Public behavioral health interventions in Arizona rely on three main funding sources: federal Medicaid funds, the State General Fund, and other federal grants<sup>62</sup>. Arizona Health Care Cost Containment System (AHCCCS) is the state Medicaid agency that contracts services through Arizona Complete Care Plans, as well as Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (TRBHA) to enroll eligible members

in care. Members in Maricopa County can typically select from one of seven health plans that serve that region, though some provide services for specific populations/needs (e.g., individuals with Serious Mental Illness). This system has gone through numerous changes over-time adding to the complexity of the health care coverage and funding landscape<sup>63</sup>. The Bipartisan Policy Center found that Medicaid expansion was “essential to providing services to individuals with opioid use disorder”<sup>64</sup>.

The majority of federal grant funding for responding to substance use is administered through the Health and Human Services’ (HHS) Substance Abuse and Mental Health Administration (SAMHSA); much of this is non-discretionary funding issued to jurisdictions based on population calculations, while a smaller portion is discretionary funds for which jurisdictions submit competitive proposals.

AHCCCS is the primary state agency that administers federal non-discretionary funds, along with the Arizona Department of Health Services (ADHS) and the Governor’s Office of Youth, Faith, and Family (GOYFF). In fiscal year 2021, AHCCCS’ total funding for behavioral health was \$2.6 billion<sup>65</sup>. That same year, SAMHSA funded a total of \$275.3 million in Arizona, with a little over half (\$159.8 million) designated specifically for substance abuse, and 76.5% of this was funded through AHCCCS<sup>66</sup>. With non-discretionary funding, AHCCCS issues competitive grants for other organizations and government agencies. The largest of these grants are the

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*About 72% of funding for public behavioral health services in Arizona is from federal Medicaid dollars. Annual substance use grant totals range from \$80-180 million, and comprise a minority of behavioral health funds in the state.*

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<sup>62</sup> Joint Legislative Budget Committee (2021). Behavioral health funding overview.

<https://www.azjlb.gov/units/behavioralhealthfunding.pdf>

<sup>63</sup> AHCCCS Complete Care: The Future of Integrated Healthcare.

<https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/>

<sup>64</sup> Bipartisan Policy Center. (2019.) *Tracking federal funding to combat the opioid crisis.*

<https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

<sup>65</sup> Joint Legislative Budget Committee (2021). Behavioral health funding overview.

<https://www.azjlb.gov/units/behavioralhealthfunding.pdf>

<sup>66</sup> SAMHSA. (2023). Arizona summaries FY2022. <https://www.samhsa.gov/grants-awards-by-state/AZ/2022>



State Opioid Response III grant (SOR III) and Substance Abuse Prevention and Treatment Block Grant (SABG). SOR III funding specifically focuses on continuum of care services for OUD and extends services to underinsured and uninsured Arizona residents regardless of Medicaid eligibility, with a focus on populations that have identified unmet needs, including individuals in rural and isolated areas; veterans, military service members and military families; pregnant women and parents with opioid use disorder; individuals experiencing homelessness; tribal populations; individuals who have experienced trauma, toxic stress or adverse childhood experiences; and individuals re-entering the community from correctional settings<sup>67</sup>. SABG funds primary prevention services and treatment services for individuals without health insurance or other resources who seek specialty treatment and prevention services for SUD, with a specific focus on certain populations (pregnant, injection drug users, women with dependents; and others as funding is available)<sup>68</sup>.

Tens of millions of federal COVID-related relief funds for mental health and substance use disorders were also administered through AHCCCS, and these funding sources end in 2024-2025<sup>69</sup>. These additional funds specifically addressed service gaps for underserved and marginalized populations, including people of color, LGBTQ+ individuals, rural populations, justice-involved, people experiencing homelessness, and others at risk for secondary diseases from substance use<sup>70</sup>.

Smaller federal grants addressing substance use and related harms are also available through the CDC and Department of Justice (DOJ).

Primary grant sources for explicitly addressing substance use are shown below in Exhibit 7.

**Exhibit 7. Primary Federal Grant Sources for Substance Use in Arizona**

Funder	Local Administrator	Grant	Amount/Funding Timeframe	Focus of Funds
SAMHSA	AHCCCS	State Opioid Response Grant III (SOR III)	\$63,212,924 2023-2024	Continuum of care for OUD, with requirement to make medication available
SAMHSA	AHCCCS	Substance Abuse Prevention and	\$43,466,912 2022	SUD prevention, treatment, and recovery for people with low resources

<sup>67</sup> AHCCCS. (2023). State Opioid Response III.

<https://azahcccs.gov/Resources/Grants/SORIII/SORIII.html>

<sup>68</sup> AHCCCS. (2023). Substance Abuse Prevention and Treatment Block Grant.

<https://wwwazahcccs.gov/Resources/Grants/SABG/>

<sup>69</sup> AHCCCS. (2023). Current Grants. <https://wwwazahcccs.gov/Resources/Grants/>

<sup>70</sup> Ibid.

Funder	Local Administrator	Grant	Amount/Funding Timeframe	Focus of Funds
		Treatment Block Grant (SABG)		
CDC	ADHS for State MCDPH for County	Overdose to Action (OD2A)	<b>\$5,100,478</b> for State <b>\$2,247,897</b> for Maricopa County 2021-2023	Collect comprehensive and timely data on nonfatal and fatal overdoses
DOJ- OJJDP	AZ Criminal Justice Commission	Mentoring for Youth Affected by the Opioid Crisis and Drug Addiction	<b>\$1,217,477</b> 2021	Mentoring services to youth affected by drugs
CDC	---	White House Office of National Drug Control Policy "Drug-Free Communities" Grants	Up to <b>\$125,000/year</b> for 5 years Multiple coalitions in 2022	For community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use

An FY2018 funding analysis found that allocation of Arizona's substance use funds roughly aligned with population concentrations; Maricopa County comprised 61% of the state population and received 60% of the funding<sup>71</sup>.

## Funding Landscape Changes

Harm reduction services and supplies have historically faced barriers to funding. In 2021, a federal determination lifted the ban on purchasing clean syringes for intravenous drug users with federal funds in Arizona, designating the state as high-risk for secondary infections due to injection drug use<sup>72</sup>. Also in 2021, Arizona laws shifted to de-criminalize harm reduction supplies such as fentanyl testing strips and legalize organizations offering syringe services. In 2022, SAMHSA released the first discretionary grant funding explicitly available for harm

<sup>71</sup> Bipartisan Policy Center. (2019.) *Tracking federal funding to combat the opioid crisis*. <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

<sup>72</sup> CDC. (2022). Determination of Need for Syringe Services Programs. [https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Frisk%2Fsps-jurisdictions.html](https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Frisk%2Fsps-jurisdictions.html)

reduction,<sup>73</sup> funding up to 25 governments or organizations at \$400,000 a year for 3 years<sup>74</sup>; no organizations in Arizona were awarded.

The 2023 cycle of CDC Overdose to Action (OD2A) grants focuses on interdisciplinary and multisectoral partnerships, and a comprehensive public health approach to reducing substance-related harms<sup>75</sup>. The direction of this funding underscores the importance of collaboration and coordination at multiple levels to address the rising rates of opioid-involved fatalities.

## Related Funding Streams

Substance use often intersects with issues of mental health, homelessness, incarceration, and heat-related mortality. Major grant sources for providing services and supports for affected populations in these areas are shown below in Exhibit 7.

**Exhibit 8. Primary Federal and State Grant Sources for Issues Related to Substance Use in Arizona**

Funder	Local Administrator	Grant	Amount/Funding Timeframe	Focus of Funds
SAMHSA	AHCCCS	Community Mental health Services Block Grant	\$24,207,604 2022-2024	Comprehensive mental health services for adults experiencing Serious Mental Illness (SMI), and children with serious emotional disturbances
SAMHSA	AZ Center for Disability Law	Protection and Advocacy for Individuals with Mental Illness	\$696,274 2022	Protection and advocacy system for individuals with mental illness
SAMHSA	AHCCCS	Projects for Assistance in Transition from Homelessness	\$1,349,810 2022	Services for people experiencing or at risk of experiencing homelessness

<sup>73</sup> SAMHSA. (2022). *Harm reduction*. <https://www.samhsa.gov/find-help/harm-reduction>

<sup>74</sup> SAMHSA. (2021). Harm reduction grant program. <https://www.samhsa.gov/grants/grant-announcements/sp-22-001>

<sup>75</sup> CDC. (2023). Apply for Overdose Data to Action (OD2A) Funding. <https://www.cdc.gov/drugoverdose/od2a/funding-announcements.html>.



Funder	Local Administrator	Grant	Amount/Funding Timeframe	Focus of Funds
SAMHSA	AHCCCS	Cooperative Agreements for States and Territories to Build Local 988 Capacity	\$1,000,000 2022	988/Lifeline Crisis center capacity, through hiring, training, and response structure
DOJ	AZ Criminal Justice Commission	Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program	\$6,000,000 2021	Assist governments to develop, implement, or expand comprehensive efforts to identify, treat, and support those impacted by illicit drugs
DOJ	AZ Criminal Justice Commission	Residential Substance Abuse Treatment for State Prisoners Program	\$1,161,006 2022	Enhance capabilities of governments to provide residential substance use disorder treatment to incarcerated or re-entering adult and juvenile populations
ADHS	ADHS	Proposition 207: Justice Reinvestment Program	Percentages of annual marijuana-related taxes: 35% to County Public Health Departments (proportional to population); 35% to ADHS for granting to non-profit organizations; 30% to ADHS to address important public health issues in the state	Providing or redistributing grants for public and behavioral health programs, restorative justice, jail diversion, workforce development, and addressing the underlying causes of crime in economically disadvantaged communities

## Opioid Settlement Funding

All of Arizona's 15 counties, along with 90 cities and towns, entered into a One Arizona Agreement to distribute funds across Arizona from national opioid settlements. Funds must be spent on nationally recognized strategies for opioid abatement, with 56% of the settlement monies allocated for local governments, and 44% to the State. While funds must be tracked separately, there is flexibility for local governments to braid settlement fund resources with other funding.

## Funding Gaps

While various types of OUD/SUD services are eligible for public funding, the different sources and terms of funding can contribute to fragmentation between organizations and along the continuum of care. With a more itemized approach, the funds may not consistently support a care continuum, incorporate harm reduction services, ensure access to services, stabilize organizational services, or support evaluation of OUD/SUD responses. These potential gaps are briefly outlined below.

### Continuum of Care

While a continuum of varying care levels is recognized as best practice in addiction science<sup>76</sup>, the grant funding fragmentation shown in Exhibits 6 and 7 create inconsistency in this practice. As a dominant funding source, Medicaid covered services support transition between care levels, but require a certain level of service availability and provider capacity to be successful<sup>77</sup>. Professional associations estimate a 10-40% award rate of grants applied for<sup>78</sup>, which can create competition between organizations and disrupt previously funded services.

### Harm Reduction

For the past three decades, prevention, treatment, and recovery interventions for substance use have had explicit, designated public funding streams<sup>79</sup>, though the actual dollars apportioned to each one through Medicaid and various grants is difficult to discern. While the primary prevention, treatment, and recovery fields aim to prevent or stop drug use, the harm reduction

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<sup>76</sup> American Society of Addiction Medicine. (2023.) *About the ASAM criteria*.

<https://www.asam.org/asam-criteria/about-the-asam-criteria>

<sup>77</sup> Storholm, E. D., Ober, A. J., Hunter, S. B., Becker, K. M., Iyiewuare, P. O., Pham, C., & Watkins, K. E. (2017). Barriers to integrating the continuum of care for opioid and alcohol use disorders in primary care: A qualitative longitudinal study. *Journal of substance abuse treatment*, 83, 45–54.

<https://doi.org/10.1016/j.jsat.2017.09.015>

<sup>78</sup> Society for Nonprofits. (2023). Pros and Cons: Grants. <https://www.snpo.org/funding/grants.php>

Grant News by GrantWatch. (2022). How to Increase Your Chances of Being Awarded a Grant.

<https://www.grantwatch.com/grantnews/how-to-increase-your-chances-of-being-awarded-a-grant/>

<sup>79</sup> SAMHSA. (2023). *Substance Abuse Prevention and Treatment Block Grant*.

<https://www.samhsa.gov/grants/block-grants/sabg>

field acknowledges people's use of illicit drugs and aims to support their safety. This philosophical difference has historically inhibited public dollars for harm reduction strategies, though increasingly, naloxone and clean syringe access<sup>80</sup> are recognized as part of a continuum of care for people with substance use disorders. The historical siloing of harm reduction from treatment and recovery services created a practical gap in the spectrum of OUD/SUD care. For example, one study of east coast states showed that among MOUD-only programs, 80% of clients actively used drugs, and among harm reduction only programs, 40% of clients wanted treatment services<sup>81</sup>. There appears to be significant overlap between the types of supports that may benefit individuals using substances, but the system does not align in this way.

### ***Social Barriers to Accessing Services***

National surveys regularly show that only about 10% of people aged 12 or older with a substance use disorder receive any form of treatment<sup>82</sup>. About 95% of those not receiving treatment felt that they did not need it<sup>83</sup>. This highlights a gap in service access and utilization, even when funded services are available. Addressing the “ecosystem” in which people navigate SUD – such as public education about substance use, self-stigma, and social stigma – happens at jurisdictional levels and requires local/state funds. Of the 9 core abatement strategies in the national opioid settlement agreement, 8 are focused on specific services and 1 is about data collection<sup>84</sup>. Itemized approaches to funding support evidence-based practices, but may not focus on the environment which can enable or hinder access to those practices.

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*Only about 10% of people with a substance use disorder receive any treatment for it.*

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<sup>80</sup> CDC. (2022). Determination of Need for Syringe Services Programs.

[https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Ffrisk%2Fspps-jurisdictions.html](https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Ffrisk%2Fspps-jurisdictions.html)

<sup>81</sup> Krawczyk, N., Allen, S. T., Schneider, K. E., Solomon, K., Shah, H., Morris, M., Harris, S. J., Sherman, S. G., & Saloner, B. (2022). Intersecting substance use treatment and harm reduction services: Exploring the characteristics and service needs of a community-based sample of people who use drugs. *Harm Reduction Journal*, 19(1), 95. <https://doi.org/10.1186/s12954-022-00676-8>

<sup>82</sup> SAMHSA. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. HHS Publication No. PEP20-07-01-001, NSDUH Series H-55. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/>

<sup>83</sup> Ibid.

<sup>84</sup> Johns Hopkins University. (2022.) *Primer on spending funds from the opioid litigation: A guide for state and local decision makers*. <https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/04/Primer-on-Spending-Funds.pdf>

## Reliable Funding

Competitive grant funding for short periods contains “hidden costs” of seeking it, administering it, and reporting on it<sup>85</sup>. The content and scope of organizations’ SUD services can wax and wane with grant funding, which creates concerns for sustainability and consistency of the response<sup>86</sup>. Health insurance is a more reliable funding stream, though not accessible to everyone: the 2021 Behavioral Risk Factor Surveillance System (BRFSS) data in Arizona showed that nearly 10% of adults did not have health care coverage, and about 22% did not have a doctor<sup>87</sup>. A national 2021 study of mental health ranked Arizona 46<sup>th</sup> in the nation for access to care, which includes insurance adequacy and workforce availability<sup>88</sup>. Thus, both provider organizations and patients seeking health care face payment challenges.

## Data and Evaluation Infrastructure

Required and optional measures of success vary across funding sources, which hinders jurisdiction-level efforts to determine if funded efforts are working to effectively reduce overdoses, facilitate access to appropriate services, and reduce preventable infections associated with intravenous use<sup>89</sup>. Few funding sources fully pay for data and evaluation infrastructure at the organizational level, which limits measures of outcomes and effectiveness to those measured under single funding streams.

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<sup>85</sup> Center for Substance Abuse Treatment. (2000). *Integrating substance abuse treatment and vocational services, Treatment Improvement Protocol (TIP) Series, No. 38, Chapter 6: Funding and policy issues*. Rockville, MD. <https://www.ncbi.nlm.nih.gov/books/NBK64279/>

<sup>86</sup> Bipartisan Policy Center. (2019.) *Tracking federal funding to combat the opioid crisis*. <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

<sup>87</sup> CDC. (2021). *BRFSS Prevalence & Trends Data*. <https://www.cdc.gov/brfss/brfssprevalence/>

<sup>88</sup> Reinert, M, Fritze, D. & Nguyen, T. (2021). *The state of mental health in America 2022*. Mental Health America, Alexandria VA. <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>

<sup>89</sup> Bipartisan Policy Center. (2019.) *Tracking federal funding to combat the opioid crisis*. <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

# FINDINGS

The primary categories of OUD/SUD interventions to reduce substance-related harms are prevention, harm reduction, treatment, and recovery – each of which contains a constellation of evidence-based or evidence-informed practices for different populations, various outcomes, and with various provider licensure requirements. In this section, qualitative and quantitative data findings from across the interviews, electronic survey, and listening sessions that were conducted are arranged by OUD/SUD intervention. Findings are organized by cross-cutting themes. Background literature is used to contextualize and ground the findings.

## Overarching Themes

Knowledge of and support for evidence-based practices was common across all types of provider participants. Organizational capacity, limited time for collaboration and professional development, and funding constraints were cited as the main limitations in implementing certain evidence-based practices – such as specialty services for subpopulations and connections to other levels of care. Structural factors outside of providers’ control – particularly housing, transportation, and insurance coverage – were also noted as barriers to care. Providers in all intervention areas also noted that the nature of the opioid epidemic has changed over time, and more consistent training for providers, first responders, and government officials would be useful to “level-set” how the issue is approached.

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*“Housing should really be integrated into all strategies and measures of effectiveness.”*

*- Key informant interview*

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Maricopa County surveillance data shows clear disparities in overdoses by race, ethnicity, and geography, and other county assessments have identified people of color, people with low income, and LGBTQ+ people as marginalized subpopulations disproportionately affected by substance use. While providers were asked specifically about these groups, and agreed services specifically geared toward marginalized groups are necessary, they frequently referenced the other systems which also see disproportionate representation of marginalized groups: incarceration, child abuse/neglect, and homelessness. Thus, providers’ experience of marginalized subpopulations was also in relation to other law enforcement and economic systems.

A summary of the key factors providers indicated affect Maricopa County’s OUD/SUD response system and population health outcomes are summarized in Exhibit 9: this is a systems-level view of the dominant dynamics providers indicated affect their work. Common barriers within the continuum of care noted by providers are visualized at the individual level in Exhibit 10.

Exhibit 9. Key Factors in a Population Health Approach to OUD/SUD in Maricopa County

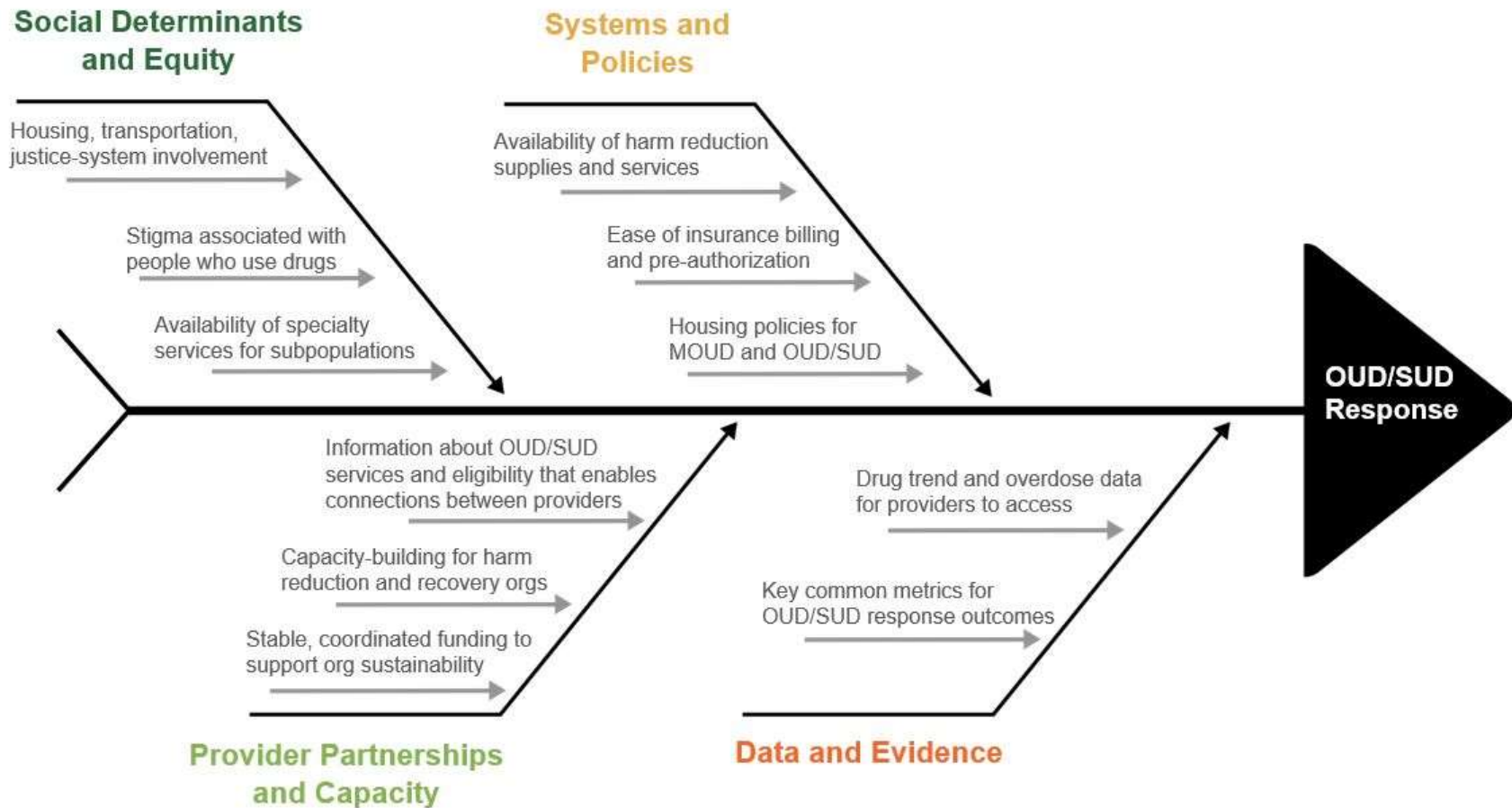
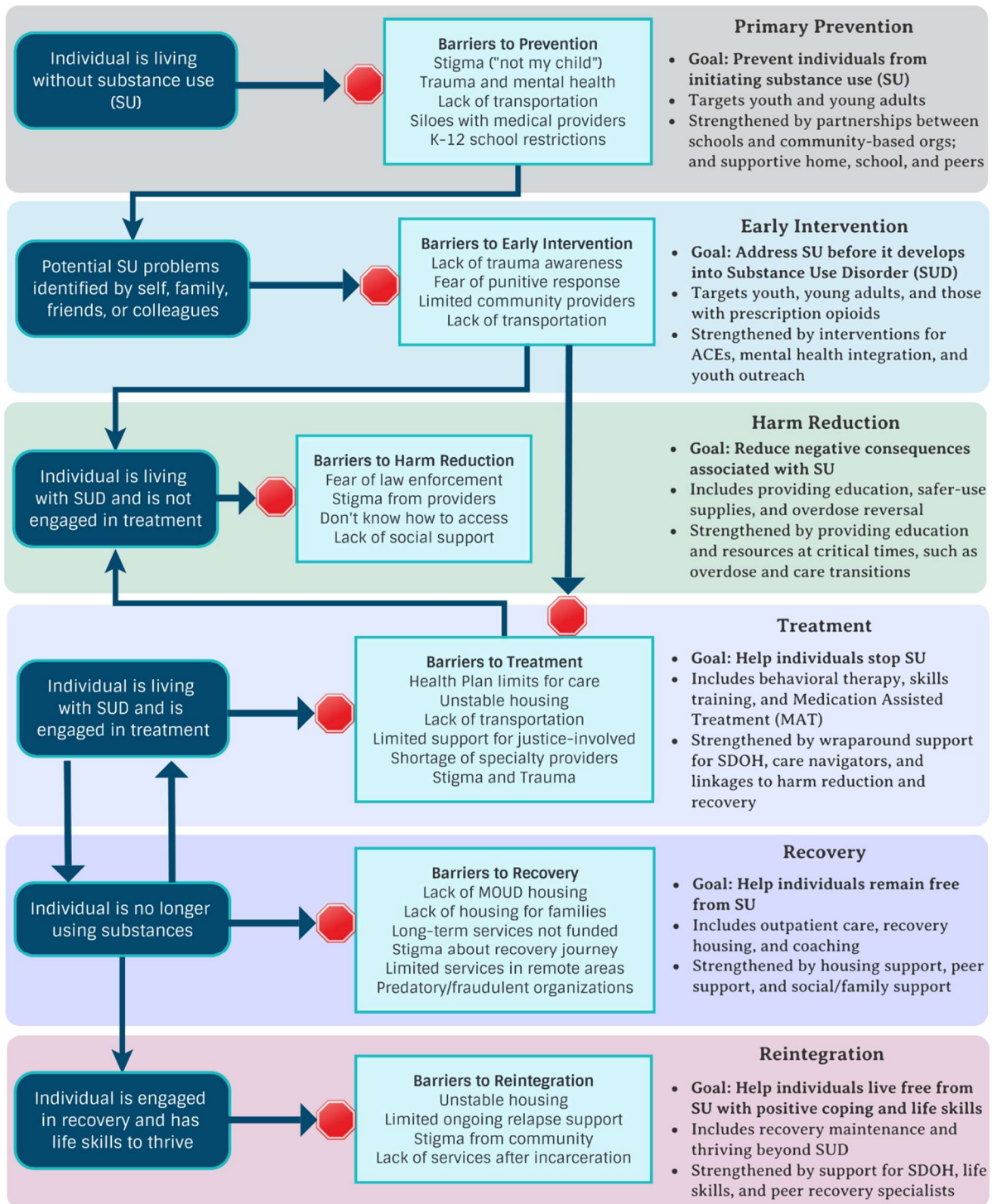




Exhibit 10. Flowchart of Barriers Individuals Face Within the OUD/SUD Response System

## Barriers in Maricopa County Care Continuum for Opioid and other Substance Use



# Prevention Findings

## Overview

Primary prevention seeks to prevent disease from ever occurring and is targeted at healthy individuals. Primary prevention strategies leverage two approaches for health promotion and disease prevention, strengthening protective factors and minimizing risk factors. Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact<sup>90</sup>. Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes<sup>91</sup>. Protective and risk factors exist at the individual, family, and community levels and are tightly associated with social determinants of health. Primary prevention for OUD/SUD typically exists in the form of specific educational and positive youth development programs developed for youth, their families, and the community.

Secondary prevention, or early intervention, engages people with early signs of substance use for the purpose of preventing dependency and other negative consequences. Tertiary prevention aims to reduce the impact of drug use, and intersects with harm reduction strategies like naloxone training and hygienic supplies for drug use.

## Prevention Themes

Key themes about primary and secondary prevention from the assessment are shown in Exhibit 11.

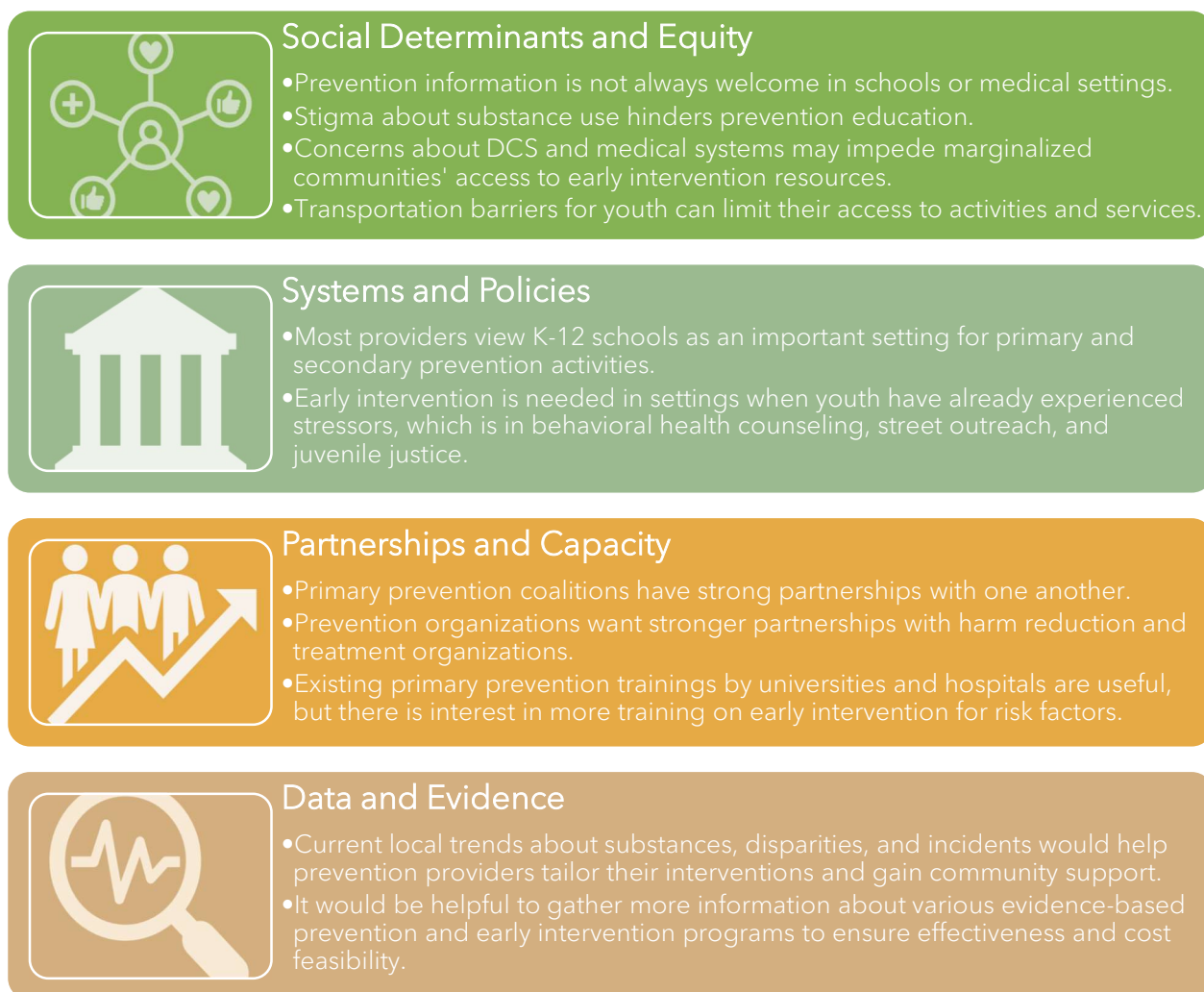
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<sup>90</sup> SAMHSA. (2019). *Risk and Protective Factors*. <https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf>

<sup>91</sup> Ibid.



## Exhibit 11. Summary of Themes that Affect Prevention Services

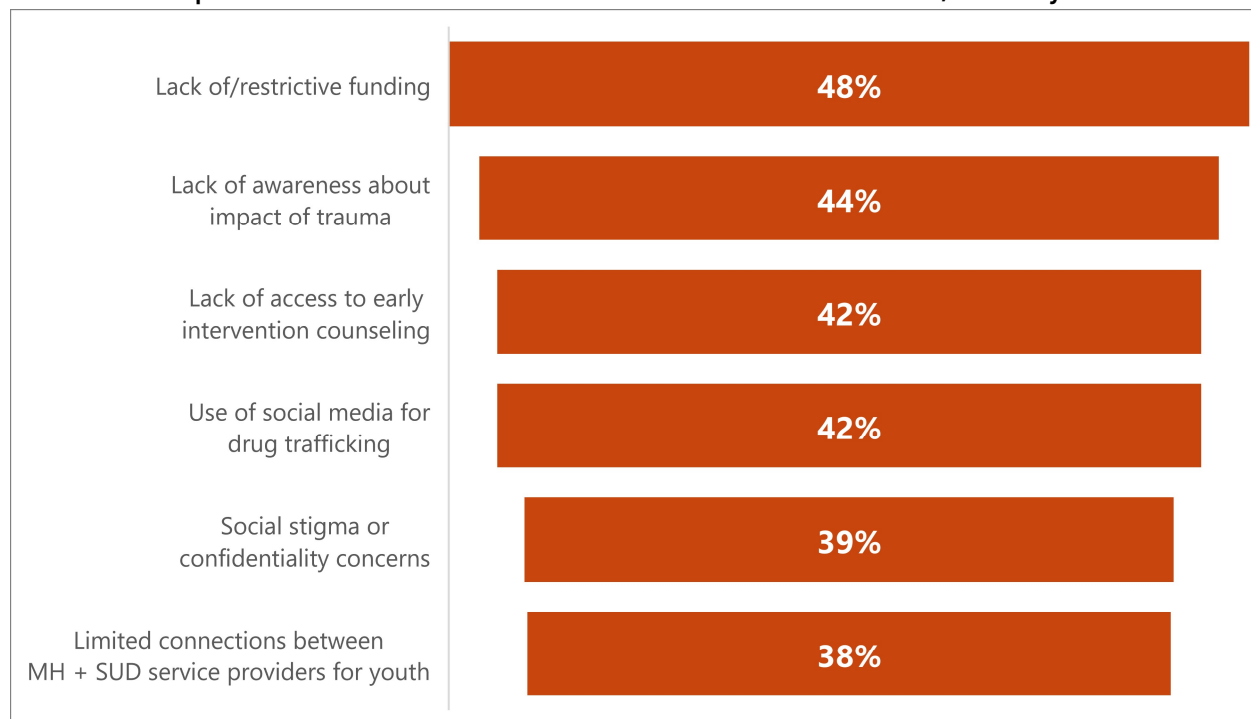


Questions throughout this needs assessment asked providers about primary prevention, though many of the top concerns voiced were about secondary and tertiary prevention. Many of the prevention coalitions in Maricopa County are funded by the national Drug-Free Communities grant, which focuses on primary prevention activities. Thus, providers noted that there are limited resources available for early intervention programs that address young people's risks, mental health and trauma, and education about staying safe if using substances.

Nearly half of survey respondents identified funding restrictions as a "serious concern" in the prevention arena, and three other top concerns (out of 15 options) were about early intervention: lack of systemized screening processes to identify youth with higher substance use risk factors, lack of access to counseling/behavioral health services, and limited integration between youth mental health and substance use providers. A focus group with prevention coalitions revealed that their main barriers were logistical and policy ones to carrying out their

programming—such as transportation for young people to participate in activities, and navigating church or school policies about substance use education. Top serious concerns in the prevention arena ranked by providers in the electronic survey are shown in Exhibit 12.

**Exhibit 12. Top Issues Ranked as Serious Concerns in the Prevention Arena, E-Survey**



N=181-187

## Social Determinants and Equity

**Medical system.** A 2022 report by the Arizona Child Fatality Review team found that substance use was a factor in 43% of the deaths of minors<sup>92</sup>. This report recommended trauma-informed prevention and early intervention efforts targeted to youth experiencing adverse childhood experiences, as well as encouraging pediatricians to co-prescribe naloxone to youth at risk of opioid overdose<sup>93</sup>. However, prevention organizations cited significant barriers to connecting with the medical care system. Community-based organizations noted that medical facilities, such as primary care offices, disallowed the informational pamphlets and naloxone trainings they

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*“Primary care, pediatricians, parents should all be having conversations – we should be teaching them how to have these conversations.”*

*- Listening Session participant*

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<sup>92</sup> ADHS Arizona Child Fatality Review Program. (2022). *Twenty-ninth Annual Report*.

<https://www.azdhs.gov/documents/director/agency-reports/29th-annual-child-fatality-report.pdf>

<sup>93</sup> Ibid.

offered, and felt this was representative of a divide between licensed professionals and grassroots “foot soldiers.”

**Population disparities.** A predominantly African American-serving organization said they struggled with where to refer youth with signs of mental health or substance use problems due to “historical trauma and distrust of the medical system.” One provider noted that African American and Mexican American families may fear acknowledging potential substance use problems due to concerns of repercussions with DCS: “They don’t want to tell DCS there’s a need because they don’t want to split up their family.”

Many of the prevention coalitions in Maricopa County operate under the Substance Abuse Coalition Leaders of Arizona (SACLA AZ) umbrella, and identified a need for “materials to reach specific populations,” such as “Native Americans, LGBTQ, African Americans, and people with mental health issues or learning impairments.” Some noted that prevention funding is not allocated in proportion to groups negatively affected by OUD/SUD and “tends to favor the dominant culture group instead of communities of color.”

**Stigma.** Providers repeatedly mentioned that stigma around substance use can translate to a parental attitude of “not my kid,” which limits them supporting their child in prevention or early intervention programs. One prevention coalition member suggested that having a parent who lost a child to a drug overdose could be a powerful testimonial for overcoming denials that “it can’t happen here.” This speaks to the newer dynamics of synthetic opioid potency and presence in other drugs, where youth may not be aware of what is in a pill they or others are taking. It also highlights a tension between abstinence-only and harm reduction approaches to substance use education with young people.

**Transportation.** Youth participation is often contingent on family support, and transportation can be a barrier for young people to get to activities or programs. Organizations engaged in primary, secondary, and/or tertiary prevention mentioned the need for City support and/or grant funding to obtain a vehicle that enables them to transport youth or conduct street outreach. While prevention providers employ program staff, they face limited resources for helping families with structural supports like transportation, food, and governmental benefits.

## Systems and Policies

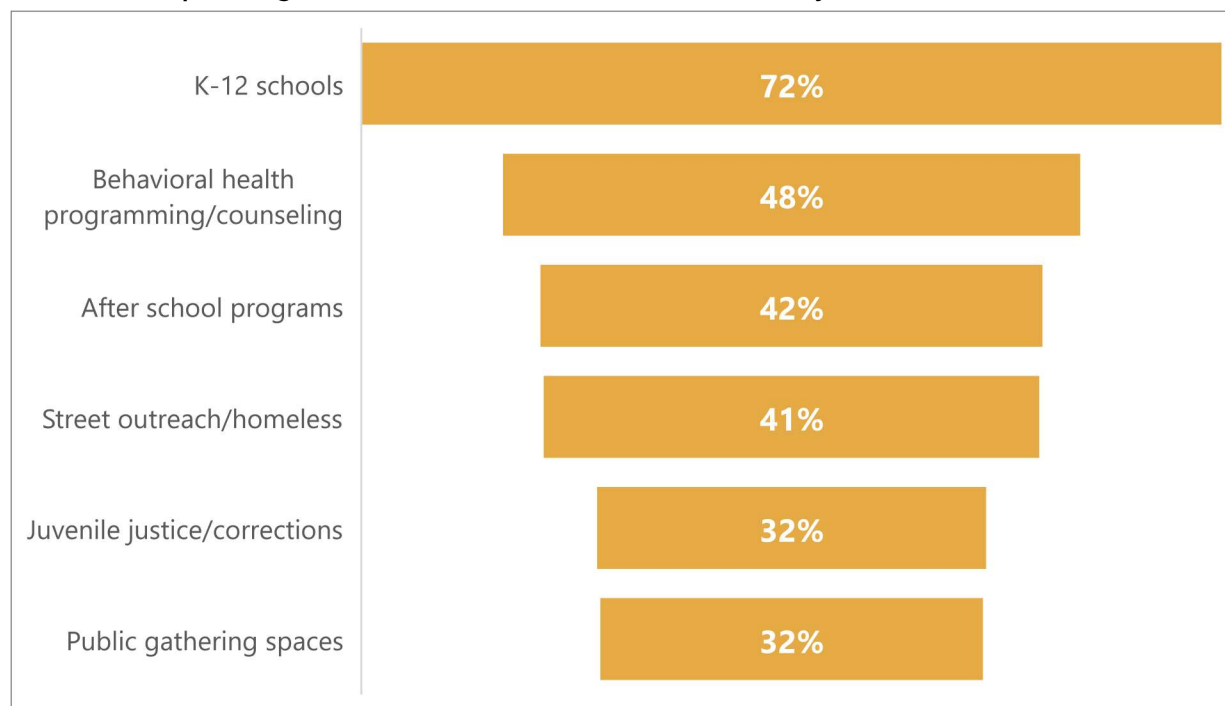
**Schools and other settings.** When asked about important settings for prevention in the e-survey, K-12 schools were cited by 72% of survey respondents, and after school programs by 42%. Yet prevention coalition members relayed multiple ways that some schools “rejected” drug education due to concern about public perception as well as school district policies. One school staff member shared that it took them three years to bring a coalition’s life skills and drug prevention education into their middle school, and described gathering data about

community need, garnering school board support, and creating a process for opt-out parental consent. Coalitions noted using door-knocking tactics, repeated attempts to reach school decision-makers, and the importance of a “persistent personality and time to get through” for substance use informational programming.

Other settings identified for secondary prevention included behavioral health counseling (48%), street outreach (41%) and juvenile justice or correctional settings (32%). Relatedly, some providers felt that there was limited funding for programs and interventions for young people aged 18-24.

Top settings providers recommended for conducting prevention activities are shown in Exhibit 13.

**Exhibit 13. Top Settings to Conduct Prevention Activities, E-Survey**



N=191

**Finding: Primary prevention and early intervention to reduce harms to youth are limited by funding restrictions and school policies.**

## Partnerships and Capacity

**Partnerships within prevention.** In listening sessions with prevention coalitions, members often knew one another and mentioned collaboration with one another as essential to their success. Coalitions gave examples of teaming up for events to reach broader audiences, cross-promoting each other's activities, and sharing knowledge resources with one another. Coalitions also noted each having a "specific niche" in where, who, and how they serve, and wanted "more freedom to do what we do" instead of all "fitting in the same shoe-hole."

**Partnerships with harm reduction and treatment.** Multiple prevention coalitions expressed interest in closer partnerships with harm reduction and treatment organizations to collaborate for educational trainings and referrals. A few noted that sometimes the well-known harm reduction organizations were "booked out for 2 to 3 months for harm reduction trainings." In their outreach roles, prevention coalition members encounter situations necessitating a treatment response. For example, one prevention provider said: "I've been asked several times 'What does detox look like for youth?'"

**Trainings.** Local and national prevention coalitions offer various training sessions for prevention providers; Banner Health and Arizona State University's Project ECHO (Extension for Community Healthcare Outcomes) trainings about substance use and Arizona Safe Net trauma-informed care trainings were also mentioned as helpful. Prevention and treatment providers expressed interest in better identifying substance use risk factors to target early intervention efforts. However, they noted that doing so requires community trust in supportive rather than punitive responses.

## Data and Evidence

**Data trends.** Providers noted the importance of current local trends to gain support for their programs and tailor their interventions, such as about specific substances available, street names for drugs, racial disparities in who's affected by OUD/SUD, and incident trends that Health Plans are seeing. One respondent noted that seeing trend data motivates them in their work: "heat map data would be amazing."

**Evidence-based programs.** Some providers observed that certain prevention programs could be costly and difficult to scale, and felt that looking into various evidence-based options, along with their costs and sustainability, would support providers and youth-serving organizations in expanding access to prevention and early intervention education.

## Important to Fund

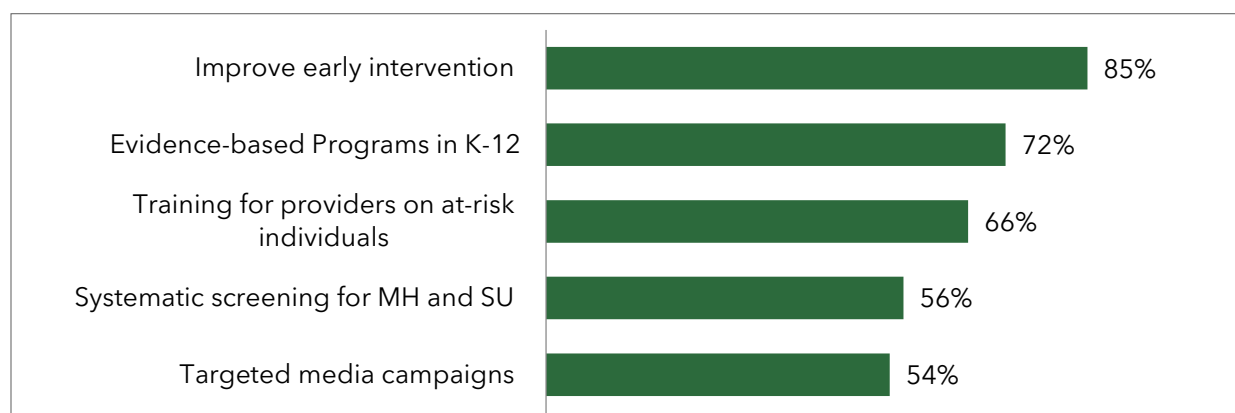
When asked about prevention strategies most important to fund in the e-survey, more than two-thirds of providers cited improving early intervention through screening and training for providers, and incorporating prevention programming into schools. Community-based service

providers also more highly recommended (61%) targeted media campaigns than did governmental staff (45%). Prescription drug related interventions such as safe prescribing and drug take-back events were not highly cited as important to fund.

The situational analysis conducted with Advisory Committee members articulated that prevention effectiveness would involve evidence-based prevention resources with broad reach and scale, people getting help before full-blown SUD and related harms, and measurably reduced problematic substance use.

The top five strategies identified by providers in the e-survey as “most important” to fund for OUD/SUD prevention are shown in Exhibit 14.

**Exhibit 14. Top 5 Prevention Strategies Identified as Most Important to Fund, E-Survey**



N=188

Increasing primary prevention, early intervention, and mental health interventions in school settings features prominently as solutions to improving the OUD/SUD response with youth, though a pre-condition to these requires engagement with school policies and decision-makers to allow this programming.

It is notable that “improve early intervention” was selected as a top strategy to fund by 85% of survey respondents, which is one of the highest rates of endorsement of any strategy across all intervention types.



# Harm Reduction Findings

## Overview

Harm reduction aims to reduce negative consequences associated with drug use, including death. The National Harm Reduction Coalition considers the following principles central to harm reduction practice<sup>94</sup>:

1. Accepts that drug use is part of our world and chooses to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex continuum of behaviors and acknowledges that some ways of using drugs are safer than others.
3. Establishes quality of individual and community life and well-being as the criteria for successful interventions and policies.
4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs in order to assist them in reducing attendant harm.
5. Ensures that people who use drugs and those with a history of drug use have a real voice in the creation of programs and policies designed to serve them.
6. Affirms people who use drugs themselves as the primary agents of reducing the harms of their drug use and seeks to empower them to share strategies which meet their actual conditions of use.
7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, discrimination, and other social inequities affect capacity for dealing with drug-related harm.
8. Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

In the context of OUD/SUD, harm reduction refers more specifically to services such as: education and supplies for overdose reversal; education and supplies for safer substance use; navigation services to ensure linkage to screening, treatment, and recovery services; elimination of barriers to treatment and access to MOUD; and decreasing stigma surrounding addiction and treatment<sup>95</sup>. Harm reduction strategies have been shown to save lives: a 2018 study found opioid overdose deaths decreased by 14% in states that enacted naloxone access laws<sup>96</sup>.

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<sup>94</sup> National Harm Reduction Coalition. (2022). *Principles of Harm Reduction*. <https://harmreduction.org/about-us/principles-of-harm-reduction/>

<sup>95</sup> Substance Abuse and Mental Health Services Administration. (2022). *Harm Reduction*. Retrieved from: <https://www.samhsa.gov/find-help/harm-reduction>

<sup>96</sup> McClellan, C., et al. (2018). Opioid-overdose laws association with opioid use and overdose mortality. *Addictive Behaviors*, 86: p. 90-95.

Additionally, statistical modeling suggests that high rates of naloxone distribution among laypersons and emergency personnel could avert 21% of opioid overdose deaths<sup>97</sup>.

## Harm Reduction Themes

Key themes about harm reduction from the assessment are shown in Exhibit 15.

### Exhibit 15. Summary of Themes that Affect Harm Reduction Services



#### Social Determinants and Equity

- Stigma from the general public, justice system, and other providers against people who use drugs inhibits engagement in multiple types of care services.
- There are disparities in accessing harm reduction services, particularly outside of urban areas and for people with limited transportation.



#### Systems and Policies

- Street-based services for people experiencing homelessness are important, yet impeded by some local policies around gathering in parks and streets.
- Drug abstinence-only education in middle and high schools prevents harm reduction and naloxone education for youth.



#### Partnerships and Capacity

- Connection to harm reduction services is important during crisis or transition.
- Partnerships with Cities and law enforcement is challenging due to the criminalization of substance use and requirements to enforce existing laws.
- There is a unique need for increasing harm reduction agency capacity to procure resources, organize human and financial capital, and meet demand particularly because these activities were only legalized in recent years.



#### Data and Evidence

- Real-time drug use and overdose trends by geography would enable providers to respond to new methods and dangers of use.
- Collecting data about harm reduction program participants is sensitive due to the illegality of substance use.

When asked about “harm reduction,” the majority of providers spoke about naloxone or Narcan access, and viewed it as an essential tool. Multiple types of providers, including first responders, case managers, and community outreach teams, are involved in distributing and using naloxone to stop potentially fatal overdoses. Organizations involved in the broader set of harm reduction activities cited above, view naloxone as a first-aid item not unlike the widely-

<sup>97</sup> Townsend, T., et al. (2019). Cost-effectiveness analysis of alternative naloxone distribution strategies: First responder and lay distribution in the United States. *International Journal of Drug Policy*.

distributed defibrillator. More holistic harm reduction providers stressed the importance of treating people who use drugs with dignity, offering options for safer drug use and other resources, and accepting rather than denying that drug use exists. However, some providers expressed concern that this approach “enables” drug use without prompting more care, which highlights tensions about effective ways to address opioid and other substance use.

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*“Naloxone alone is not harm reduction, it’s just something everyone should have in their medicine cabinet right next to the ibuprofen.”*

*- Listening Session participant*

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Top barriers and important settings for harm reduction services identified by providers on the electronic survey are shown in Exhibits 16 and 17.

## Social Determinants and Equity

**Stigma.** Stigma is a “mark of disgrace connected to a situation or quality of a person” and is often “based on assumptions or misconceptions”<sup>98</sup>. Stigma against people who use drugs was repeatedly cited as a major barrier to care. Referring to a person with lesions from injecting drugs, one provider said the person “would literally rather lose his leg or die than be stigmatized by a provider.... to be dehumanized over and over again like that, it breaks something in you.” Some providers noted building trust with communities through engagement events like pancake breakfasts, free community trainings on safe injection, and peer support specialists that greet people as they enter a place.

Research-supported principles to address stigma include<sup>99, 100</sup>:

1. Emphasizing the societal, rather than individual, causes of addiction;
2. Incorporating solution messages wherever possible;
3. Using sympathetic narratives including person-first and recovery-centered language;
4. Emphasizing that effective treatment exists;
5. Establishing regular communication on addiction topics with clinic staff and leadership
6. Using evidence-based educational efforts and tools to address stigma with the public; and

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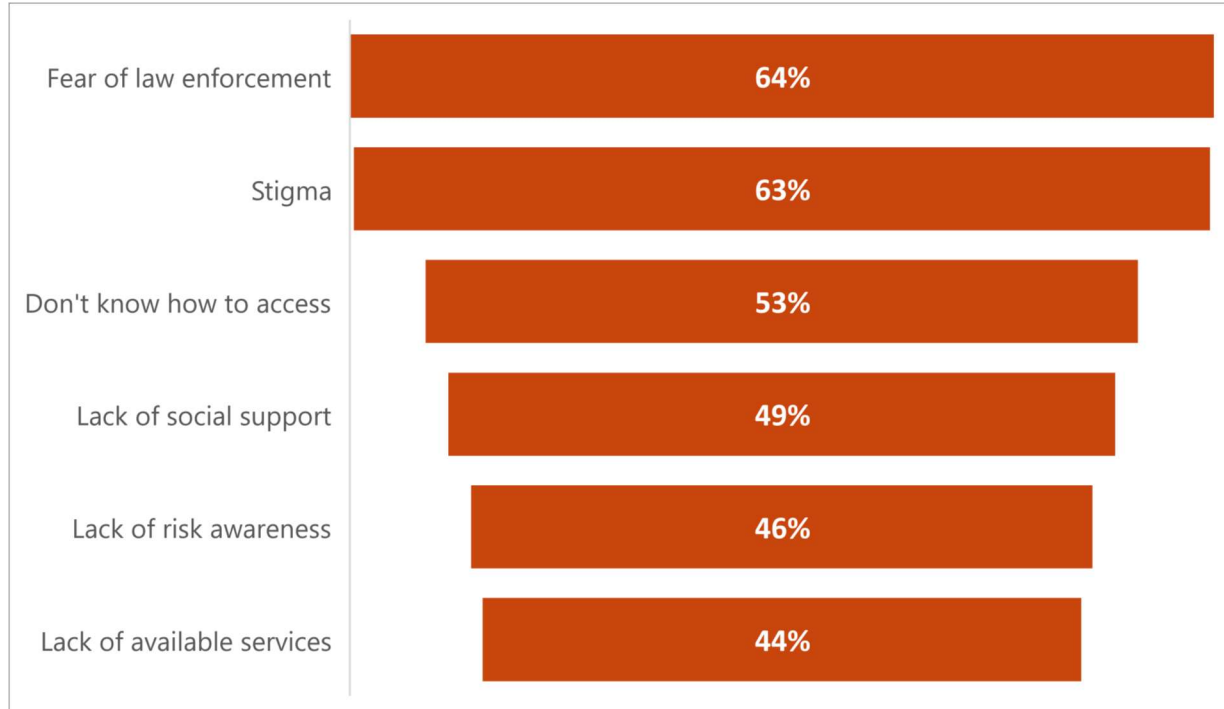
<sup>98</sup> Zwick, J., Appleseth, H. & Arndt, S. (2020). Stigma: how it affects the substance use disorder patient. *Substance Abuse Treatment and Prevention Policy* 15(50). <https://doi.org/10.1186/s13011-020-00288-0>

<sup>99</sup> McGinty E., Pescosolido B., Kennedy-Hendricks A., & Barry, C. L. Communication strategies to counter stigma and improve mental illness and substance use disorder policy. *Psychiatric Services*. 2017;69(2):136-146.

<sup>100</sup> Lough, K., & McIntyre, K. (2019). Visualizing the solution: An analysis of the images that accompany solutions-oriented news stories. *Journalism*, 20(4), 583–599. <https://doi.org/10.1177/1464884918770553>

7. Engaging and employing people with lived experience, and trained, licensed, and skilled addiction specialists.

**Exhibit 16. Top Barriers to Harm Reduction Interventions, E-Survey**

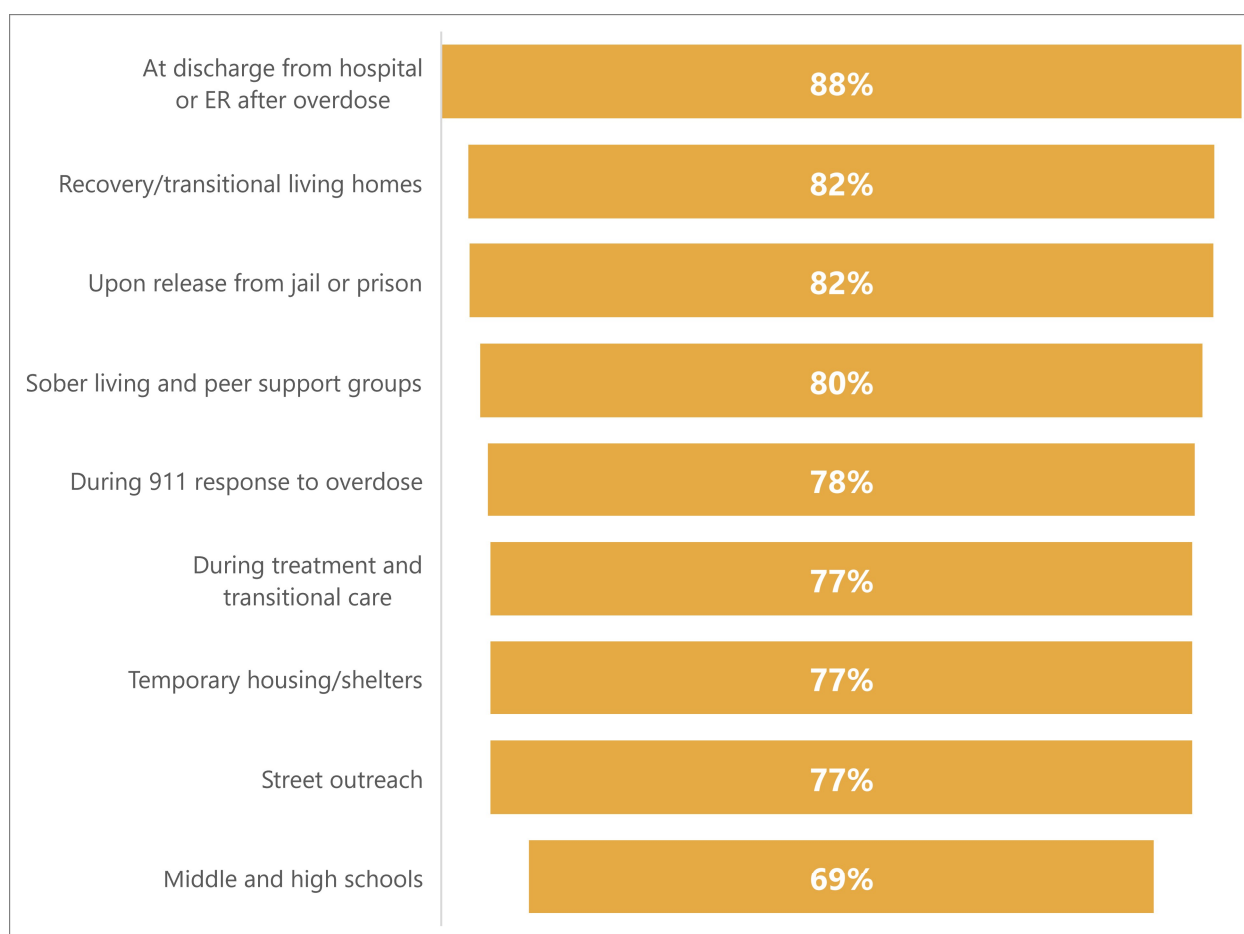


N=178

**Disparities in access.** Lack of available services and not knowing how to access existing services were cited as barriers by about half of providers, and particularly by those outside of urban areas. Similarly, some noted that transportation barriers have existed for decades and prevent people from accessing service providers. Incentives to support transportation, like a bus pass or gift card, can help ameliorate this challenge. Organizations offering a range of harm reduction services stressed the importance of physically meeting people who use drugs or are at risk for using drugs where they are. This involves street and mobile outreach for education, positive engagement through other activities like haircuts or sober events, safer use supplies, and resources about treatment and recovery services.

**Finding: Stigma associated with people who use drugs hinders organizations providing OUD/SUD interventions, as well as individuals' access to care.**

### Exhibit 17. Top Settings for Providing Harm Reduction Activities, E-Survey



N=172-179

## Systems and Policies

**Street services for people experiencing homelessness.** Other Maricopa County assessments show a rising rate of homelessness over the past six years, with about 9,600 people unhoused during 2023's Point-In-Time count<sup>101</sup>. In 2022, there were 463 drug-related deaths among people experiencing homelessness that occurred in Maricopa County, representing over a fifth (21.3%) of all drug-related deaths investigated by the county in 2022.<sup>102</sup> Some providers said that local policies which prevent unhoused people from congregating hindered service provision to this vulnerable subgroup, especially in public places like parks and streets. Community spaces where people can gather for various supportive services was proposed as

<sup>101</sup> Maricopa County Association of Governments. (2023). *2023 Point-in-Time Homelessness Count*. <https://azmag.gov/Programs/Homelessness/Data/Point-In-Time-Homelessness-Count#pit-count-reports>

<sup>102</sup> Maricopa County Office of the Medical Examiner. (2022). *Medical Examiner Annual Report: 2022*. <https://www.maricopa.gov/ArchiveCenter/ViewFile/Item/5601>

an antidote to policed spaces. Notably, providers working in the treatment and recovery fields felt that unstable housing was a top risk factor for relapse.

**Drug abstinence-only education.** School practices or policies preventing harm reduction education and naloxone distribution were mentioned by various providers as a barrier to preventing youth overdose deaths. A review of youth programs found that those focusing solely on abstinence from substances can be a deterrent for youth participation, as this expectation is often unrealistic.<sup>103</sup> Youth are also less likely than adults to be referred to a harm reduction program, so pediatric healthcare providers can play an important role in ensuring their patients have information on needle and syringe exchange, as well as other harm reduction services that are available in their area<sup>104</sup>.

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*“Legal changes have to happen at some point if we want to reduce fatal overdoses.”*

*- Key informant interview*

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## Partnerships and Capacity

**Connections to harm reduction services.** Connection to harm reduction services was seen as particularly important for people who just experienced an overdose, are transitioning out of incarceration, during treatment for substance use, when transitioning to recovery services, as well as for people experiencing homelessness and adolescents who may be experimenting with or using drugs. Additionally, over half of providers saw it as important to integrate harm reduction into treatment and recovery interventions. This highlights how simultaneous OUD/SUD interventions can be beneficial for supporting people’s various paths to health and self-directed lives.

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*“Dead people don’t get a chance to recover.”*

*- Listening Session participant*

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In general, organizations offering a variety of harm reduction education and supply services mentioned positive relationships with other community-based service providers, with some having wait lists for the education and training sessions they provide to other organizations. In listening sessions across the county, providers indicated there was inconsistent knowledge about what organizations provide naloxone and training, and how to access it.

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<sup>103</sup> Nairn, S. A., Audet, M., Stewart, S. H., Hawke, L. D., Isaacs, J. Y., Henderson, J., Saah, R., Knight, R., Fast, D., Khan, F., Lam, A., & Conrod, P. (2022). Interventions to reduce opioid use in youth at-risk and in treatment for substance use disorders: A scoping review. *Canadian Journal of Psychiatry*. SAGE Publications Inc. <https://doi.org/10.1177/07067437221089810>

<sup>104</sup> Robinson, C. A., & Deanna Wilson, J. (2020). Management of opioid misuse and opioid use disorders among youth. *Pediatrics*, 145(2). <https://doi.org/10.1542/PEDS.2019-2056C>



**Partnerships with Cities and law enforcement.** More than any other intervention, the intersection of harm reduction activities and law enforcement contained tensions stemming from the illegality of drug use. Harm reduction providers noted that the “criminalization of drug use” contributed to difficult partnerships with police and other justice system staff whose role is to enforce existing laws. Justice system and other governmental staff also recognized this tension, with 49% of this group responding that justice diversion was a top harm reduction strategy to fund. Emergency first responders in various cities said that in responding to an overdose call, their primary options are to “take the person to the hospital or to jail, neither of which may be the best place for them.”

**Capacity for organizations focused on harm reduction.** Aside from a couple larger organizations providing diverse harm reduction services, many harm reduction organizations or coalitions were formed to meet the need to reduce overdose deaths and prevent other substance use harms among people who use drugs. The situational analysis showed that historically, the harm reduction field has had federal and state funding restrictions, legal gray areas about supplies distribution, and social resistance due to perceptions of enabling drug use. Since most harm reduction activities were only legalized and eligible for public funding in Arizona within the past three years, institutional capacity-building for harm reduction organizations is needed to facilitate their abilities to procure resources, organize human and financial capital, and meet the demand for harm reduction services. This is a unique dynamic faced within the harm reduction intervention owing to its newly authorized place in the OUD/SUD response system. Limited funding was repeatedly cited as a barrier to expanding services.

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*“We’re in the landscape of scarcity here, but our people are also dying and we have to figure out how to respond the best we can and shift our services to meet their needs.”*

*- Key informant interview*

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**Finding: Providing safer substance use services became legal in Arizona within the past 3 years, and organizations providing them need infrastructure support and development to meet harm reduction demands.**

Grassroots and smaller scale harm reduction providers reported developing organizational relationships “organically,” especially for related services like HIV and Hepatitis C testing. They faced constraints for other types of partnerships, particularly when most staff and volunteers were focused on direct harm reduction service with people who use drugs. Referrals and warm hand-offs are not always within the scope of the organization, and may be done

informally. The time, consistency, and resources to provide linkages to care is an infrastructure issue for smaller, less well-funded, or primarily volunteer-based organizations.

Harm reduction providers interviewed expressed seeking out training resources to support their work. Motivational interviewing was repeatedly cited as a useful training to explore a person's own reasons for change in a compassionate way. Others noted that trainings provided by the National Harm Reduction Coalition were useful, including topics like person-first language and overdose prevention for professionals.

## Data and Evidence

**Drug use and overdose trends.** Harm reduction service providers stressed the importance of being adaptive and shifting to the needs of the people they serve. Recently, this has included giving out safe smoking supplies, responding to xylazine in the drug supply, and increasing naloxone distribution. Providers obtained this information while conducting street outreach, as well as following published local and national trends.

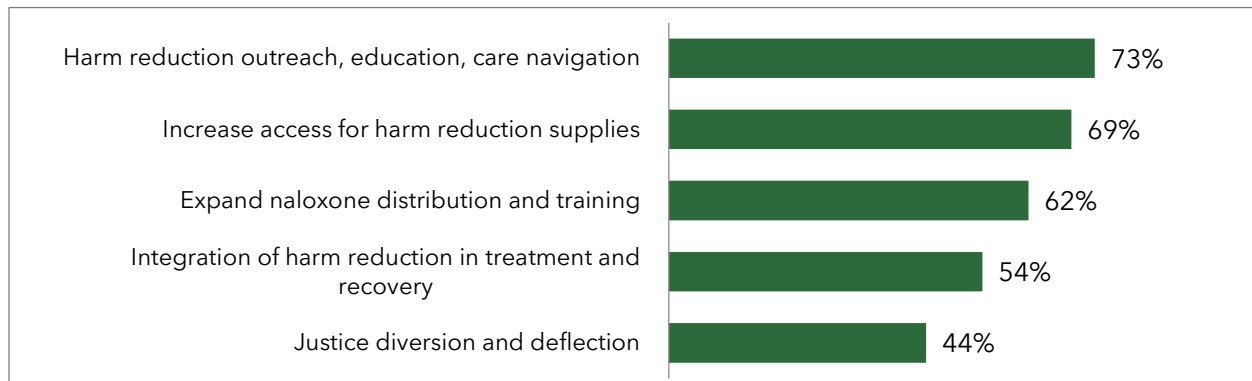
**Data collection culture.** Regarding data collection, a couple harm reduction providers mentioned purposefully collecting a bare minimum of information from participants to combat a "culture of surveillance." They did note tracking the number of various supplies they provide to people who use drugs, as these output numbers assist with their funding and reporting. The importance of confidentiality due to use of illicit drugs is also a dynamic specific to harm reduction interventions, and even more so for people involved in the justice or DCS systems.

Finding: Common metrics for substance-related harms, service utilization, and outcomes would support organizational partnerships and activities, and facilitate public health monitoring of the response.

## Important to Fund

When asked what harm reduction strategies were the most important to fund, more than two-thirds of survey respondents recommended increased outreach and harm reduction supplies. As shown in Exhibit 18, integrating harm reduction into the other intervention types (prevention, treatment, recovery) also ranked highly, as did diverting drug use offenses from the criminal justice system. Qualitative data collection noted the importance of anti-stigma campaigns to facilitate broader awareness and acceptance of harm reduction programs, as well as capacity-building to better integrate harm reduction organizations into the spectrum of care, and a focus on de-criminalized safe consumption gathering spaces for people who use drugs.

**Exhibit 18. Top 5 Harm Reduction Strategies Identified as Most Important to Fund, E-Survey**



N=177

The situational analysis articulated that harm reduction effectiveness would result in a reduction in overdose and drug-related illness and death, people who use drugs feeling more support and knowing where to turn for help, improved health and economic outcomes, and decreased family separation through DCS, jail, or death.

# Treatment Findings

## Overview

Treatment for OUD and other SUDs is designed to help people stop opioid and/or other substance use. Individual treatment might involve a team of professionals including social workers, counselors, doctors, nurses, psychologists, psychiatrists, peer support specialists, or other professionals. Traditionally, treatment for OUD/SUD focused solely on behavioral therapy including contingency management therapies, cognitive behavior and skills training therapies, motivational interviewing, couples and family treatments, and life skills training<sup>105</sup>. Medications for Opioid Use Disorder (MOUD) started to gain federal approval in the 1970's and expanded in the 1990's with the irresponsible promotion of prescription opioids<sup>106</sup>. Medication Assisted Treatment (MAT), the combination of behavioral therapy and MOUD, has become the standard of care for the treatment of addictive disorder<sup>40</sup>. Although MOUD is the standard of care for treating OUD, less than one-half of privately-funded substance use disorder treatment programs offer MOUD and only one-third of patients with OUD at these programs actually receive it<sup>107</sup>.

## Treatment Themes

Key themes about OUD/SUD treatment from the assessment are shown in Exhibit 19.

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<sup>105</sup> Carroll, K. M., & Onken, L. S. (2005). Behavioral therapies for drug abuse. *The American Journal of Psychiatry*, 162(8), 1452-1460.

<sup>106</sup> Menzies, P.M. (2021). *A Brief History of Medication Assisted Treatment (MAT)*.

<https://www.arcamidwest.com/post/a-brief-history-of-medication-assisted-treatment-mat#:~:text=The%20first%20break%20in%20the,seen%20as%20a%20controversial%20measure.>

<sup>107</sup> Knudsen, H.K., Abraham, A.J., & Roman, P.M. (2011). Adoption and implementation of medications in addiction treatment programs. *Journal of Addiction Medicine*, 5(1): 21-27.

## Exhibit 19. Summary of Themes that Affect Treatment Services



### Social Determinants and Equity

- Unstable housing, transportation, and income are prominent barriers to accessing or completing treatment.
- A lack of specialty providers for marginalized populations hinders treatment engagement by those disproportionately affected by OUD/SUD.
- MAT access and utilization is limited by stigma from treatment and recovery providers.



### Systems and Policies

- Health plan prior authorization requirements cause delays and inability to initiate care, and limits on service duration negatively affects care outcomes.
- More than other interventions, treatment providers said insurance reimbursement limits negatively affected staff pay, recruitment, and retention.



### Partnerships and Capacity

- Transitions to and from treatment could be facilitated by care navigators, on-call teams, and post-overdose response teams.
- Staff turnover creates challenges for inter-organizational partnerships.
- A majority of treatment providers wanted stronger relationships with housing organizations.
- Making relevant referrals to recovery programs and housing was challenging, and providers wanted an updated resource database of programs and their eligibility criteria.



### Data and Evidence

- Overdose and healthcare utilization data would be helpful for more shared knowledge and a cohesive response across provider organizations.

## Social Determinants and Equity

**Unstable housing, transportation, and income.** When asked about primary barriers to treatment, structural determinants of health were highly cited, with providers noting that unstable housing, long distances and limited transportation access, and financial insecurity greatly limit a person's ability to engage in and complete treatment (see Exhibit 20). Even though AHCCCS can assist with transportation services, this was noted by some participants as not always reliable. Material and case management support for social

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*"I think the problem is that we look down at people using drugs, instead of up at the system."*

*- Listening Session participant*

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determinants of health are often referred to as “wraparound services,” which are often not fully covered by health insurance plans.

Behavioral health care providers, including those in recovery themselves, shared how demoralizing it is to try to follow-through on treatment goals while facing structural stressors like eviction, food insecurity, probation requirements, and insurance coverage limits: “Even if you get the services that you need to do the things that you need to do, somehow you're always stuck somewhere.”

**Marginalized populations.** Few providers explicitly racialized treatment access, though they did note the lack of specialty providers to respond to specific populations including African Americans, AI/ ANs, Latinx, LGBTQ+, youth, families, justice-involved, and persons experiencing homelessness. Providers mentioned that MAT/MOUD for youth is highly geographically limited, and that confidentiality worries intersect with perceived stigma for people living in tribal or rural areas. National studies show that patients who experience discrimination are more likely to underuse the health system and put off getting necessary medical care.<sup>108</sup> For marginalized minority groups, trusted community and faith organizations could be engaged in designing OUD/SUD interventions to better reach those experiencing the greatest health disparities<sup>109</sup>. During qualitative data collection, community-based providers stressed the importance of remaining flexible with evidence-based practices because “no one-size fits all.”

**Finding: Greater support for housing, transportation, justice-system transitions, and populations with health disparities is needed for positive care outcomes.**

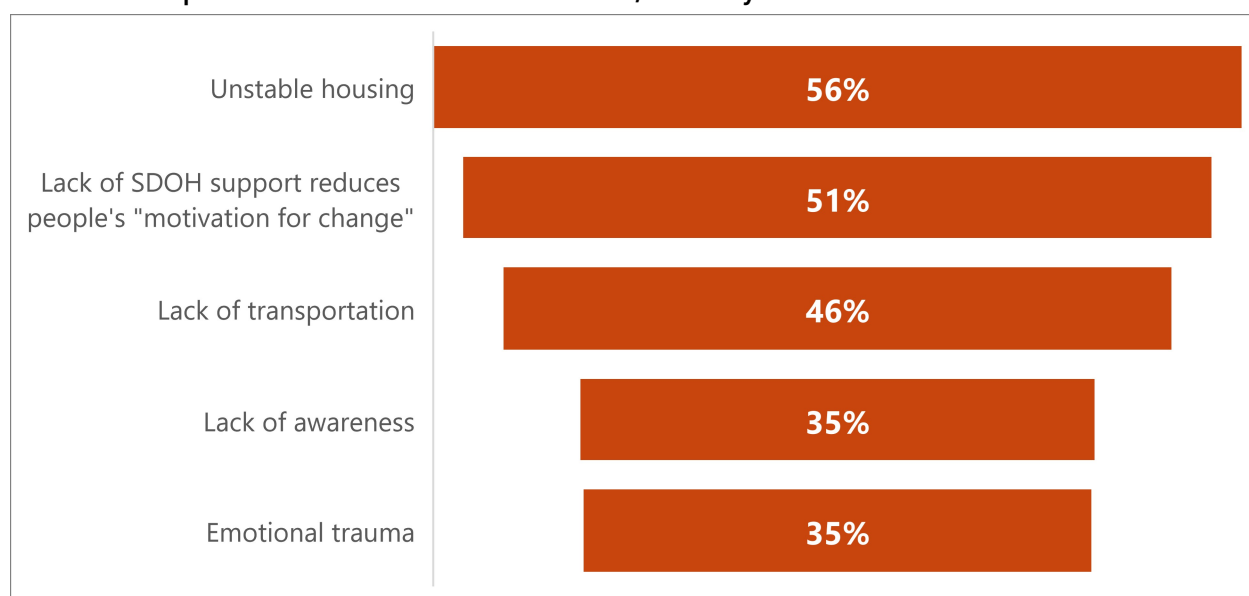
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<sup>108</sup> Bleich, S. N., Findling, M. G., Casey, L. S., Blendon, R. J., Benson, J. M., SteelFisher, G. K., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of Black Americans. *Health Services Research*, 54(S2), 1399–1408. <https://doi.org/10.1111/1475-6773.13220>

<sup>109</sup> Hughes, M., Suhail-Sindhu, S., Namirembe, S., Jordan, A., Medlock, M., Tookes, H. E., Turner, J., & Gonzalez-Zuniga, P. (2022). The Crucial Role of Black, Latinx, and Indigenous Leadership in harm reduction and addiction treatment. *American Journal of Public Health*, 112(S2), S136–S139. <https://doi.org/10.2105/AJPH.2022.306807>



**Exhibit 20. Top Barriers to Treatment Interventions, E-Survey**



N=218

**MOUD/MAT access and stigma.** Varied access to MOUD/MAT was framed as both an issue of stigma and structural issue. Providers noted that DCS does not always view MOUD as a viable option, and that many recovery homes do not accept residents using MOUD. Drug-testing is often a requirement for justice system-involved people, as well as those in recovery housing, and drug tests that can distinguish between illicit opioids and prescription opioid agonist medications like methadone or buprenorphine are significantly more expensive.

Some recovery-focused providers also expressed various views on MOUD, with one saying they advise against it because “someone on MAT is more likely to be homeless,” referring to limited MOUD housing options. A recent qualitative study in Arizona conducted 131 interviews with people currently receiving medication for opioid use disorder and found that *no* participants received a 14- or 28-day supply of take-home methadone allowed under federal regulations<sup>110</sup>. All participants reported that more multi-day take-home doses and home delivered medication would improve their treatment access<sup>111</sup>. This illustrates the complex relationship between evidence-based treatment services, housing rules, and attitudes toward people using pharmaceutical interventions.

<sup>110</sup> Meyerson, B. E., Bentele, K. G., Russell, D. M., Brady, B. R., Downer, M., Garcia, R. C., Garnett, I., Lutz, R., Mahoney, A., Samorano, S., Arredondo, C., Andres, H. J., Coles, H., & Granillo, B. (2022). Nothing really changed: Arizona patient experience of methadone and buprenorphine access during COVID. *PloS one*, 17(10), e0274094. <https://doi.org/10.1371/journal.pone.0274094>.

<sup>111</sup> Ibid.

## Systems and Policies

**Health Plan insurance coverage.** Prior authorization required for certain services was viewed as causing delays, or even impeding access to treatment care. As a result, they said care was not available when the individual was ready to accept it. Providers also noted that for those leaving incarceration, their understanding was that AHCCCS insurance coverage does not take effect until 72 hours after release, which reduces service access during a critical transition time. Limits on duration of care services were also cited as negatively affecting treatment outcomes, since some Health Plans only cover a certain number of sessions. Providers said they could bill AHCCCS for treatment services, but not for the related supports necessary for people to engage in treatment, such as food, rent, hygiene items, and clothing. Grant funding outside of insurance did not entirely cover these cost gaps, and even State Opioid Response (SOR) funding has lifetime limits on expenditure for a single patient. A few providers mentioned that the federal Mental Health Parity and Addiction Equity Act – which requires health insurance companies to cover behavioral health services in parity with physical health services – seemed like it should allow for more coverage of OUD/SUD services.<sup>112</sup>

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*“It takes a lot of time and energy to try to get that reimbursement.”*

*- Listening Session participant*

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**Finding: Health insurance authorization and coverage restrictions cause delays and limitations for treatment and recovery services.**

**Billable rates.** To a greater extent than respondents in other OUD/SUD interventions, treatment organizations cited staff pay, recruitment, and retention as challenges to service delivery. Providers felt that insurance and grant reimbursement levels for billable services affected staff wages and other provider resources. In addition, the policy level these rates are set at may vary: AHCCCS sets unit cost limits for each service, Health Plans set limits that are within these, and behavioral health organizations further decide staff pay and benefits based on their reimbursement business models.

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<sup>112</sup> AHCCCS covered services and justice-system information suggest some of this information may be already being changed or is not clear across the system. Complexity of the system likely is a barrier to consistent knowledge of service access statewide. Statements here are intended to reflect provider participant understanding at the time this needs assessment was conducted rather than describe Medicaid, AHCCCS, or Health plan specific policy.

## Partnerships and Capacity

**Transitions to and from treatment.** Providers noted that bridges to treatment from settings like emergency rooms and correctional settings were critical for care, but faced challenges for warm hand-offs: “the nurses are overwhelmed” and “jail release times are not always communicated in advance.” Another provider said that this transition—facilitated by inter-organizational coordination and transportation—“is key to getting someone into treatment. If you delay by a day or later, they might have changed their minds.” Transitions from treatment to recovery were also discussed as highly important, since OUD/SUD is not a linear health condition and requires years of care and support. Care navigators, on-call teams, and post-overdose response teams were recommended by 42% of survey respondents as solutions to support entry into treatment and recovery. Stronger relationships with housing organizations was at the top of multiple providers’ recommendations for ways to improve treatment outcomes.

Survey respondents ranked MOUD in correctional settings as highly important for OUD/SUD care, and studies show this practice promotes treatment engagement while reducing overdose deaths and recidivism<sup>113</sup>.

**Staff capacity.** Treatment providers noted that knowledge and use of referral resources often depended on staff relationships, and that staff turnover made contacts at partner organizations more challenging. They also felt that there was a shortage of specialty providers or that they did not know about them.

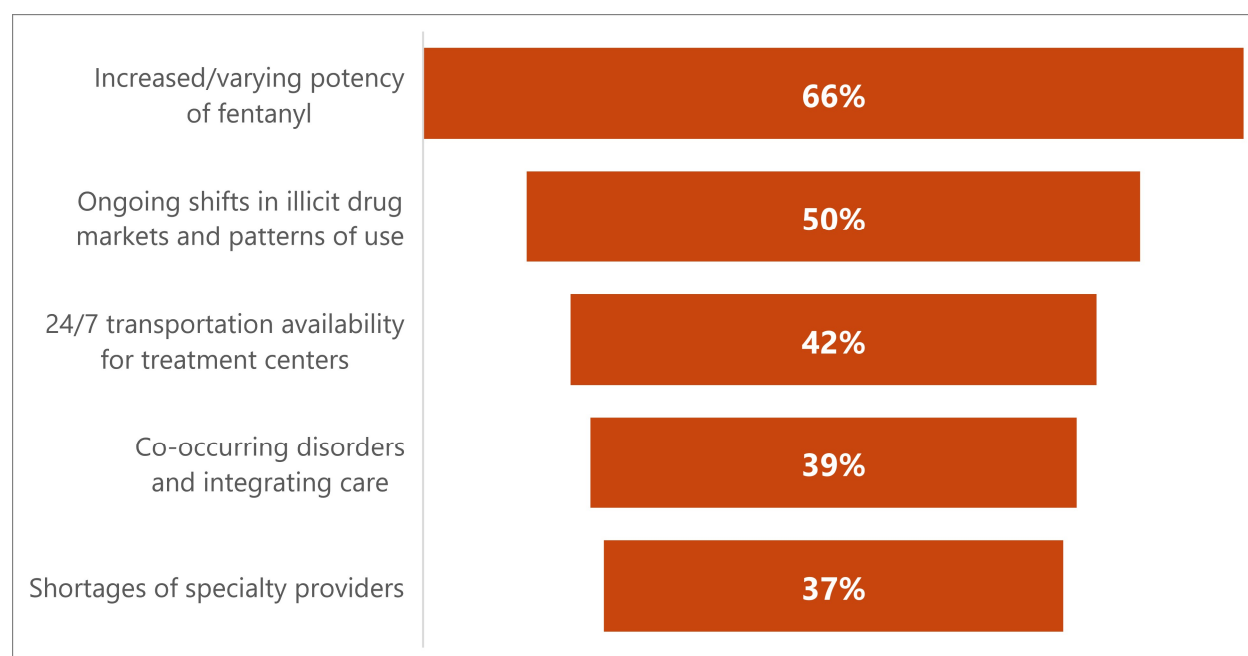
Treatment practitioners said that continuing virtual education sessions about working with different populations (i.e., women, veterans) was useful, as were core evidence-based practices like motivational interviewing, trauma-informed care, and naloxone training.

Issues of serious concern for treatment services identified by survey respondents are shown below in Exhibit 21.

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<sup>113</sup> National Sheriffs’ Association & National Commission on Correctional Health Care. (2018). *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*. <https://www.ncchc.org/wp-content/uploads/Jail-Based-MAT-PPG-web.pdf>

**Exhibit 21. Top Issues Identified as Serious Concerns in Providing Treatment Services, E-Survey**



N=201-209

**Relevant referral resources.** Providers repeatedly said they wanted more updated resources for available programs, including the various enrollment and participation rules. Treatment staff specifically mentioned wanting resource and referral information about 24-hour clinics, MOUD/MAT clinics, specialty services, naloxone training, and recovery housing to be able to rapidly and effectively navigate care.

First responders also said a simple resource about clinics and their open hours would be useful during their emergency overdose response, and enable them to immediately transition someone to detox care.

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*"I would love if 2-1-1 line could come up with an easy access number for halfway houses, clean living facilities...they change so much."*

*- Key informant interview*

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## Data and Evidence

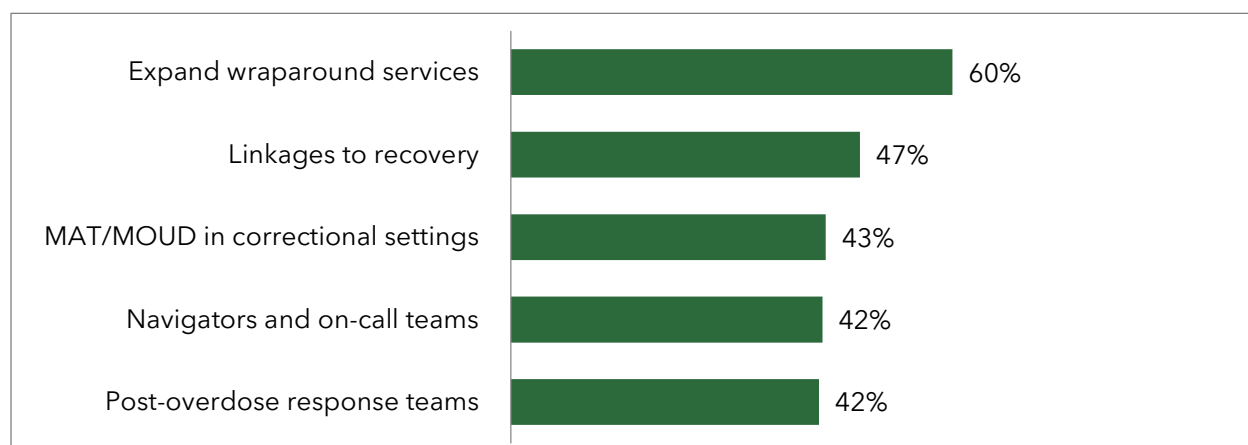
**Overdose and healthcare utilization data.** Some providers accessed local trend data, but said it can be "hard to find cohesive, collective information" that could "get everyone on the same page." They expressed interest in being proactive about drug trends by demographics and zip codes, as well as substance-related hospitalizations. One provider noted that they receive the majority of their information through other agencies, but it would be helpful to have a specific report that went out to providers about trends and services in Maricopa County. An American Indian service provider cautioned that there can be a lot of data missed from tribal jurisdictions because they do not have to report in the same way at the state level. For individual patient

care, providers said they are not always able to access someone’s health record to understand their previous experiences.

## Important to Fund

As shown in Exhibit 22, survey respondents ranked wraparound support, linkages to treatment through on-call and post-overdose response teams, linkages to recovery, and MAT/MOUD in jail as top strategies to fund. Qualitative data showed the importance of Health Plan authorization and billable services requirements in timely and appropriate care.

**Exhibit 22. Top 5 Treatment Strategies Identified as Most Important to Fund, E-Survey**



N=218

The situational analysis conducted by the Advisory Committee articulated that treatment effectiveness would involve reduced barriers for providers and patients, which leads to integrated care and improved outcomes.

# Recovery Findings

## Overview

Recovery refers to the voluntary process of change after experiencing treatment for OUD/SUD through which people remain in remission. During recovery, with the proper support system, people can handle negative feelings and life events without using substances. Supportive recovery programs could include<sup>114</sup>:

1. Systems of care that embrace chronic care management through outpatient care, recovery housing, and coaching;
2. Community-based support services that provide emotional and practical support for continued remission including mutual aid groups, recovery housing and coaching, and education including family-centered treatment and services for children and families affected by OUD/SUD; and
3. Social and recreational opportunities that make it easier for people in recovery to enjoy activities and social interaction that do not involve alcohol or drugs.

The recovery process can also include continued use of MAT. A recent, large-scale, national cohort study found individuals who remained on MOUD had greater sustained abstinence when compared to those who did not receive MAT 18 months after the start of the study<sup>115</sup>. On a community-level, recovery is facilitated by strengthening protective factors related to the social determinants of health including economic stability, a positive neighborhood and physical environment, continued education, food access, positive community and social contexts, and access to quality health care<sup>116</sup>.

Recovery philosophies and services cited by needs assessment respondents were more varied than the other OUD/SUD interventions, involving a range of approaches like: equine therapy; meditation; culturally significant practices such as smudging and sweat lodges; life skills and technology training; family involvement; spirituality; Alcoholics Anonymous/Narcotics Anonymous; sober events like exercise and barbeques; residential recovery programs; and structured sober living. Many of the top barriers and proposed solutions in this intervention area aligned with those noted by treatment providers as well. This underscores the critical link

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<sup>114</sup> National Institute on Drug Abuse. (2022). *Recovery*. <https://nida.nih.gov/research-topics/recovery>

<sup>115</sup> Boyett, B., Nadipelli, V.R., Solem, C.T., Chilcoat, H., Bickel, W.K., Ling, W. (2023). Continued posttrial benefits of buprenorphine extended release: RECOVER study findings. *Journal of Addiction Medicine* 17(2):p 182-189.

<sup>116</sup> Hser, Y.I, Evans, E., Grella, C., Ling, W., & Anglin, D. (2015). Long-term course of opioid addiction. *Harvard Review of Psychiatry*, 23 (2); pp. 76-89.



between treatment and recovery interventions, as most people with OUD/SUD engage in these services simultaneously or sequentially at various times in their journeys.

Recovery housing in Arizona falls into three categories: evidence-based peer-run Oxford Houses, recovery homes certified by the Arizona Recovery Home Association, and free-market homes that do not follow specific models or licensing. These different models are a source of confusion for providers regarding eligibility and criteria, and unregulated homes have varying requirements and protections in place for residents.

## Recovery Themes

Key themes about OUD/SUD recovery from the assessment are shown in Exhibit 23.

### Exhibit 23. Summary of Themes that Affect Recovery Services



#### Social Determinants and Equity

- Unstable housing was the most frequently cited barrier to people's recovery.
- Stigma about misunderstanding of recovery's non-linear process hinders support and financial coverage for care.
- People leaving jail need more support than most health insurance will cover.



#### Systems and Policies

- Health insurance limits on recovery services lead to insufficient service coverage.
- Many recovery homes do not allow for people on MOUD due to various philosophies about prescription-assisted recovery and high costs, which limits options for people with OUD/SUD.



#### Partnerships and Capacity

- Transitions from treatment to recovery are challenging due to health insurance coverage restrictions, eligibility criteria, and different housing rules.
- Peer recovery support specialists are critical for relapse prevention and support, but more are needed to meet diverse needs.
- A recovery housing resource list would be useful to distinguish between recovery home types, costs, and criteria.



#### Data and Evidence

- Drug and mental health trends, along with outcome data from recovery programs, would be helpful for recovery providers to improve their services.

## Social Determinants and Equity

**Unstable housing.** Providers repeatedly stressed the importance of stable housing – and a means to pay for it – to sustain recovery. At the same time, some recovery homes will not accept people using MOUD, due to increased costs for drug-testing and clinical staff that are not part of their business models. As shown in Exhibit 24, survey respondents identified housing as the top barrier to recovery interventions.

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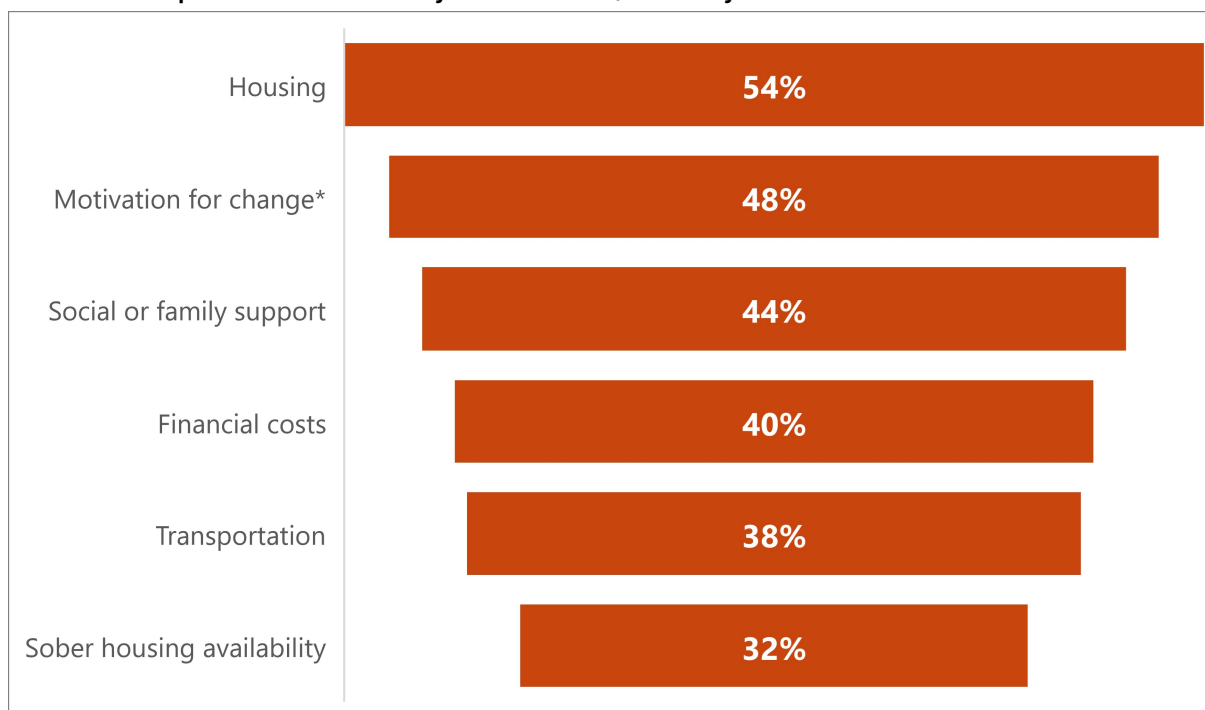
*“When the barrier of housing is removed, people have better results in treatment and recovery.”*

*- Key informant interview*

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One recovery provider noted that this creates a difficult choice for people recovering from opioid misuse: “Do I continue MAT treatment, or do I seek shelter?”

**Exhibit 24. Top Barriers to Recovery Interventions, E-Survey**



N=196

**Stigma.** Providers mentioned that self, family, and community stigma affect recovery care access, and that there is still misunderstanding about the non-linearity of people’s recovery journeys. Going beyond beliefs about recovery, providers noted that mentalities of rapid and linear recovery are even codified in health insurance and grant funding limits.

**Justice-system involvement.** When asked about specific populations disproportionately affected by recovery service limitations, justice- and DCS-involved groups were frequently mentioned. Involvement with justice systems due to OUD/SUD is indicative of other legal and

social stressors, and involves participating in additional requirements such as drug tests, probation check-ins, and court hearings. Providers noted it takes more time and support to navigate these dynamics. Some organizations specifically provide resources to transition back into the community from incarceration, such as support with fines and identification cards: “People need extra support in the first year of re-entry.”

## Systems and Policies

**Health Plan insurance coverage.** Similar to treatment providers, recovery organizations providing clinical or structured living services rely on health insurance payers to cover costs. Authorization for recovery services can be delayed or denied based on sobriety status, particularly for those leaving incarceration. “Clients coming directly from Corrections are not eligible for coverage because they have been sober for the length of their corrections stay.”

Additionally, transitional living or recovery housing services may only be billable to insurance for 30 days, which providers said is not enough time for people to truly “get their feet under them.”

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*“Our biggest barrier is saying, No, we can’t take your insurance.”*

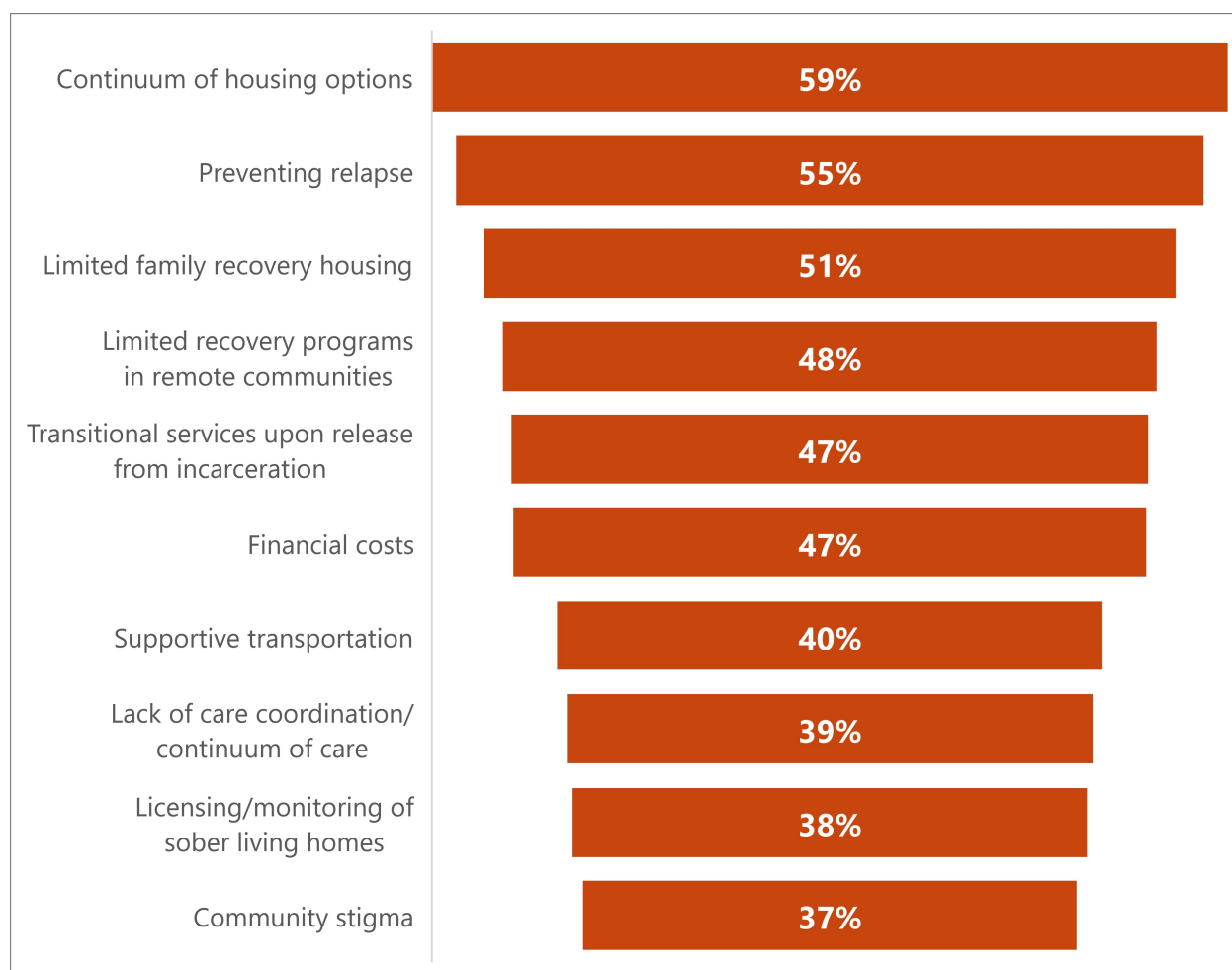
*- Key informant interview*

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**MOUD barriers in recovery housing.** Discussion with dozens of providers revealed confusion around recovery housing regulations, particularly about accepting people with prescribed medications for OUD/SUD. Organizations not operating recovery homes wondered if stigma, perceptions of “substituting one drug for another,” and strict definitions of “sobriety” were driving housing policies that prohibited MOUD, or only allowed certain medications like naltrexone (Vivitrol) which blocks opioid receptors, rather than ones that activate them (like methadone and buprenorphine/Suboxone). Federal and State housing policies allow for all prescription medications, though specific housing funding and liability requirements may vary by provider organization. Organizations operating recovery homes cited the cost-prohibitive nature of drug tests that can distinguish between illicit opioids and methadone/buprenorphine, as well as the need for more clinical staff to manage these opioid agonist medications.

Issues of serious concern for recovery services identified by survey respondents are shown below in Exhibit 25.

**Exhibit 25. Top Issues Identified as Serious Concerns for Providing Recovery Services, E-Survey**



N=193-195

## Partnerships and Capacity

**Transitions from treatment to recovery.** Providers talked about how ongoing dynamics of mental health and trauma affect the recovery process, which stresses the need for continued counseling and care through various modalities. Transitions between treatment and recovery care was noted as a key challenge, particularly with various recovery housing eligibility stipulations and health care coverage. Treatment providers mentioned having difficulty locating appropriate and available recovery housing, since it varies by gender-specific housing, family availability, Health Plans accepted, MAT/MOUD housing rules, and stay duration.

Qualitative data indicated that competition for funding was a barrier to inter-organizational partnerships. One provider said that their successful partnerships tended to be formalized ones with annually updated MOUs.

**Workforce training and peer recovery specialists.** Recovery providers interviewed mentioned that training in peer support, ethics and boundaries, leadership/supervision, naloxone, safety, and de-escalation was helpful to them. A few organizations said they wanted more training in mental health, underserved populations, and training access at a lower cost.

Various types of providers expressed a need for more peer support specialists, in terms of quantity, diversity, and availability in non-urban areas. They felt that peer support was an underutilized strategy in recovery services.

When asked about potential reasons for peer specialists limits, they mentioned that the pay for peer recovery support specialists was low:

AHCCCS' current fee schedule allows billing \$15.62 per 15 minutes of peer support services<sup>117</sup>. However, Health Plans can establish lower rates, and provider organizations establish employee wages. Further, provider organizations may also stipulate other requirements for peer recovery support specialists, such as completing their own training course, or disallowing former program participants from employment at their agency.

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*"Most people need to connect with other people they can relate to. They need hope and seeing someone who has gone through the same thing...it gives them hope."*

*- Key informant interview*

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**Finding: Social support is essential for maintaining recovery from opioid and other substance use.**

**Recovery housing resource list.** Treatment providers wanted to see improvements and more regular updates in the 2-1-1 Information and Referral Service<sup>118</sup> line to easily access halfway houses, clean living facilities, and other housing resources: "It's discouraging to call and find out that a place doesn't exist anymore." To be useful, such a resource list would need to detail eligibility criteria, stay duration options, costs, and insurance acceptance. Recovery housing providers noted that there is a market for unlicensed and non-evidence-based transition/recovery homes that they perceived could be exploiting people and causing harm.

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<sup>117</sup> AHCCCS. (2023). *Behavioral Health Fee-for-Service Rates & Codes: Outpatient Fee Schedule*.

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/BehavioralHealthrates.html?id=Outpatient>

<sup>118</sup> <https://211arizona.org/get-help/search-by-category/maricopa/>

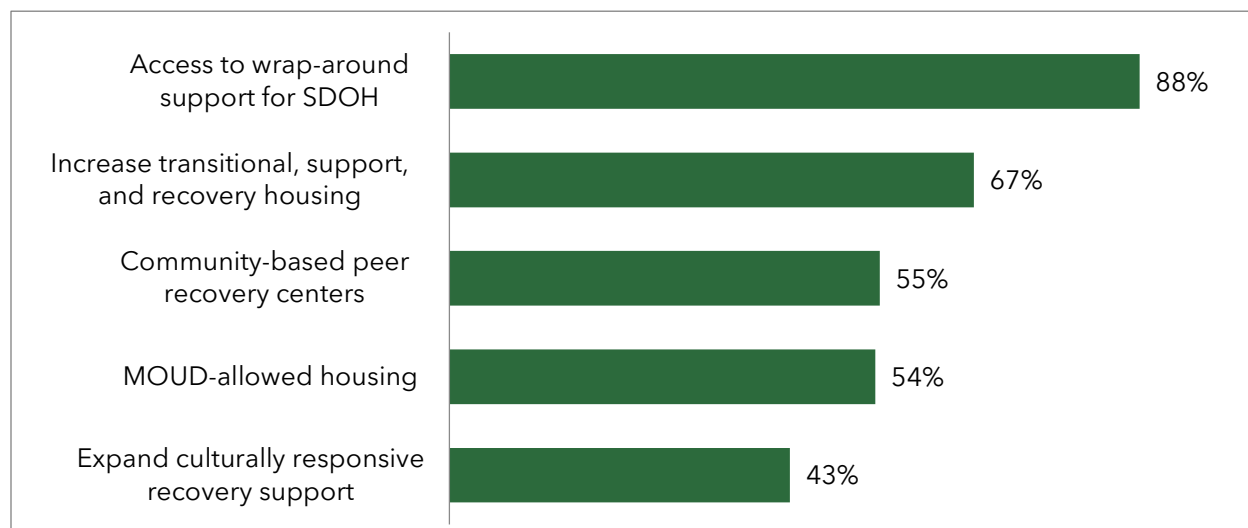
## Data and Evidence

**Trend and Outcome data.** Recovery providers mentioned using information about emerging drug concerns, opioid use trends, police reports, and suicide statistics from the National Alliance on Mental Illness. Others said that visualizing the information is helpful: “It would be nice to have data like heat maps on overdoses.” Some felt that more accurate recovery and outcome data would support providers in targeting their interventions. However, there is no consensus on “what recovery success looks like,” particularly given people’s various circumstances and the high relapse rates of OUD.

## Important to Fund

When providers were asked to identify the top barriers and concerns for recovery, most of the highest-ranking responses related to support for social determinants of health: housing and MOUD housing, financial support, transportation, and family and social support (see Exhibit 26). This theme was also reflected in providers’ selections for the top recovery strategies important to fund, with over half citing housing options, as well as a community-based peer recovery center for greater social support. About 43% of respondents also recommended expanding culturally responsive recovery support to meet the needs of populations disproportionately affected by OUD/SUD.

**Exhibit 26. Top 5 Recovery Strategies Identified as Most Important to Fund, E-Survey**



N=175

The situational analysis conducted by Advisory Committee members articulated that recovery effectiveness would result in decreased homelessness and improved connectedness, increased understanding about SUD among the general public, increased access to care for all demographics and longer-term care coverage, and increased trust in the SUD response system.

# Coordination and Continuum of Care Findings

## Overview

While aspects of care coordination between agencies and simultaneous care provision across types of interventions were discussed in the previous sections, this assessment's data collection highlighted the extent to which care coordination is an essential activity for OUD/SUD response outcomes. This section is organized by critical points along the care continuum, and explicitly outlines barriers and potential improvements to a coordinated OUD/SUD care response in Maricopa County.

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*"This mass of disconnected care delivery arrangements requires numerous patient interactions with different providers, organizations, and government agencies...which is a source of significant patient suffering."*

*- U.S. Institute of Medicine<sup>115</sup>*

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A continuum of care refers to a system in which a person is guided to different health and support services over time, ranging in intensity, and based on their comprehensive needs—including before, during, and after illness. Care coordination relies on provider communication and collaboration across institutions, which is negatively affected by role confusion and role conflict across provider systems, limited interdisciplinary standards for crisis response, segmented funding sources, and inconsistent data-sharing<sup>119,120</sup>.

Nearly all providers involved in this assessment underscored the importance of a continuum of care to support people's OUD/SUD treatment journeys, while also articulating key barriers to successful care integration or hand-offs. During the situational analysis exercise, providers said that OUD/SUD response activities are largely serving the same people, yet practitioners are divided by intervention field. Many of these divisions have structural roots: federal and state funding sources are often segmented by intervention or care type; the care system is complex and individual staff do not have the time or resources to learn all the options for navigating it; and role mandates vary for professionals in social services, behavioral health and

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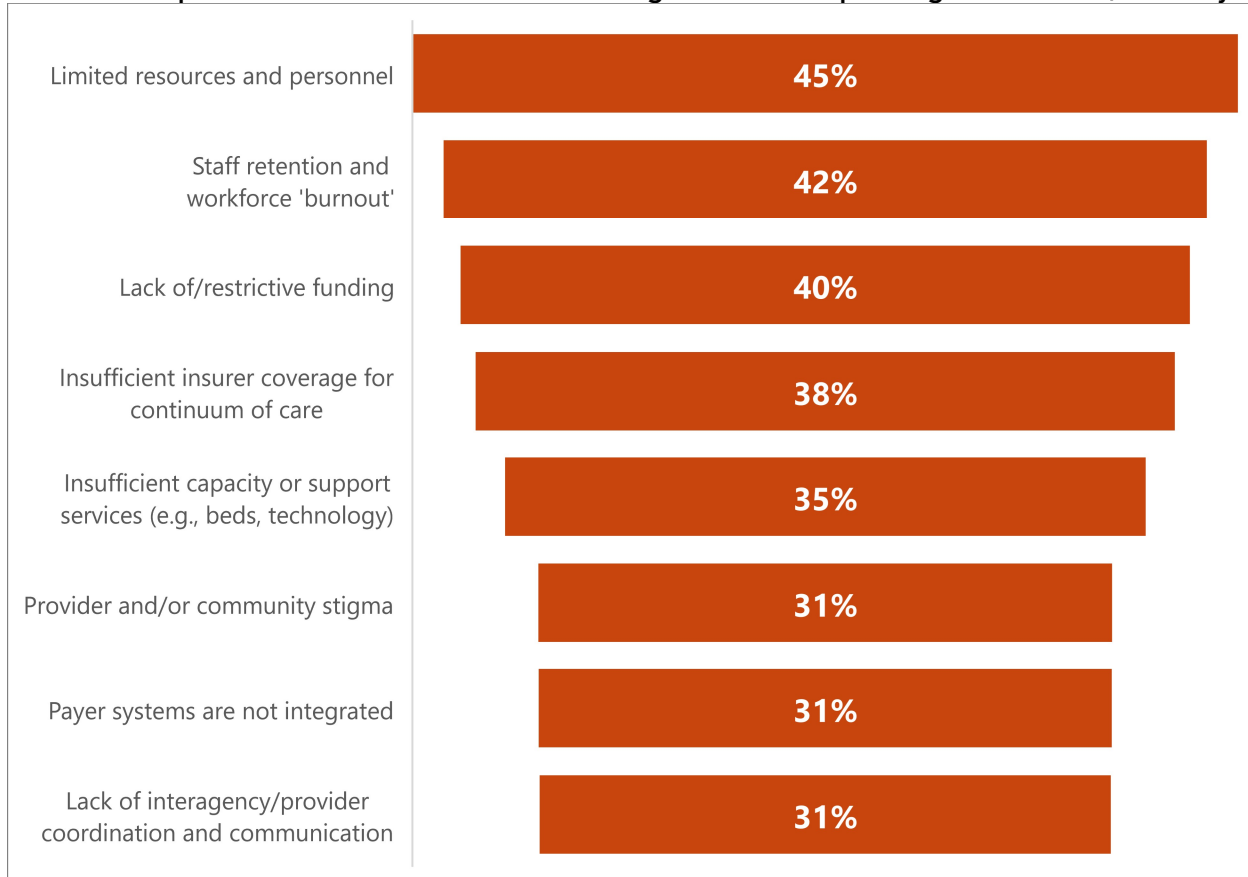
<sup>119</sup> Institute of Medicine, U.S. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. (2006.) *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington DC: National Academies Press.  
<https://www.ncbi.nlm.nih.gov/books/NBK19833/>

<sup>120</sup> Pinals, D. A. (2022). *Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders*. Technical Assistance Collaborative Paper No. 10. Alexandria, VA: National Association of State Mental Health Program Directors.  
[https://www.nasmhpd.org/sites/default/files/2022-11/Improving-Partnerships-and-Coordinated-Practices-between-Behavioral-Health-Police-and-other-First-Responders\\_NASMHPD-10.pdf](https://www.nasmhpd.org/sites/default/files/2022-11/Improving-Partnerships-and-Coordinated-Practices-between-Behavioral-Health-Police-and-other-First-Responders_NASMHPD-10.pdf)



public safety. As shown in Exhibit 27, among executive leaders at organizations involved in OUD/SUD services, over one-third said that insufficient Health Plan coverage for continuum of care was a “serious concern;” they also referenced limited resources, restrictive funding, disparate payer systems, and lack of interagency coordination – all of which inhibit smooth, timely transitions between services or providers.

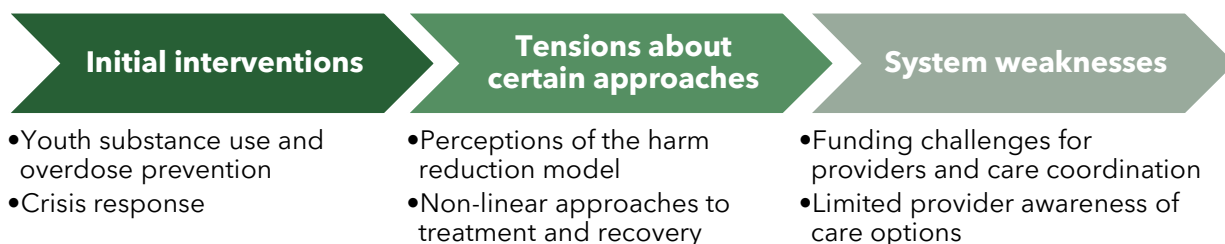
**Exhibit 27. Top Concerns of Executive Leaders at Organizations Responding to OUD/SUD, E-Survey**



N=56-95

Assessment participants identified critical junctures in coordinating OUD/SUD services and referrals. Key challenges in coordinating care are shown in Exhibit 28 and discussed in the sections below.

**Exhibit 28. Key Challenges in Offering Coordinated Care**



## Youth Substance Use and Overdose Prevention

Evidence-based programs that protect children and adolescents from the harms of substance use include positive youth development activities and skill-building, substance use prevention curricula, and education about overdoses and life-saving responses. Currently, different governmental agencies, coalitions, and organizations are involved in these different arenas and struggle with inter-agency coordination. School-based primary or secondary prevention efforts are contingent on state and local policies and school decision-makers, and the majority of community-based organizations said they faced difficulties gaining entry to these environments.

Stigma associated with people who use drugs, along with fears that talking about drugs would promote their use, were cited as primary reasons for community, medical, and parental resistance to holistic youth education about substance use and overdose prevention.

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*“Primary care, pediatricians, parents should all be having conversations – we should be teaching them how to have these conversations.”*

*- Listening Session participant*

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## Crisis Response

During a substance-related crisis or overdose situation, public safety officers such as fire and police departments are often called and respond with their emergency training. Yet, it is not first responders’ role to provide referral or counseling services, and their primary options are transporting the person to a hospital or jail and leaving them with one or two naloxone doses. Some first responder departments partner with the statewide community-based behavioral health crisis provider (Solari) to go on non-violent substance-related emergency calls, though community-based crisis response funding waxes and wanes with grant dollars. Statewide crisis response varies or providers may not be familiar with how to access crisis services covered by AHCCCS.<sup>121</sup>

After being revived from an opioid-involved overdose, a person with opioid dependence will experience acute withdrawal symptoms, such as nausea, agitation, headache, or tremors. Clinical care can mitigate this discomfort, and the emergency situation can prompt a willingness to accept treatment. However, any delay in this care due to lack of referral or health insurance prior authorization

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*“If they’re ready at that point today and there’s nothing available until tomorrow, and I have no place to place them, and then I go back to them tomorrow and they’re high, they don’t want to go.”*

*- Listening Session participant*

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<sup>121</sup> <https://www.azahcccs.gov/BehavioralHealth/ArizonaCrisisSystem.html>

requirements can close the “instant gateway” that the crisis opened for the person with OUD/SUD. Providers also noted a lack of a “bridge” between detox and other inpatient or outpatient services for people to continue in treatment care.

## **Perceptions of the Harm Reduction Model**

Listening sessions revealed uncertainty among some providers about the purposes and benefits of harm reduction services such as safer use supplies and naloxone. They were unsure if these methods “enabled” harmful substance use, rather than promoted health. Other providers articulated that preventing fatal overdoses is a worthy standalone goal, and that these actions are necessary to continue until a person wants to do something else.

Discussions of different viewpoints were respectful, and providers felt they were an opportunity to share and collaborate with one another. Still, divergent provider understanding of OUD/SUD interventions and a lack of shared goals can contribute to limits in service coordination and referrals.

## **Non-linear Approaches to Treatment and Recovery**

Discussions with providers revealed a tension between “old” and “new” approaches to OUD/SUD care. They said that “old” approaches view recovery as a linear process and treat the symptoms to avert the immediate crisis. As a result, state and federal governments direct funding to short-term treatment options with narrow benchmarks (such as recent days of sobriety) and do not support longer-term treatments like MAT for physical dependence on highly potent synthetic opioids. They noted that the “predictable, linear, medical model of disease” does not work for addressing substance use, as people need different types and lengths of care, different support services to enable access to care, and access to different forms of care at the same time (such as MOUD and naloxone, or MOUD and recovery housing).

A few providers drew parallels with physical health care assumptions, noting that payer systems seem to assume that treating OUD/SUD is akin to treating an acute issue such as a simple broken bone, which would likely involve the same linear treatment steps: X-rays, cast, physical therapy, full discharge. However, they remarked that OUD/SUD is more like a chronic disease without a cure, such as diabetes or heart disease, and that services depend on severity and needs at different points in time: health counseling, medications, surgery, medical devices, in-home care, etc.

The “new” model of care recognizes that recovery is an iterative process and multiple types of services are needed to support it. This approach also uses a harm reduction model, which recognizes that the individual may experience multiple relapses and may need many “second chances” to get well. They said the goal is no

longer complete abstinence, but keeping people alive and honoring smaller achievable goals. They emphasized that newer research shows that it takes longer to heal brain receptors and resolve comorbidities such as substance use, trauma, and other mental health diagnoses.

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*“All the science shows you cannot focus on a job and do task by task if your brain is still going through withdrawal. It does take two years for your dopamine receptors to heal and for trauma to get recovered. Funding says, ‘Sorry, we can’t pay for your housing, we can’t pay for your job search, we can’t give you food stamps.’”*

*- Listening Session participant*

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Finding: The interplay between harm reduction, abstinence from substances, treatment, relapse, and recovery is important for many people’s substance use journeys, and coordination for simultaneous services from different interventions is needed.

## Funding Challenges for Providers and Care Coordination

Funding was a pain point cited by all types of providers. Community-based and grassroots organizations that rely largely on grant and donation funding said that often feels like a “constant scramble to chase funding.” Short-term grants, and grants seeking to fund only new services rather than existing ones, were stressors on smaller organizations’ business models and sustainability. Providers stressed that funding is needed for longer-term treatment because the ability for individuals to stay in sober living homes while making the transition back into self-directed lives are essential for full recovery.

Organizations billing insurance companies for services stated that the seven different Health Plan payers in the state seem to have different authorization and billing regulations, which creates administrative challenges. These providers still require other sources of revenue to pay for uncovered services, which hinders their ability to scale. Further, organizations said they

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*“We put a lot of resources in the sprint, but this is a marathon.”*

*- Listening Session participant*

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have seen their costs increase, while the rates for billable services have not increased in proportion.

In an environment of limited or uncoordinated funding, limited personnel time is allocated to seeking appropriate referrals, supporting care transitions, or conducting “warm hand-offs” to the next level of care.

## Awareness of Providers along the Care Continuum

A profound display of provider interest in collaboration was attendance at listening sessions held for this needs assessment: many brought business cards or pamphlets to distribute, about half explained their organizational services to the group because others did not know about them, the discussion occasionally shifted into sharing resources with one another, and some provider staff attended multiple sessions to hear from even more providers.

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*“I just found out we have a methadone clinic in Buckeye, and we didn’t know it, the cops didn’t know it.”*

*- Listening Session participant*

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Maricopa County’s OUD/SUD response landscape is complex and evolving, and providers expressed interest in easier ways of knowing what organizations are doing, and what services are available and funded. This knowledge is important at the level of individual provider staff, since they are interacting directly with people needing care services, but it is also important to institutionalize this knowledge due to staff turnover and service changes.

Finding: Timely service access and coordination of care is hindered by inadequate resource and referral information, fragmented funding, and limited partnerships for crisis and care transitions.

## Actions to Support Care Coordination

Multiple providers engage in activities for the purpose of collaboration and continuity of care, such as cross-organizational outreach, creating resource and referral lists, and hiring care navigators. However, these are rarely mandated, sustained, or system-wide efforts. Thus, coordination across providers would be enabled by entities or information systems that can provide consistent benefit to multiple types of providers.

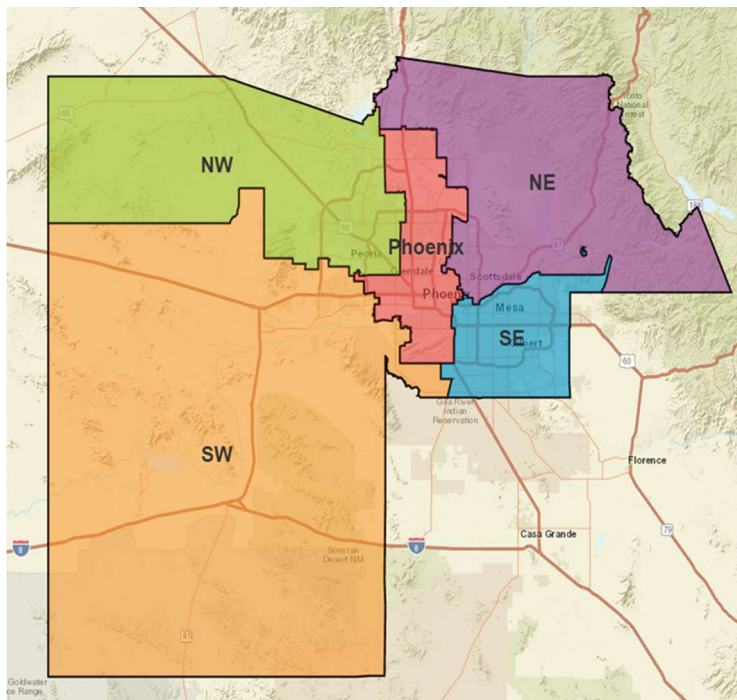
Assessment participants specifically mentioned City- or County-level leadership they would find useful to coordinating care:

- Provide updated data relevant to the OUD/SUD response;
- Facilitate provider convenings to enhance partnerships;
- Lead inter-agency collaboration for overdose crisis response strategies;
- Maintain updated resources about available services and their eligibility requirements; and;
- Require settlement funding grant applicants to demonstrate connections to at least one other intervention type.

# REGIONAL FINDINGS

This section supplements countywide findings by using provider survey and listening session data to highlight key themes from each of the county's five geographic regions as shown in Exhibit 29.

**Exhibit 29. Maricopa County Regions**



Northwest: Aguila, El Mirage, Glendale, Peoria, Surprise, Wickenburg, Youngtown

Northeast: Carefree, Cave Creek, Fountain Hills, Paradise Valley, Scottsdale

Central: Phoenix metro area

Southwest: Avondale, Buckeye, Gila Bend, Goodyear, Litchfield Park, Tolleson

Southeast: Apache Junction, Chandler, Gilbert, Guadalupe, Mesa, Tempe, Queen Creek

For data analysis for this section, organizations were classified into two major groups:

- 1) Community-based provider – which applies to any private or non-profit organization involved in prevention, treatment, harm reduction or recovery activities; and
- 2) Governmental – applies to any position that is funded by the City or County departments such as police, government employees, and public-school staff.



# Northwest Region

Aguila, El Mirage, Glendale, Peoria, Surprise, Wickenburg, Youngtown

## Overview

The Northwest region accounted for an average of 13.3% of the county's fatal overdoses from 2019 to 2021. Rates of fatal overdoses in the northwest region increased by about 20% during this time period. While most fatal overdoses in the northwest region are among white non-Hispanic decedents, the proportion of fatal overdoses among Hispanics increased by 92% from 2019 to 2021, signaling an important opportunity for prevention outreach.

In this region, limited primary prevention education, as well as limited naloxone education and access, were largely attributed to resistance from schools and community stigma. Challenges with housing and transportation were frequently mentioned as barriers to accessing treatment and recovery care for opioid and other substance use. Providers said that more support for social determinants of health, school-based efforts, and centralized information about drug trends and resources would help the OUD/SUD response in the Northwest region.

A total of **26 providers** (21 community-based, 5 government) completed the online survey, and **26 people from 22 organizations** (11 community-based, 11 governmental) participated in listening sessions. Key themes from this data collection are summarized in Exhibit 30.

## Exhibit 30. Summary of Themes about OUD/SUD Response in the Northwest Region

### Social Determinants and Equity

- **Unstable housing:** Meeting housing and other basic needs was cited as a barrier to OUD/SUD interventions across NW cities and towns.
- **Need for transportation to services:** Limited localized treatment options for adolescents, young adults aged 18-24, and family-involved services require travelling to other cities for care.

### Systems and Policies

- **Reluctance for prevention and early intervention in schools:** Practitioners felt resistance from parents and schools for OUD/SUD prevention and naloxone training.
- **Health insurance does not cover full continuum of care:** Service limits hinder appropriate care services and durations.
- **Funding challenges for smaller organizations:** Without professional grant-writers or evaluators, smaller organizations face barriers in applying for grants or paying for larger-scale evidence-based programs.

### Provider Partnerships and Capacity

- **Limited naloxone education and access for providers and teachers:** Lack of awareness about how to obtain, use, and store naloxone.
- **Lack of youth treatment for mental health and OUD/SUD:** No inpatient facility for youth in the Northwest Valley, so travel to other cities is required but this creates transportation difficulties; youth aged 18-24 do not have many treatment options.
- **Resource and referral information:** Providers are interested in an online directory of organizations' OUD/SUD services to make referrals and allow for networking.

### Data and Evidence

- **Drug trend data:** Providers expressed interest in identifying geographic areas where drug overdoses were rising, and what drugs were involved to be able to apply resources and respond in that area.
- **Impact data:** Providers are interested in knowing if their activities are making a difference.

## Prevention

Similar to the responses from across Maricopa County, Northwest providers stressed the importance of school-based prevention efforts, but felt they faced more barriers to gain acceptance and entry into schools for both primary prevention and early intervention/harm reduction education. They attributed this largely to stigma from parents, school decision-makers, and the community at large. To a slightly greater degree than the rest of the county (60% vs 54%), Northwest

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*"Parents can also be dismissive of the problem – they don't know something is wrong until there is an issue."*

*- NW Listening Session participant*

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providers rated targeted media campaigns as “important to fund,” to encourage broader awareness of and willingness to address substance use issues.

## Harm Reduction

Access to harm reduction supplies and education, particularly naloxone, was cited as limited. Providers felt that teachers and other providers did not have adequate information about how to obtain, use, and store naloxone. Fear of law enforcement, stigma, and lack of risk awareness were regularly described as limiting harm reduction services.

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*“We have to get the boards on board with supporting the schools [to deliver Narcan trainings]. It's a district by district struggle.”*

*- NW Listening Session participant*

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Similar to other regions, during the listening sessions, two distinct schools of thought about the harm reduction approach emerged, with one stance advocating for the foremost importance of saving lives, and another stance proposing that harm reduction services continue to enable substance use. One provider articulated this as a tension with the Stages of Change model, which is often used in health fields as a way of conceptualizing increased readiness for behavior change:

“To get someone from ‘pre-contemplation’ to the ‘contemplative’ stage, the Stages of Change model says ‘crisis.’ But the thing is, once that’s your lifestyle, homelessness is not a crisis, losing family is not a crisis, because they’ve already been through that. Well, we’re eliminating those other crises that would push them into the contemplative stage of change. I understand wanting to save lives, but at the same time, if you remove every barrier for someone to get help, for someone to continue living their lifestyle, that’s what they’re going to do.”

While another noted, “Not everyone is ready for treatment – it’s meeting them where they are. These are the resources we have when you’re ready.”

In the context of Opioid Settlement funding and planning, this tension underscores the importance of regional decision-makers and fund distributors to articulate clear goals for the OUD/SUD response.

## Treatment

When asked about OUD/SUD treatment barriers, providers noted that “there is a mental health crisis among youth,” yet felt that in the Northwest Valley there are limited inpatient facilities for youth, which creates transportation barriers to access care in other cities. Providers also felt there were limited services for young adults aged 18-24, and for family-involvement in care. Transportation to programs was also cited as a key obstacle to treatment access, along with not having basic needs met through housing and health insurance.

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*“Not everybody has transportation to get to the programs. So as far as access goes, transportation is something that's a struggle.”*

*- NW Listening Session participant*

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As is the case for providers across the county, Northwest providers shared pain points about limited Health Plan coverage for detox time and treatment duration. They stressed that treatment does not always “go in one direction,” and people may need to return to inpatient services from outpatient ones. They did not feel there is adequate insurance funding for appropriate level of care and relapses.

## Recovery

Recovery barriers cited by Northwest providers aligned with those noted for treatment: unstable housing, lack of transportation, lack of family/social support, and prohibitive financial costs of services. Housing difficulties for people using MAT/MOUD was also mentioned, as many sober living facilities do not allow prescriptions for methadone or buprenorphine.

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*“Without housing, without basic needs – you can't stabilize anybody.”*

*- NW Listening Session participant*

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Additionally, providers felt more credentialed peer support specialists and care navigators were needed to support the recovery phase(s) of people’s OUD/SUD journeys. They stressed that being able to provide “lived cultural experience... for all the underserved populations throughout these areas” is important for connecting with those disproportionately affected by opioid and other substance use.

## Coordination and Continuum of Care

In addition to feeling that transitioning between level of care and corresponding billable services was not adequately covered by Health Plans, providers said greater awareness of and networking between “all the players who are part of the solution” was needed. Primary improvements for coordinating OUD/SUD responses involved more opportunities for providers to be visible to one another through an online directory of care resources.

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*“We need to educate people about the importance of the continuum of care. AHCCCS needs to pay for the whole continuum of care.”*

*- NW Listening Session participant*

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To more rapidly allocate resources and response efforts, providers were interested in a centralized database that showed geographic areas where overdose deaths were rising, and what substances contributed to them. Providers also indicated an interest in data to support their efforts to treat clients and prevent overdose deaths—including understanding if their efforts were having a long-term impact.

Funding was noted as a challenge for smaller organizations that do not have the professional staff needed to acquire and administer grants. They felt this could be improved through support for grant writers and evaluators, as well as easing the process for becoming an AHCCCS provider.

# Northeast Region

Carefree, Cave Creek, Fountain Hills, Paradise Valley, Scottsdale

## Overview

The Northeast region accounted for the least fatal overdoses in the county, with an average of 5.1% of the county's fatal overdoses from 2019 to 2021. The rate of fatal overdoses in the northeast region increased by 15.1% during this time period, though the actual proportion of county overdose deaths decreased. The proportion of fatal overdoses involving benzodiazepines, which can increase one's risk for an overdose when combined with opioids, was higher in the northeastern region in comparison with the other county regions.

In this region, providers focused on the need for broad and consistent education about opioids and other substances, data about the scope of the problem, and cross-provider coordination for services. Disparate attitudes, awareness levels, and stigma were social factors that participants said negatively affected the OUD/SUD response in this region. At a structural level, they felt that youth secondary prevention and harm reduction services were lacking, and that access to treatment services was hindered by limited wraparound support. Providers proposed more coordinated efforts across various OUD/SUD interventions, organizations, and overdose data as ways to strengthen the accessibility and continuum of care in this region.

A majority of Northeast organizations participating in the assessment were from government agencies. A total of **60 providers** (16 community-based, 44 government) completed the online survey, and **18 people from 8 organizations** (2 community-based, 6 governmental) participated in listening sessions. Key themes from this data collection are summarized in Exhibit 31.

## Exhibit 31. Summary of Themes about OUD/SUD Response in the Northeast Region

### Social Determinants and Equity

- **Stigma from community, schools, parents, and providers:** Negative perceptions or denial about substance use, mental health, and harm reduction ranked high as a barrier to all types of OUD/SUD interventions.
- **Limited housing, transportation, and wrap-around services to support care:** Youth, treatment, and recovery providers felt that greater and longer-term support was needed for people to fully access care services.

### Systems and Policies

- **Zero tolerance policies discourage disclosure of drug use:** Fear of losing services, children, or jobs was cited as a barrier to accessing services.
- **Funding challenges:** Organizations noted that health insurance and grants do not cover the full cost of care; smaller organizations face difficulties applying for grants.

### Provider Partnerships and Capacity

- **Confusion about naloxone access and role in OUD response:** Providers noted mixed messages about how individuals could get naloxone, and perceptions that it "enabled" substance use.
- **Limited awareness of care services within provider community:** Greater care and referral coordination was highlighted as a need among providers.
- **Resource and referral information:** Providers are interested in an online list of available resources to quickly connect people to services.

### Data and Evidence

- **Drug trend data:** Providers expressed interest in better understanding the scope of substance-related harms.

## Prevention

Similar to the responses from across Maricopa County, Northeast providers stressed the importance of school-based prevention efforts and felt these should be approached in tandem with youth mental health care and family education. Some listening session participants felt there was a “let’s hide it” mentality in the region (and particularly in Scottsdale), which led to escalating mental health

crises and substance use harms among young people. A bit more so than other regions, over half of survey respondents (56%) noted juvenile justice settings as highly important for early intervention programs, in addition to K-12 schools (78%).

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*“We need education about fentanyl in schools and to normalize people talking about it.”*

*- NE Listening Session participant*

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## Harm Reduction

Lack of awareness about or denial of substance risk was cited as a top barrier for harm reduction services, along with limited services. Providers felt that their community did not know how to access harm reduction, did not have social support to do so, and were afraid of law enforcement. Participants agreed that more education about fentanyl's variability, potency, and prevalence is needed to reduce overdose deaths.

Regarding naloxone access, participants said communication about it is

"mysterious" and how to obtain it is "murky." Individuals can only obtain it free through other organizations, and providers say they face resistance when distributing it due to perceptions of "enabling" substance use and using

naloxone as a "crutch." This perception about harm reduction approaches was echoed throughout the county, and calls for greater clarity about different providers' roles in mitigating harms from opioid and other substance use emerged.

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*"The worst feeling in the world is not having naloxone...seeing somebody who's dying in front of you...we need to get it in everyone's hands."*

*- NE Listening Session participant*

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Some first responders shared about repeat overdoses with the same people, and frustrations about not getting at the root cause. This highlights a disconnect between public safety departments and community-based service providers in terms of roles, hand-offs for care, and shared measures of success in responding to OUD/SUD.

## Treatment

The most frequently mentioned barriers to treatment revolved around social determinants of health: lack of housing, transportation, and insurance. Similar to other regions, providers expressed pain points with Health Plan coverage, saying that it limits people's options for care. Related to this dynamic, they also said

that some providers are unwilling to prescribe methadone or buprenorphine if they are not sure patients will be able to continue to access it. This echoes discussions across the County about the need for longer-term coverage for OUD/SUD care services. Another key barrier noted was lack of awareness among providers about treatment and mental health services, due to limited coordination and stigma.

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*"As a physician in Scottsdale, we don't necessarily know. We have a feeling that there are some services that are available, but we wouldn't know if they're widely available or not, what their capacity is, or what's the demand."*

*- NE Listening Session participant*

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Providers said that “zero tolerance” policies from DCS, treatment programs, and employers are barriers to people disclosing that they are using substances, as they fear losing services, children, and jobs. They also noted that there are few treatment facilities that serve people experiencing homelessness.

## Recovery

To a higher degree than the county as a whole, Northeast providers felt that lack of social or family support hindered people’s recovery efforts. This could relate to the community stigma cited with OUD/SUD interventions in general, perhaps compounded when families are not involved in care services.

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*“The perception is that someone is ‘cured’ rather than in recovery.”*

*- NE Listening Session participant*

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Recovery strategies important to fund aligned with other regions: wrap-around support for social determinants of health, housing, and a community-based peer recovery center. Providers felt that youth recovery was particularly fraught, as the youth return to the same home and school environment, and that more follow-up services would be beneficial for recovery maintenance.

## Coordination and Continuum of Care

There was general consensus among participants that greater coordination of substance-related education, awareness, and services was needed to develop the region’s care continuum. Actions to support this were marketing campaigns that reduce stigma and normalize substance use issues, data to better define the problem, and an easily accessible list of available resources.

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*“Connecting the dots between people providing care to people with little-to-no means is our biggest challenge.”*

*- NE Listening Session participant*

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Listening session participants expressed frustration with grant funding, saying that the process is tedious, has numerous requirements, takes a long time to begin the contract, and does not cover true expenses like staff pay increases, transportation, or childcare. Grant funding was particularly difficult for smaller organizations that do not have the professional staff needed to acquire and administer grants.

# Central Region

Phoenix metro area

## Overview

The Central region drives countywide fatal overdose patterns, accounting for an average of 49% of the county's fatal overdoses from 2019 to 2021. When factoring in the population size of the Central region, this region also had the highest fatal overdose rate of all the county regions. The rate of fatal overdoses in the Central region increased by 39% during this time period. The proportion of overdose deaths among known people experiencing homelessness is also higher in the Central region compared to other county regions; in 2020, a quarter of the overdose deaths in the Central region were among people experiencing homelessness. Methamphetamines were involved in more fatal overdoses in the Central region than countywide.

In this region, providers noted various structural and coordination barriers to delivering care services. Challenges with housing, Health Plan limits, and care coordination were frequently mentioned as barriers to accessing treatment and recovery care for opioid and other substance use. Providers said that more support for social determinants of health, school-based and youth services, specialty services for specific populations, and a centralized service resource database would help the OUD/SUD response in the Central region.

A total of **267 providers** (161 community-based, 104 government, 2 other) completed the online survey, and **27 people from 15 organizations** (10 community-based, 5 governmental) participated in listening sessions. Key themes from this data collection are summarized in Exhibit 32.

## Exhibit 32. Summary of Themes about OUD/SUD Response in the Central Region

### Social Determinants and Equity

- **Unstable housing:** Meeting housing and other basic needs was cited as a key barrier to OUD/SUD interventions and people's ability to engage in care.
- **Need for specialty services to support specific populations:** Providers wanted to see more service options for LGBTQ youth and youth of color, women and families, and people leaving incarceration.

### Systems and Policies

- **Unclear policies for prevention and early intervention in schools:** Providers faced different interpretations of state policies at different schools, which limited programming options.
- **Health insurance limits care duration:** Service limits hinder longer stays in treatment facilities and recovery housing.

### Provider Partnerships and Capacity

- **Limited resources for coordinating care across providers:** Practitioners wanted to see greater collaboration among emergency responders, community-based organizations, and probation to limit gaps in services.
- **Integration of harm reduction into care transitions:** To prevent deaths, many providers felt it was important to increase awareness of and access to harm reduction supplies during care, during transitions from one environment to another, and at street outreach.
- **Resource and referral information:** Providers are interested in an online directory with real-time information about organizations' OUD/SUD services to make referrals.

### Data and Evidence

- **Impact data:** Some providers expressed an interest in more consistent tracking for outcomes and funding deliverables.

## Prevention

Similar to the responses from across Maricopa County, Central providers stressed the importance of school-based prevention efforts, but felt that funding and support for them had decreased. Providers reported inconsistencies in what programs and services different schools would allow on their campuses, and confusion about related Department of Education (DOE) regulations. At the same time, they noted that schools are often where mental health and substance use problems manifest: “that’s where they’re needing these supports, there’s suicides, attempted suicides, vaping, but they’re putting

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*“When I first started in the field, there were several good prevention programs in the elementary schools, high schools – I don’t know what happened to them all.”*

*- Central Listening Session participant*

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a lock on what schools can and cannot do.” Some felt that community and parents strongly influenced what substance use education schools allowed.

When asked what strategies were important to fund, early intervention was recommended by 83% of survey respondents. Responding to questions about prevention, listening session participants also spoke to “overdose prevention” and naloxone access at schools, highlighting the way that multiple types of programs are deployed simultaneously with the same population to reduce substance-related harms.

## Harm Reduction

To a greater degree than the rest of the county (75% vs 63%), Central region providers saw stigma as a top barrier to harm reduction services; more than half also cited fear of law enforcement and not knowing how to access harm reduction services as barriers. A majority of survey respondents felt that integrating harm reduction into treatment and recovery services was an important strategy to fund, as it is a way to “meet people where they are” during critical transition times.

More than two-thirds of survey respondents indicated that increased access for harm reduction supplies and naloxone was important to fund, and some listening session participants

proposed making them as “low barrier” as possible, such as through a vending machine, or having kits available at schools and tent encampments.

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*“A lot of the folks we serve are unhoused and asking these people to walk anywhere for services is harmful and violent.”*

*- Central Listening Session participant*

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## Treatment

Providers repeatedly talked about the importance of basic needs – such as housing, utilities assistance, transportation, and food – before a person is ready to address a substance use problem. Unstable housing was cited as the top barrier to treatment by 58% of respondents on

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*“All of our residents are in low income or affordable housing. Because of the crime-free addendum, people are reluctant to admit to their drug use because they’re fearful they’ll lose their housing.”*

*- Central Listening Session participant*

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the provider survey, and discussions revealed that housing, income, and legal pressures can limit people’s engagement with care systems. “Housing first” approaches seek to stabilize people as they engage in other types of care, but providers said that Housing and Urban Development (HUD)-funded housing disqualifies people for drug use offenses, which further exacerbates homelessness and people’s substance use.

Consistent with providers across the county, Central region providers shared pain points about limited Health Plan coverage for inpatient stays and treatment duration. Some listening session participants identified as being in recovery, and spoke about the stress of trying to get their lives back together while only having housing and other wrap-around support covered for 28 days. Most providers felt that the general public perception was that people should get treatment and be “healed” within 30 to 90 days, but said that the reality – particularly with highly addictive opioids – is that it takes a year or more. Thus, expanded support for wrap-around services was recommended by a majority of survey-takers, and nearly half (47%) said that linkages to recovery are also important to fund.

Central providers spoke more about specific specialty services than other regions, noting a need for treatment facilities to serve: LGBTQ youth and youth of color, women and families, as well as people in or leaving jail.

## Recovery

Recovery barriers cited by Central region providers aligned with those noted for treatment: unstable housing, lack of transportation, lack of family/social support, and prohibitive financial costs of services.

Housing also ranked in the top recovery strategies to fund, with 91% endorsing wrap-

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*“The housing crisis has displaced a lot of people, and programs have dropped off.”*

*- Central Listening Session participant*

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around support for social determinants of health, 71% specifically said housing, and 55% noted MOUD housing that permits prescribed treatment medications. Additionally, 61% felt a community-based peer recovery center was important to fund, as it would create a safe space for ongoing social support.

Some felt that there are different perceptions among providers about what “recovery” means, saying the “norm is that recovery equals abstinence,” but that this does not always “honor people’s goals.” This variation about what qualifies as recovery is important as it relates to covered care services, program qualification criteria, and inter-agency collaboration.

Additionally, they expressed interest in identifying and being accountable to service outcomes or deliverables, and being able to report on this impact data.

## Coordination and Continuum of Care

Providers saw coordinating step-down, step-up, or additional care services as a serious barrier to the continuity and success of OUD/SUD responses. They expressed interest in more coordination between first responders and community-based providers in handling the initial response to an overdose, better referral processes to get someone to available care, and strong

re-entry programs to support people leaving incarceration in building social and independent living skills.

Listening session participants proposed a centralized services database to facilitate care coordination, which would reduce the time staff spend trying to contact other organizations and vet recovery homes for eligibility and legitimacy. They noted that such a resource would support all types of providers and strengthen the region's response system as a whole.

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*"That would be something, to have a central place where we can understand what resources are available in real time. That would help a lot."*

*- Central Listening Session participant*

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## Southwest Region

Avondale, Buckeye, Gila Bend, Goodyear, Litchfield Park, Tolleson

### Overview

The Southwest region accounted for an average of 6.3% of the county's fatal overdoses from 2019 to 2021, though the rate of fatal overdoses in the southwest region increased by 40.7% during this time period, the largest increase of all the regions. A higher proportion of Hispanics accounted for fatal overdoses in the Southwest region than countywide.

In this region, providers mentioned stigma as a cause of resistance across all types of OUD/SUD interventions, and they expressed the need for more common community education about the severity of opioid-related problems and the services available. Providers agreed that there were limited local treatment facilities, including ones that support gender-specific care and offer childcare, as well as a lack of transportation to reach treatment in other cities. In addition, providers acknowledged that they are not fully aware of all the regional service resources that do exist, and felt that more provider convenings and accessible resource lists would be useful to increase collaboration.

A total of **24 providers** (10 community-based, 14 governmental) completed the online survey, and **19 people from 15 organizations** (10 community-based, 5 governmental) participated in listening sessions. Key themes from this data collection are summarized in Exhibit 33.

## Exhibit 33. Summary of Themes about OUD/SUD Response in the Southwest Region

### Social Determinants and Equity

- **Unstable housing** Meeting housing and other basic needs was cited as a key barrier to OUD/SUD interventions and people's ability to engage in treatment and recovery.
- **People experiencing homelessness:** Access to OUD/SUD and co-occurring mental health services is a challenge.

### Systems and Policies

- **Prevention and early intervention in schools hindered by stigma:** Providers faced difficulties bringing curricula and materials to schools due to administrator and parental perceptions.
- **Confusion about naloxone access:** Providers felt access was impeded by administrative barriers for community-based organizations to distribute naloxone, and confusion about naloxone availability and cost at pharmacies.

### Provider Partnerships and Capacity

- **Lack of specialty treatment facilities:** Lack of gender-specific and family care means that people have to travel longer distances to receive care in another city.
- **Lack of peer recovery support services:** Providers noted a greater need for peer support services due to this region's large geographic area.
- **Resource and referral information:** Providers are interested in an online database of available resources to quickly connect people to services.

### Data and Evidence

- **Drug trend data:** Providers felt that some barriers to interventions were due to a lack of awareness about the scope of substance-related harms.

## Prevention

Similar to the responses from across Maricopa County, Southwest providers stressed the importance of school-based prevention efforts, including early intervention. However, organizations providing substance use education said that the programming that is allowed varies heavily by school and hinges on decision-makers' perceptions of risk and how parents would react to prevention programs. Some youth providers felt that school or community resistance to substance use education and naloxone access was related to a lack of awareness about drug trends and harms in their geographic area.

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*"Part of the key to prevention is breaking the stigma. Most people in general probably associate this with a homelessness issue, which it's not."*

*- SW Listening Session participant*

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While multiple providers felt it was "more realistic" to blend primary prevention and harm reduction education for overdose prevention, they noted that funders will often not allow the two strategies to be used together.

## Harm Reduction

When asked about harm reduction approaches, this region's listening session participants largely focused on naloxone access, crisis response, as well as greater community-wide awareness about fentanyl, addiction, and care services. They felt that targeted media campaigns could reach certain audiences, while street outreach could reach others.

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*"This whole crisis is bigger than it's ever been; it's getting worse. [The need for] education out there is huge."*

*- SW Listening Session participant*

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They noted that there is still confusion about where to get naloxone and its cost at a pharmacy.

Organizations that have contracts with ADHS can obtain naloxone for free, and felt that partnerships with schools, cooling stations, and street outreach facilitate distributing it to those that need it.

Though they also mentioned that the "target audience" for naloxone is not the person using opioids, but their family and friends.

## Treatment

Similar to other regions, unstable housing was frequently cited as a barrier to engaging in or completing treatment services. Providers also noted the challenge of health plan preauthorization requirements so that "when people are ready for care, they can get it immediately."

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*"Without having basic needs met, it's hard to stay sober when you feel despair."*

*- SW Listening Session participant*

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When discussing treatment, the theme of stigma around substance use, treatment, and MAT was cited as a foundational barrier to knowing about and accessing care services. Providers also mentioned that the Southwest region lacks treatment facilities, including ones that offer gender-specific and family care. They said people have to travel longer distances to get care in another city.

## Recovery

Providers strongly connected recovery outcomes to social determinants of health. They said people need support with food, housing, and clean clothes for their families in order to feel capable of being healthy. They also noted that maintaining sobriety requires support networks, whether virtual or in-person. Particularly with this region's large geographic span, providers felt that increasing peer support specialists could support longer-term recovery.

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*"I think people need something to do... So a community type center where they could go to where they could be engaged in things outside of treatment and that help move them towards independence, that will help with their sobriety as well as possibly lessen homelessness from being unemployed."*

*- SW Listening Session participant*

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They felt that support for social determinants of health, along with MAT/MOUD housing and a community-based peer recovery center could improve recovery outcomes.

## Coordination and Continuum of Care

Participants expressed wanting a way to share resources between community-based providers, first responders, and individuals receiving services. First responders mentioned that they are aware of frequent overdose sites, but do not have a way of sharing this information with other providers that could do more to address it.

Similar to other regions, they proposed a centralized, easily accessible list of resources that includes locations other than emergency rooms where people in crisis can go—including cooling stations and food distribution sites. Some providers wondered if resources could be organized on a mobile application that would recommend providers based on a person's symptoms or situation.

## Southeast Region

Apache Junction, Chandler, Gilbert, Guadalupe, Mesa, Tempe, Queen Creek

### Overview

The Southeast region accounted for an average of 23.1% of the county's fatal overdoses from 2019 to 2021. The rate of fatal overdoses in the southeast region increased by 30.4% during this time period.

In this region, providers talked about a tension between “old” and “new” ways of addressing substance use, treatment, and recovery: they felt that barriers to OUD/SUD care hinged on limited, linear services that focus on the symptom rather than the cause, and that do not acknowledge the long-term nature of treatment and recovery. These barriers manifested in limited insurer/grant coverage for care services, resistance to naloxone distribution, and few local treatment services for youth populations. Providers said that greater support for the continuum of care, and greater public support for naloxone and youth-focused efforts would help the OUD/SUD response in the Southeast region.

A total of **116 providers** (64 community-based, 50 governmental, 2 other) completed the online survey, and **34 people from 21 organizations** (11 community-based, 10 governmental) participated in listening sessions. Key themes from this data collection are summarized in Exhibit 34.

## Exhibit 34. Summary of Themes about OUD/SUD Response in the Southeast Region

### Social Determinants and Equity

- **Limited transportation hinders care access:** Some types of treatment and recovery services are located in other cities and regions, and transportation to get there is a challenge.
- **People experiencing homelessness:** Access to OUD/SUD and co-occurring mental health services is a challenge.

### Systems and Policies

- **Prevention and early intervention in schools is important for overdose prevention:** Participants stressed the need for mental health support at younger ages.
- **Funding challenges:** Organizations noted that health insurance, and federal and state grants do not cover the full cost of care; smaller organizations face fiscal management difficulties for grant funding.

### Provider Partnerships and Capacity

- **Naloxone distribution is controversial:** Providers faced resistance to naloxone distribution in schools, to high risk populations, and to the general public.
- **Lack of youth treatment facilities:** Providers felt there are limited facilities in the region to place adolescents under age 18 for OUD/SUD or trauma treatment.
- **Resource and referral information:** Providers are interested in an online database of available resources to quickly connect people to services.

### Data and Evidence

- **Drug trend data:** Providers expressed interest in better understanding overdose rates.

## Prevention

Similar to the responses from across Maricopa County, Southeast providers stressed the importance of school-based prevention efforts, and felt these should be approached in tandem with youth mental health care and family education. To a greater extent than other regions, almost all survey respondents (93%) cited improving early intervention efforts as an important strategy to fund. Listening session discussions showed that in practice, providers see primary prevention programs, naloxone education, and mental health interventions as ideally occurring in the same place with the same population in order to prevent fatal overdoses and other substance use harms.

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*"Adolescent trauma counseling is very much lacking."*

*- SE Listening Session participant*

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## Harm Reduction

During listening sessions, differing views about harm reduction approaches emerged, particularly around naloxone distribution and use. Providers said that free distribution of naloxone was controversial, and some expressed ambivalence about its repeated use: “I’ve given this person Narcan six times. Why am I even bothering with this person?” While others stated that more than “second chances” are needed, as it can take multiple relapses to recover from addiction, and that the ultimate goal is to “help people not to die.”

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*“The diabetic who keeps overeating sugar still gets as much care as they need, but an addict who overdoses and uses Narcan multiple times is judged and people want to limit access. More education and attitude change are needed.”*

*- SE Listening Session participant*

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Fear of law enforcement, lack of available services, stigma, lack of risk awareness, and lack of social support were cited as the top barriers to harm reduction services by Southeast provider survey respondents. About half (53%) also felt it was important to integrate harm reduction services into treatment and recovery programs.

## Treatment

When asked about OUD/SUD treatment barriers, providers felt that the region has limited facilities for substance use and trauma treatment for youth under age 18. Providers said that high staff turnover causes organizations to be hesitant about starting services in the area. They referenced people needing to travel to Mesa or Phoenix to get MAT, and noted the absence of a crisis drop-in facility in the far East Valley for mental health or substance use interventions.

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*“Transportation can be a real barrier to services because nothing comes out this far to pick people up and take them where they need to go.”*

*- SE Listening Session participant*

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Similar to providers across the County, providers in the Southeast shared pain points about limited Health Plan coverage for detox time and treatment duration, and said they never get fully reimbursed from insurance plans due to claims denials: “It takes a lot of time and energy to try to get that reimbursement.” Participants advocated for funding that covers at least a year in a treatment facility to allow healing from trauma and substance-related brain changes. Smaller organizations in the region noted they had to rely on private donations because “grant money tends to go to bigger non-profits.”



## Recovery

Recovery barriers cited by Southeast providers aligned with those noted for treatment: lack of support for social determinants of health including housing, transportation, costs of care, and family/social support. Some providers expressed that federal and state funding expectations for quick 90-day transitions from recovery to reintegration into the workforce and stable lives were unreasonable, and do not allow for the wrap-around recovery care that people need.

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*“Funding benchmarks don’t allow us to do what we need to do for the goal of long-term recovery.”*

*- SE Listening Session participant*

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They felt that support for social determinants of health, along with MAT/MOUD housing and a community-based peer recovery center could improve recovery outcomes.

## Coordination and Continuum of Care

Providers felt a breakdown in the continuum of care started with the initial emergency response to overdoses, as they perceived that fire and police departments are not adequately equipped to make care transitions or handle relapses.

They felt that on-call and post-overdose response teams better positioned to make immediate care connections would be beneficial.

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*“There has to be some kind of warm hand-off where you’re actually physically getting them from Point A to Point B, versus ‘show up in two weeks and good luck to you.’”*

*- SE Listening Session participant*

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Another area of weakness discussed was the transition from a detox facility to outpatient treatment, as a delay to start follow-up services can cause people to feel unsafe or unable to cope, and limit their participation in subsequent treatment services.

# CONCLUSIONS AND RECOMMENDATIONS

This needs assessment was conducted to improve understanding of the response system to opioid and other substance use across Maricopa County, with the purpose of informing community, health, and governmental organizations about gaps and improvements in the system of care for opioid and other substance use.

## Key Findings

High-level findings that speak to critical issues in the OUD/SUD response and care continuum throughout Maricopa County are shown below in Exhibit 35.

**Exhibit 35. Key Findings from Needs Assessment**

System-level	1. High and varied potency of illicit drugs necessitate a rapid, coordinated, and multi-pronged response.
	2. Timely service access and coordination of care is hindered by inadequate resource and referral information, fragmented funding, and limited partnerships for crisis and care transitions.
	3. Greater support for housing, transportation, justice-system transitions, and populations with health disparities is needed for positive care outcomes.
	4. Common metrics for substance-related harms, service utilization, and outcomes would support organizational partnerships and activities, and facilitate public health monitoring of the response.
	5. Stigma associated with people who use drugs hinders organizations providing OUD/SUD interventions, as well as individuals' access to care.
Intervention-level	6. Primary prevention and early intervention to reduce harms to youth are limited by funding restrictions and school policies.
	7. Providing safer substance use services only became legal in Arizona within the past 3 years, and organizations providing them need infrastructure support and development to meet harm reduction demands.
	8. Health insurance authorization and coverage restrictions cause delays and limitations for treatment and recovery services.
	9. Social support is essential for maintaining recovery from opioid and other substance use.
	10. The interplay between harm reduction, abstinence from substances, treatment, relapse, and recovery is important for many people's substance use journeys, and coordination for simultaneous services from various interventions is needed.

More details about these findings are below.

## System-level findings

System-level findings relate to factors that affect the entire OUD/SUD response system; they affect all intervention areas and the continuum of care.

- 1. High and varied potency of illicit drugs necessitate a rapid, coordinated, and multi-pronged response.**

Deaths from opioids and other substances have been rising in Maricopa County for the past 10 years due to potent fentanyl that can be found in many other substances and only detected through testing. This creates two types of crises: overdoses through experimental or casual use, and rising rates of opioid addiction among people who regularly use drugs. These crises touch various institutional systems and call for an interdisciplinary response.

- 2. Timely service access and coordination of care is hindered by inadequate resource and referral information, fragmented funding, and limited partnerships for crisis and care transitions.**

Connections during critical junctures of care — such as during crisis response, transitioning from one level of care to another, and leaving incarceration — are delayed by structural and partnership barriers within the OUD/SUD response system. Providers lack adequate information about other available services, health insurance and grant funding can be unreliable for covering all services, and there are limited formalized partnerships and procedures for crisis or transition care.

- 3. Greater support for housing, transportation, justice-system transitions, and populations with health disparities is needed for positive care outcomes.**

The dominant social determinants of health affecting OUD/SUD outcomes are stable housing during care and recovery, transportation to access various care services, re-entry after incarceration, and subpopulations facing greater health disparities (people of color, with low income, LGBTQ+). Without basic needs stabilization, engagement in treatment, recovery, or other wrap-around services is difficult and inconsistent.

- 4. Common metrics for substance-related harms, service utilization, and outcomes would support organizational partnerships and activities, and facilitate public health monitoring of the response.**

While many organizations involved in the OUD/SUD response collect and/or use various data points to inform or report about their programming, few of these data

points are sufficiently comprehensive, up-to-date, and actionable. Providers repeatedly stressed the importance of drug, overdose, and hospitalization trend data by geographic area and subpopulation to help organizations “get on the same page,” identify opportunities for partnerships and improved services, and mobilize when new trends appear.

**5. Stigma associated with people who use drugs hinders organizations providing OUD/SUD interventions, as well as individuals' access to care.**

Stigma manifests as shame or denial about substance use and its harms, and leads to inaction or resistance to addressing OUD/SUD. It contributes to lack of information about the issue, misinformation, and not offering certain care services; it can even be internalized so that it impedes individuals from seeking help. Practitioners in each intervention area described how negative perceptions of substance use and people who use drugs inhibited access to care, evidence-based programming, and naloxone education.

Prevention providers noted stigma from the general public, schools, parents, communities, and medical system, which hinder primary and secondary prevention education and interventions. Organizations offering a suite of harm reduction services said they felt stigma from the general public, law enforcement, schools and neighborhood coalitions, and treatment and recovery providers, which hindered their outreach and supplies distribution efforts. Treatment providers mentioned feeling stigma from DCS, law enforcement, families, and other treatment and recovery providers, which limits engagement or re-engagement in certain types of treatment services. Organizations conducting recovery services discussed how general public and health insurance perceptions that a person with OUD/SUD “should quickly get cured” limited cost coverage for recovery services, housing, and peer support.

### Intervention-level Findings

Intervention-level findings relate to key barriers and dynamics within each OUD/SUD intervention type: prevention, treatment, harm reduction, and recovery.

**6. Primary prevention and early intervention to reduce harms to youth are limited by funding restrictions and school policies.**

Schools and provider funding sources have stipulations about what types of youth-focused prevention activities are permitted or not. Funding sources typically distinguish between primary and secondary prevention (aka early intervention), and combined activities or curricula are often not allowable. While state policy is often cited as the reason for prevention education prohibitions, school decision-makers also have

some authority, with some allowing multiple types of programming and others allowing none at all. Early intervention seems to be an underfunded area of programming, which involves identifying mental health problems and/or substance use in their early stages and intervening through counseling and education. More information from school stakeholders regarding these systems and barriers may be needed.

**7. Providing safer substance use services only became legal in Arizona within the past 3 years, and organizations providing them need infrastructure support and development to meet harm reduction demands.**

Commonly stated barriers to accessing safer use supplies and naloxone were a lack of services, not knowing where to access services, and fear of law enforcement. These barriers are indicative of a service field that was only legalized and legitimized recently. Among the organizations providing a suite of harm reduction services that participated in this assessment, the majority were small-scale or grassroots efforts. They are not institutionalized and scaled to the same extent as providers in the other intervention areas. Thus, organizational capacity-building – including fiscal, human resources, and capital equipment management and support – is needed to overcome access barriers to harm reduction services.

**8. Health insurance authorization and coverage restrictions cause delays and limitations for treatment and recovery services.**

While some regions noted a lack of certain types of treatment or recovery services (particularly those for youth, women and families, low-rent recovery housing, and peer recovery support), a dominant issue for providers was limited health care coverage for treatment, recovery, and wrap-around services. There are 7 Health Plans under AHCCCS, which providers said have varied pre-authorization and service limit requirements. Pre-authorization requirements cause delays for detox care, care transitions, and insurance coverage for people leaving incarceration – and providers noted that any care delay increases the risk of relapse. Providers felt that Health Plan limits for treatment and recovery services duration ended services too soon, which also creates risk for relapse and other negative consequences. The overall complexity of this system can lead to confusion about what is covered, by whom, and for how long – functioning as a barrier both to providers and individuals seeking care.

**9. Social support is essential for maintaining recovery from opioid and other substance use.**

All literature reviewed and provider participants underscored that “recovery” from OUD/SUD is not time-bound; it is life-long. Some organizations provide acute recovery care during early stages of reintegrating into society after treatment or incarceration,

while others provide ongoing recovery support. Recovery maintenance is a critical aspect of relapse prevention, and even being able to rapidly get care for a relapse is key. Providers wanted to see more support for recovery maintenance through peer support specialists, caregiver and family support services, longer-term services funded by health insurance, and community-based peer recovery centers.

**10. The interplay between harm reduction, abstinence from substances, treatment, relapse, and recovery is important for many people’s substance use journeys, and coordination for simultaneous services from different interventions is needed.**

Many providers described the balance and debate between harm reduction and treatment services, while also recognizing that more understanding across interventions is needed. Much of the field is moving toward greater inclusion of harm reduction strategies to reduce overdose deaths, and this recent change to the intervention landscape is yet to fully be understood. More information, education, and guidance on where and how harm reduction activities are best utilized might benefit stakeholders more skeptical or unsure of how to encourage these services legally. Greater access to multiple services available for the continuum of interventions and recovery journey will help as substance use becomes more widely understood as a non-linear path for many people.

## Recommendations

The recommendations below resulted from the needs assessment findings, as well as review of literature and best practices. Recommendations are organized by the framework cross-cutting factors. Also included are the intervention area(s) affected and related findings (as defined in Exhibit 34). It is understood that MCDPH is only in a position to impact some of the stated findings, and others suggest more state clarification of policies in areas such as coverage limits for AHCCCS funded services.

Social Determinants and Equity Recommendations			
Cross-Cutting theme	Intervention Area(s)	Related to Key Findings (Exhibit 34)	Community Recommendation
Social Determinants + Equity	All	3	1. Improve access to longer-term housing through existing funding and policies.
	All	3	2. Improve transportation support for people engaging in OUD/SUD services.
	All	5	3. Address stigma associated with people who use drugs through educational and media campaigns.
	Harm reduction	1,7	4. Increase naloxone access points by limiting administrative, financial, and legal barriers to access, with particular focus on geographic areas with lower access and/or higher overdose rates.
	Recovery	2,3,8	5. Improve access to longer-term recovery housing (more than 90 days), including MOUD-permitted housing, through health insurance coverage for services.
	Treatment, Recovery	3,8	6. Improve support for people leaving incarceration through immediate eligibility for services, hand-offs to providers, and longer-term services that support reintegration.
	Treatment, Recovery	3	7. Support specialty treatment and recovery services for individuals and families disproportionately affected by OUD/SUD harms, including people of color, people with low income, LGBTQ+, and justice-involved individuals.



Systems and Policies Recommendations			
Cross-cutting theme	Intervention Area(s)	Related to Key Findings (Exhibit 34)	Community Recommendation
<b>Systems + Policies</b>	All	2,7	8. When creating grant funding opportunities, make the application process accessible to smaller organizations, incentivize connections to other levels of care services, and include planning, evaluation, and resources/support in the funding.
	Prevention	6	9. Work with school districts and schools to ease prevention and early intervention barriers in K-12 settings. First, learn more about these barriers directly from these education stakeholders.
	Prevention	2,6	10. Incorporate early intervention for youth at high risk for OUD/SUD in settings such as schools, behavioral health programs, foster care, street outreach, and the juvenile justice system.
	Harm reduction	3,5,7,10	11. Bolster harm reduction street outreach efforts through capacity funding to increase services that reach people experiencing homelessness. Increase dialogue between community-based harm reduction providers and jurisdictions to support street- and park-based efforts.
	Harm reduction	1,7	12. Support policies that reduce legal and administrative barriers to accessing and using naloxone, fentanyl test strips, and other harm reduction services.
	Harm reduction	3	13. Support justice system diversion and deflection for drug-related charges that do not pose a threat to others.
	Treatment, Recovery	8	14. Work with AHCCCS to explore issues of prior authorization, covered service limits, and health care parity. Encourage clarifications regarding coverage while larger policy issues are explored.
	Recovery	2,9	15. Establish a centralized registry of recovery homes for quality control, and include their services, eligibility criteria, costs, and insurance coverage.

Provider Partnerships and Capacity Recommendations			
Cross-cutting theme	Intervention Area(s)	Related to Key Findings (Exhibit 34)	Community Recommendation
Provider Partnerships + Capacity	All	2,8	16. Establish centralized care navigators to facilitate transitions between service providers and levels of care.
	All	2,4	17. Identify a system, such as a centralized database of OUD/SUD providers and services, to facilitate visibility and coordination of care across providers.
	All	2,10	18. Create opportunities for providers to convene to share information and strengthen partnerships.
	Prevention	6	19. Improve trainings for youth providers to identify youth at risk for mental health and/or substance use problems.
	Prevention	6	20. Assess existing evidence-based and cost-effective practices for primary and secondary prevention in K-12 settings.
	Harm reduction	7	21. Support capacity-building by funding organizational development, infrastructure, capital equipment, staffing, and services for organizations conducting a suite of harm reduction services (beyond naloxone distribution).
	Harm reduction, Treatment	1,2	22. Improve crisis and post-overdose response team coordination to immediately connect people in distress to the most relevant care services.
	Harm reduction, Treatment, Recovery	1,2,10	23. Integrate harm reduction education and services into treatment and recovery interventions to reduce fatal overdoses.
	Treatment	3,8	24. Continue providing MAT/MOUD in correctional settings, and ensure continuity of medication during re-entry.
	Treatment, Recovery	5	25. Consider ways to maximize MAT/MOUD access and utilization (such as increased take-home supply, insurance coverage, youth services) as an evidence-based way of reducing relapse.
	Recovery	9	26. Increase the number and diversity of Peer Recovery Support Specialists working in the field.
	Recovery	9	27. Consider establishing community-based peer recovery centers for ongoing social and skills support.

Data and Evidence Recommendations			
Cross-cutting theme	Intervention Area(s)	Related to Key Findings (Exhibit 34)	Community Recommendation
<b>Data + Evidence</b>	All	4	28. Continue substance overdose fatality surveillance through County Medical Examiner's Office to have real-time data about drug trends and harms to share with providers.
	All	4	29. Establish a process for sharing data with community partners, such as a dashboard about opioid and other substance use trends by region and updated regularly to facilitate shared knowledge, priorities, and partnerships among providers.
	All	1,4,10	30. Establish high-level metrics for success in the OUD/SUD response, so that provider-level planning, funding, and reporting can connect to common goals.

# APPENDIX A: GLOSSARY OF ACRONYMS

ACJC - Arizona Criminal Justice Commission

ADHS - Arizona Department of Health Services

AHCCCS - Arizona Health Care Cost Containment System (Medicaid)

AI/AN - American Indian/Alaska Native

BRFSS - Behavioral Risk Factor Surveillance System

CDC - Centers for Disease Control and Prevention

DCS - Department of Child Safety

DEA - Drug Enforcement Agency

DOJ - Department of Justice

ECHO - Extension for Community Healthcare Outcomes

EDGE - Enhanced Drug and Gang Enforcement

FDA - Food and Drug Administration

GOYFF - Governor's Office of Youth, Faith, and Family

HHS - Health and Human Services

HUD -Housing and Urban Development

LMA - LeCroy & Milligan Associates, Inc.

MAT - Medication Assisted Treatment

MCAO - Maricopa County Attorney's Office

MCDPH - Maricopa County Department of Public Health

MOUD - Medications for Opioid Use Disorder

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**NAS** - Neonatal Abstinence Syndrome

**OD2A** - Overdose Data to Action

**OJJDP** - Office of Juvenile Justice and Delinquency Prevention

**ODU** - Opioid Use Disorder

**PWUD** - People Who Use Drugs

**RBHA** - Regional Behavioral Health Authority

**SABG** - Substance Abuse Block Grant

**SACLAz** - Substance Abuse Coalition Leaders of Arizona

**SAMHSA** - Substance Abuse and Mental Health Administration

**SHIFT** - Safe, Healthy Infants and Families Thrive

**SMI** - Serious Mental Illness

**SOR** - State Opioid Response

**SUD** - Substance Use Disorder

**TRBHA** - Tribal Regional Behavioral Health Authority

## APPENDIX B: METHODS AND PARTICIPANTS

LeCroy & Milligan Associates used a mixed-methods approach with qualitative and quantitative components. The primary data elements of the needs assessment were:

1. *Landscape analysis* of current opioid and substance use trends, funding, and evidence-based practices.
2. A community *Advisory Committee* of subject matter experts in Maricopa County to inform the Strengths/Gaps situational analysis, as well as the direct data collection.
3. *Interviews, surveys, and listening sessions* which included diverse participants (such as coalition members, medical providers, frontline staff, first responders, harm reduction specialists, and executive leaders), representing the five regions of Maricopa County, historically marginalized populations, and various approaches to OUD/SUD (prevention, treatment, harm reduction, recovery).
4. A *Maricopa County Task Force* comprised of county departments involved in the substance use response, to support translating findings into a budgetary plan for County Opioid Settlement spending.

See Exhibit 36 for specific data collection instruments, their purpose, and participants in this assessment.

**Exhibit 36. Data Collected, Purpose, and Participants**

Data/Instrument	Purpose	Participants
Existing data	Uncover trends, funding, and evidence-based practices for OUD/SUD	Published data and literature about OUD/SUD, abatement trends, and funding sources
Situational Analysis	Develop an overview of current strengths and barriers, ideas for improvement, and priorities	Community Advisory Committee and their contacts with OUD/SUD experience
Key Informant Interviews	Gain insights on barriers and enablers of desired substance use response outcomes	OUD/SUD practitioners working with specific subpopulations
Electronic Survey	Provide concrete and quantifiable information about barriers and priorities for OUD/SUD practices	Service providers in OUD/SUD
Listening Sessions	Gain feedback and geographic context about improvements to OUD/SUD practices	Regional-based organizations

In January-March 2023, the evaluation team facilitated two situational analysis sessions and completed semi-structured interviews with 17 staff at community organizations whose primary focus is responding to substance use in various parts of Maricopa County. The organizations involved work in the four major abatement strategy areas of prevention, harm reduction, treatment, and recovery. Interview contacts were provided by the project Advisory Committee and MCDPH, and interviews were completed in-person or over Zoom, and lasted between 30 and 60 minutes. See Appendix C for organizations involved in the situational analysis, interviews, and listening sessions.

From March 13-April 28, 2023, an online Qualtrics survey for providers was active, with MCDPH and the Advisory Committee distributing the link to contacts across Maricopa County. The majority of survey questions were structured, with participants selecting one or multiple response options; each section contained an open-ended question for the respondent to share any other perspectives. The survey link was viewed by 700 people, with 521 answering questions past the introductory demographics section, and 493 of those responses coming from a valid region or organization within Maricopa County. Respondents self-selected which OUD/SUD interventions they felt knowledgeable about, and answered questions about key barriers, concerns, important settings, and strategies important to fund for that intervention.

**Exhibit 37. Survey Respondents by Region, Organization Type, and Intervention Type**

Region	TOTAL	Comm-based org	Govt agency	Other	Prevention	Harm reduction	Treatment	Recovery
Central	267	161	104	2	125	133	155	153
Northeast	60	60	44	0	33	30	31	21
Northwest	26	21	5	0	19	10	16	14
Southeast	116	64	50	2	52	53	64	59
Southwest	24	10	14	0	15	6	10	11

**Exhibit 38. Survey Respondent Demographics**

Demographic	Percentage (Number)
<b>Race/Ethnicity</b>	
American Indian/Alaskan Native	0.8% (4)
Asian	1.8% (9)
Black or African American	5.5% (27)
Hispanic or Latino	17.0% (84)



Demographic	Percentage (Number)
Multiracial, non-Hispanic or Latino	2.8% (14)
Native Hawaiian or other Pacific Islander	0.6% (3)
White	68.0% (335)
Other	2.2% (11)
No response	1.2% (6)
<b>Gender</b>	
Female	60.0% (296)
Male	36.5% (180)
Non-binary	2.4% (12)
No response	1.0% (5)

From April-May 2023, the evaluation team conducted listening sessions with providers: one virtual session with prevention coalitions, and two (1 in-person, 1 virtual) in each of the 5 regions of Maricopa County. Facilitators used structured questions and follow-up prompts to elicit discussion about OUD/SUD response challenges, potential improvements, the continuum of care, and coordination with other providers. Participant details are shown in the table below.

**Exhibit 39. Listening Session Participants**

Listening Sessions	Total Individuals	Total Organizations	Community-based Organizations	Governmental Organizations
Prevention-focused	7	7	6	1
Central region	27	15	10	5
Northeast region	18	8	2	6
Northwest region	26	22	11	11
Southeast region	34	21	11	10
Southwest region	19	15	10	5
TOTAL	131	88	50	38

## APPENDIX C. ORGANIZATIONS INVOLVED IN SITUATIONAL ANALYSIS, INTERVIEWS, AND LISTENING SESSIONS

ALT Mental Health

Area Agency on Aging

Aris Foundation

Arizona Alliance for Community Health Centers

Arizona Women's Recovery Center

Arizona Supreme Court, Administrative Office of the Courts/Adult Probation Services Division

Asylum Advocates Mobile Peer Support Barbershop/Behavioral Health Clinic

Aurora Behavioral Hospitals

Avondale Emergency Management Department

Avondale Fire and Medical Department

Avondale Office of Public Safety

Bethany Home Pharmacy

Buckeye Fire Department

Chicanos Por La Causa

Chicanos Por La Causa - West Phoenix Amanecer Prevention Coalition

Christian Family Care STRONG

Community Bridges, Inc.

Community Medical Services

Desert Spectrum Coalition

Foster360

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Fountain Hills Coalition

Full Circle

Gilbert Fire and Rescue Department

Glendale Police Department

Goodness and Mercy Communities

Help Enrich African American Lives Coalition (HEAAL) - Tanner Community Development Corporation

Homeward Bound

Honor Health

Human Services Campus

Hushabye Nursery

I Am Wellness

Intensive Treatment Systems

La Frontera Arizona

Laveen Redeem Neighborhoods Coalition

Lost One Found

Maricopa County Adult Probation Department

Maricopa County Correctional Health Services

Maricopa County Drug Court

Maricopa County Department of Public Health

MATFORCE

Mercy Care

Mesa Police Department

Mesa Prevention Alliance

Mesa Public Schools

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Molina Healthcare of Arizona

Native American Connections

Native Health of Phoenix

New Freedom

NOMI Health

Paradise Valley Unified School District

Parents of Addicted Loved Ones (PAL)

Peoria Primary Prevention Coalition

Phoenix Housing Department

Phoenix Office of Homeless Solutions

Phoenix Office of Public Health

Phoenix Rescue Mission

Reborn Assistance

Rise Up! Glendale Primary Prevention Coalition

Sanctuary Recovery Centers

Scottsdale Human Services

Scottsdale Unified School District

Southeast Valley Community Alliance Coalition

Solari Crisis and Human Services

Sonoran Prevention Works

Southwest Behavioral Health and Services

Southwest Recovery Alliance

St Joseph's Hospital and Medical Center

Stand Up AJ Prevention Coalition

Step One Halfway House

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Substance Use and Addiction Translational Research Network (SATRN)

Surprise Human Service & Community Vitality Department

Surprise Police Department

Surprise Fire-Medical Department

Tanner Community Development Corporation

Tempe CARE 7

Tempe Community Health & Human Services

Terros Health

The Faithful City

The Pathway Program

Tolleson Connections Health Solutions

Tolleson Emergency Preparedness Department

UnitedHealthcare Community Plan

UnitedHealthcare Office of Individual and Family Affairs

United Prevention Coalition

United States Interagency Council on Homelessness (USICH)

Urban Indian Coalition

Valle del Sol

Valleywise Health

Way Out West Coalition (WOW) Coalition

## APPENDIX D. SITUATIONAL ANALYSIS

Members of the Advisory Committee and their contacts generated strengths, challenges, options for improvement, and effectiveness measures for each OUD/SUD intervention area. They then refined these ideas into “narratives” to craft the situational analysis into the format:

In [Intervention area], we should continue and build on \_\_\_\_\_ (strengths). Some key challenges are \_\_\_\_\_ (challenges). Ways to overcome these are \_\_\_\_\_ (options, in a logical/priority order). So that \_\_\_\_\_ (what success looks like).

### Situational Analysis Narratives for OUD/SUD Response Strategies

Created by the MCDPH Needs Assessment Advisory Committee, March 2023

**Common barriers** across all Strategies are:

- Stigma from community, family, providers, and law enforcement
- Silos in care—no cohesive continuum, and duplicate efforts due to not knowing what other providers do; and
- Need for stable, cohesive funding that is accessible and adequate.

In **Prevention**, we should continue and build on:

- Evidence-based programs and trainings, and
- Community resource and referral networks.

Some key challenges are:

- Limited funding
- Stigma
- Siloing and de-prioritizing of prevention
- Existing programs are difficult to scale (too long; only specific groups), and
- Identifying individuals who would most benefit from additional prevention efforts.

Ways to overcome these are:

- Coordinated prevention approach across systems
- Integrate prevention efforts with social determinants of health and SUD care continuum
- Systemic stigma reduction
- Train educators and service providers on SUD information, and
- Integrate new evidence on novel prevention approaches and when to deploy them in practice.

Doing this would lead to:

- Evidence-based prevention resources with broad reach and scale
- People getting help before full-blown SUD and related harms, and
- Measurably reduced problematic substance use.

In **Harm Reduction**, we should continue and build on:

- Access to harm reduction supplies
- Integration of harm reduction in health care, public services, treatment, and recovery; and
- Building collaborative relationships.

Some key challenges are:

- Stigma
- Responsive funding for capacity-building, and
- Criminalization of SUD.

Ways to overcome these are:

- Marketing campaigns to different audiences
- Required harm reduction trainings for professionals
- Investing in capacity-building for harm reduction organizations
- Over-the-counter naloxone, fentanyl test strips, and syringes
- Decriminalizing possession, and
- State clarification for agencies on naloxone law to increase distribution.

Doing this would lead to:

- Reduction in overdose and drug-related illness and death
- People who use drugs feeling more support and knowing where to turn for help
- Improved health and economic outcomes (SDOH), and
- Decreased family separation (through DCS, jail, or death).

In **Treatment**, we should continue and build on:

- Integration of care
- Specialty options for care (such as demographic, gender, and age specific groups)
- 24/7 services
- Peer support, and
- Remaining flexible in evidence-based practices because no one-size fits all.

Some key challenges are:

- Health Plan barriers for billing and pre-authorization
- Stigma from DCS, providers, families, and law enforcement
- Federal regulations, and



- Workforce capacity and development due to difficulties with equitable pay, retention, and lack of diversity.

Ways to overcome these are:

- Consistency across Health Plans
- Further develop the continuum of care to include value in long-term care, addressing housing, and other social determinants of health; and
- Increase funding to increase pay to increase staff retention.

Doing this would lead to:

- Reduced barriers for providers and patients, which leads to integrated care and improved outcomes (including SDOH).

In **Recovery**, we should continue and build on:

- Being open to different modalities
- Evidence-based research
- Continuum of care
- Identifying gaps, and
- Grants with less restrictions.

Some key challenges are:

- Transitions between treatment and recovery steps
- Stigma, and
- Access to appropriate care.

Ways to overcome these are:

- Support transitional housing and address access issues
- Education on addiction, and change the message to reduce stigma; and
- Advocate for policy change, including audits of illegitimate recovery services, allowing MAT, and changing funding structures.

Doing this would lead to:

- Decreased homelessness and improved connectedness
- Increased understanding among the general public on recovery, addiction, and the continuum of care
- Increased access to care for all demographics and longer-term care coverage, and
- Increased trust in the SUD response system.

# APPENDIX E. KEY INFORMANT INTERVIEW QUESTIONS

## Respondent information to contextualize responses

1. What roles have you had working in substance use prevention and response?
2. What geographic areas do you work in?
3. What populations do you provide services to?

## Perception of OUD/SUD Strategies

4. Select based on strategy area from Q1:
  - a. What substance use *prevention* efforts have you seen as successful with [primary group served], and what does that success look like? What do you think made them successful?
  - b. What substance use *treatment* efforts have you seen as successful with [primary group served], and what does that success look like? What made them successful?
  - c. What substance use *harm reduction* efforts have you seen as successful with [primary group served], and what does that success look like? What made them successful?
  - d. What substance use *recovery* efforts have you seen as successful with [primary group served], and what does that success look like? What made them successful?
5. What do you experience as barriers or “pain points” in the work you’re doing?
6. What could help alleviate those barriers?

## Equity/SDOH

7. In your experience as [*refer to specific area(s) they work or specialize in*], what are some specific barriers being experienced by populations you serve?
8. What could be done to address these factors or barriers for [group mentioned above]?

## Provider Capacity

9. What kind of training has been helpful to you?
10. What, if any, other types of training do you think would be useful?
11. What other types of resources or support would be helpful to you?

## Data

12. What type of information or data is helpful to you in your work?
13. What type of information or data would be useful to you, but you don’t have it?

**Partnerships**

14. What are some successful partnerships you have for connecting people to other services or organizations?
  - a. What makes these partnerships work well?
15. What do you see as barriers or challenges to partnerships in connecting people to other services or organizations?
16. What, if any, partnerships do you wish you had?

**Priorities**

17. What investments would help improve our community's ability to address substance use?
18. Is there anything else you want to speak to that we haven't asked you about today?

## APPENDIX F. PROVIDER SURVEY TOOL

The survey was self-administered via the online Qualtrics survey platform.

### **Introduction**

#### **Maricopa County Substance Use Response Provider Survey**

In Maricopa County, opioids and methamphetamines are the most common drugs involved in overdose deaths, with the majority involving illicitly manufactured fentanyl. Overdose deaths involving multiple drugs (i.e., polysubstance) have been steadily increasing over the past several years. Maricopa County Department of Public Health (MCDPH) is interested in identifying needs and gaps in current response activities addressing overdose prevention and other harms caused by substance use. Data collected will help identify funding priorities for future substance use prevention and response activities.

**Here are the answers to some questions you may have about our survey:**

**Who should take this survey?** This survey is intended for providers from organizations serving Maricopa County residents in the areas of Prevention, Treatment, Harm Reduction, and Recovery Support. People working at various organizational levels, including executive leadership, clinical providers, program coordinators, first responders, peer workers, and others serving communities in the substance use arena can take the survey.

#### **How long will it take to complete this survey?**

About 10 – 15 minutes. Please thoroughly read and complete each question. Survey answers are auto saved, so you can pause while participating and return later to edit/finish responses and submit your survey.

#### **Are my answers anonymous?**

There is no tracking of any personal information, and answers cannot be tied to a specific person. Although MCDPH will have access to the name of your organization, any information from the survey will only be shared in grouped ways that do *not* identify specific organizations.

### **Respondent Information**

**1. Which of the following best describes your organizational role or as an individual working in substance use response activities?**

- ☐ Executive leadership (e.g., director, assistant director, administrator)
- ☐ Mid-level management (e.g., manager, supervisor)

- ☐ Medical Professionals (e.g., physician, physician assistant, psychiatrist, registered nurse, nurse practitioner)
- ☐ Frontline staff (e.g., therapist, social worker, coordinator, case manager, specialist, peer worker, counselor, front office)
- ☐ Law enforcement
- ☐ First responder/EMS
- ☐ Volunteer or community advocate
- ☐ Other (please specify): \_\_\_\_\_

**2. Please select the category which best describes the organization with which you are affiliated? Select all that apply. (Note: other sections of this survey will address areas of specific service.)**

- ☐ Social service/non-profit agency
- ☐ Substance use service provider
- ☐ Mental health service provider
- ☐ Harm reduction provider
- ☐ Prevention service provider
- ☐ Community health center/FQHC
- ☐ Primary care, group practice
- ☐ Correctional health
- ☐ Hospital
- ☐ Coalition
- ☐ Municipal government
- ☐ County government
- ☐ State government

- ☐ IHS/Tribal
- ☐ Academic/research institution
- ☐ K-12 education
- ☐ Higher education (Colleges, universities, etc.)
- ☐ Faith-based organization
- ☐ Other (please specify): \_\_\_\_\_

**3. What is the name of your organization?**

\_\_\_\_\_

**4. Please provide the zip code of your primary work location. Enter one zip code only.**

\_\_\_\_\_

**5. What is your gender identification? (Select all that apply)**

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non-binary
- ☐ Other (please specify): \_\_\_\_\_

**6. What is your race/ethnicity? (Select all that apply)**

- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White, not Hispanic or Latino

☐

Other, please describe: \_\_\_\_\_

**7. Based on your knowledge and experience, which of the following focus areas do you want to respond to in this survey? (Select all that apply; this will determine what questions you answer)**

☐

Primary Prevention – practices to prevent the initiation of substance use or the onset of substance misuse

☐

Treatment – intervening through medication, counseling, and other supportive services

☐

Harm reduction – practices for reducing negative consequences of substance use

☐

Recovery – activities to support the process of change through which individuals improve their health and wellness and live self-directed lives

### **Organizational Information**

*Displayed to executive leaders and directors:*

**1. How many staff are employed by your organization?**

☐

<10

☐

10-25

☐

26-50

☐

51-100

☐

100+

**2. Please select what cities or towns in Maricopa County your organization has one or more physical or mobile location(s) in. (Select all that apply)**

☐

Aguila

☐

Avondale

☐

Buckeye

☐

Carefree

☐

Cave Creek

- ☐ Chandler
- ☐ El Mirage
- ☐ Fountain Hills
- ☐ Gila Bend
- ☐ Gilbert
- ☐ Glendale
- ☐ Goodyear
- ☐ Guadalupe
- ☐ Litchfield Park
- ☐ Mesa
- ☐ Paradise Valley
- ☐ Peoria
- ☐ Phoenix
- ☐ Queen Creek
- ☐ Scottsdale
- ☐ Surprise
- ☐ Tempe
- ☐ Tolleson
- ☐ Wickenburg
- ☐ Youngtown
- ☐ Other, please specify: \_\_\_\_\_

**3. What priority populations or communities of focus does your organization serve? (Select all that apply)**

- ☐ Pregnant and parenting persons



- ☐ People who identify as LGBTQ+
- ☐ People who inject drugs
- ☐ People with co-occurring mental health/substance use disorders
- ☐ People designated as having a Serious Mental Illness
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ People who identify with more than one race
- ☐ People who live in rural communities
- ☐ Veterans
- ☐ Youth and young adults
- ☐ People with disabilities
- ☐ People who are incarcerated/formerly incarcerated
- ☐ People who are uninsured/underinsured
- ☐ People experiencing homelessness or housing instability
- ☐ People experiencing extreme poverty
- ☐ People with undocumented status
- ☐ People who are 65+
- ☐ No specific group, just anyone that needs services
- ☐ Other, please specify: \_\_\_\_\_

**4. Within the past year, has your organization's ability to:**

	Increased	Stayed the same	Decreased	Does not apply
Provide early intervention/primary prevention programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide outpatient treatment services for OUD/SUD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have beds available for OUD/SUD inpatient treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire and/or retain qualified staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Screen people for OUD/SUD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct/participate in diversion/deflection programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Connect individuals to recovery supports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implement motivational interviewing interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provide harm reduction supplies/education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct workforce education & training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Offer telehealth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide medications for the treatment of opioid use disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Please provide any additional details about your responses you’d like us to know:**

**5. Please indicate how much of a concern each of the following issues are for your organization relevant to the types of services you provide.**

	Not at all a concern	Somewhat a concern	Moderate concern	Serious concern	Does not apply
Insufficient training, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Underutilization of MAT/MOUD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Complexities of  
diagnosing/treating  
polysubstance use



Lack of integrated  
care for individuals  
with co-occurring  
disorders



Lack of  
interagency/provider  
coordination and  
communication



Low program  
completion rates



Restrictions on data  
sharing



Lack of culturally  
responsive and  
linguistically  
appropriate services



Lack of support for  
harm reduction  
activities



Limited resources  
and personnel



Provider and/or community stigma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insufficient insurer coverage for continuum of care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Payer systems are not integrated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff retention and workforce 'burnout'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of funding/restrictive funding sources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insufficient capacity or support services (e.g., beds, technology)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organizational policies, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Government policies/statutes, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Please provide any specific details about your responses you'd like us to know:**

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## **Prevention**

*Displayed to respondents selecting "Prevention" in Introduction section Q7.*

**1. What primary prevention activities does your organization provide and/or participate in?  
(Select all that apply)**

- ☐ Programs to address risk and protective factors
- ☐ School-based education programs
- ☐ Community outreach and education events
- ☐ Peer-leader programs
- ☐ Worksite/Employee Assistance Plans
- ☐ School-based assistance plans/intervention counseling
- ☐ Prevention screening and referral services
- ☐ Community mobilization/advocacy
- ☐ Multiagency coordination/coalitions
- ☐ Policies and regulations/enforcement
- ☐ Youth-based groups and clubs promoting positive behaviors
- ☐ Family education and parenting classes
- ☐ Faith-based services
- ☐ Provider training on appropriate prescribing practices
- ☐ Media or public awareness campaigns
- ☐ Public safety/medical provider education and training
- ☐ Mobile prevention services
- ☐ Intervention services for OUD/SUD at-risk individuals

- ☐ Multi-cultural and/or multi-language education and programming
- ☐ Other, please specify: \_\_\_\_\_

**2. What settings are the most important to conduct primary prevention activities in? Select up to 5.**

- ☐ K-12 schools
- ☐ Higher-education (e.g., Universities, community colleges, trade schools)
- ☐ After school programs (e.g., AM/PM extended stay, Boys and Girls clubs)
- ☐ Youth sports and clubs
- ☐ Public gathering spaces (e.g., community centers, recreational facilities)
- ☐ Places of worship or cultural gatherings
- ☐ Behavioral health programs/counseling
- ☐ Home visiting programs
- ☐ Juvenile justice/correctional settings
- ☐ Street outreach/homeless
- ☐ Worksites
- ☐ Government (i.e., policy change/enforcement)
- ☐ Organizational (i.e., policy change/enforcement)
- ☐ Primary care/clinical settings
- ☐ Social media/media campaigns
- ☐ Other, please specify: \_\_\_\_\_

**3. Please indicate how much of a concern each of the following issues are in the prevention arena.**

	Not at all a concern	Somewhat a concern	Moderate concern	Serious concern
Lack of evidence-based programming to meet current needs/audiences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of funding/restrictive funding sources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of access to counseling for early interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
De-prioritization of prevention activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of targeted or culturally relevant public awareness campaigns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of systemized OUD/SUD screening processes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limited connections between mental health and SUD services in school settings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Limited connections  
between mental health  
providers and SUD  
treatment services for  
youth

☐☐☐☐

Social stigma or  
confidentiality  
concerns

☐☐☐☐

Use of social media  
platforms in drug  
trafficking

☐☐☐☐

Lack of  
awareness/knowledge  
regarding impact of  
trauma on at-risk  
populations

☐☐☐☐

Individual, family or  
cultural norms/beliefs

☐☐☐☐

Lack of culturally and  
linguistically  
appropriate services

☐☐☐☐

Organizational  
policies, please  
specify:

☐☐☐☐

Government  
policies/statutes,  
please specify:

☐☐☐☐

Other, please specify:

☐☐☐☐

**4. In your opinion, what are the most important primary prevention strategies to fund? Select up to 5.**

☐

Implement evidence-based prevention programs in K-12 schools

☐

Increase training for providers (including faith-based and community organizations) on programming to connect at-risk individuals with services and supports

☐

Increase provider education/training for safe prescribing practices

☐

Implement targeted and culturally responsive media campaigns, including but not limited to focusing on risk factors and early interventions.

☐

Improve early intervention/behavioral health services, focusing on programs that are trauma-informed and culturally sensitive

☐

Expand drug take-back disposal or destruction programs

☐

Implement systematic screening (i.e., SBIRT programs) practices for mental health & substance use intervention eligibility & referrals

☐

Other, please specify: \_\_\_\_\_

**Treatment**

*Displayed to respondents selecting "Treatment" in Introduction section Q7.*

**1. What Treatment services does your organization provide? (Select all that apply)**

☐

Methadone medication

☐

Buprenorphine (suboxone) medication

☐

Naltrexone medication

☐

Non-medication treatment, alternative therapies

☐

Education and counseling services

☐

Cognitive behavioral therapy

☐

Treatment for co-occurring SUD/MH disorders

- ☐ Outpatient treatment
- ☐ Intensive outpatient treatment
- ☐ Partial hospitalization programs
- ☐ Therapeutic day treatment
- ☐ Hospital inpatient treatment
- ☐ Residential detox
- ☐ Residential short-term treatment
- ☐ Residential long-term treatment
- ☐ Recovery support/Transitional Services
- ☐ Community navigators
- ☐ Correctional health
- ☐ OUD/SUD screening
- ☐ Naloxone distribution
- ☐ Fentanyl test strips
- ☐ Clean syringe access programs
- ☐ Mobile treatment/crisis services
- ☐ Telehealth treatment services
- ☐ Other, please specify: \_\_\_\_\_

**2. What are the most significant barriers that limit people from seeking or continuing treatment? Select up to 5.**

- ☐ Lack of transportation
- ☐ Lack of affordable childcare options
- ☐ Unable to locate a MAT/MOUD provider close to home or work
- ☐ Lack of awareness of what treatment options are available

- ☐ Mistrust of healthcare providers or systems
- ☐ Fear of law enforcement/judicial involvement
- ☐ Limited times when services are available
- ☐ Myths about addiction (e.g., problem of 'willpower' or sign of 'weakness')
- ☐ Care that reflects the culture of individual/community
- ☐ Difficulty obtaining employment while on MAT/MOUD
- ☐ Lack of stable housing or support system
- ☐ Lack of insurance/cost of services
- ☐ Insurance won't cover right away (e.g., prior authorization)
- ☐ Social stigma or confidentiality concerns
- ☐ Emotional trauma
- ☐ Individual cultural norms/beliefs
- ☐ Motivation for/commitment to change
- ☐ Other, please specify: \_\_\_\_\_

**3. Please indicate how much of a concern each of the following issues are in providing treatment services.**

	Not at all a concern	Somewhat a concern	Moderate concern	Serious concern
Co-occurring disorders/integrating care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of integration in payer systems disrupts patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Restrictions on data sharing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of systemized screening for OUD/SUD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortages of specialty providers throughout county	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coordination/transition of care across systems ("feedback loop")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Challenges of treating polysubstance use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of culturally responsive and linguistically appropriate services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24/7 transportation availability for treatment centers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased and varying potency of fentanyl and related analogs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Ongoing shifts in illicit drug markets/patterns of use

☐☐☐☐

Underutilization of MAT/MOUD due to availability or access

☐☐☐☐

Stigma causing underutilization of MAT/MOUD services

☐☐☐☐

Organizational policies, please specify:

☐☐☐☐

Government policies/statutes, please specify:

☐☐☐☐

Other, please specify:

☐☐☐☐

**4. In your opinion, what are the most important treatment strategies to fund? Select up to 5.**

☐

Implement post-overdose response teams to connect the person to treatment services

☐

Expand wraparound services like medical transportation, child and family support for caregivers

☐

Increase integration of harm reduction programs in treatment settings

☐

Increase culturally competent services and options for people

☐

Expand services such as navigators and on-call teams to begin MAT/MOUD in hospitals and emergency departments

☐

Make MAT/MOUD available in correctional settings and upon release

- ☐ Expand treatment for pregnant/postpartum women and infants
- ☐ Increase care coordination to provide patient linkages to recovery supports
- ☐ Expand telehealth and mobile treatment options for OUD/SUD
- ☐ Support workforce development for addiction professionals
- ☐ Increase distribution of MAT/MOUD to uninsured/underinsured individuals
- ☐ Other, please specify: \_\_\_\_\_

### **Harm Reduction**

*Displayed to respondents selecting "Harm Reduction" in Introduction section Q7.*

#### **1. What Harm Reduction services does your organization provide? (Select all that apply)**

- ☐ Youth education and intervention
- ☐ Family education and intervention
- ☐ Community-based education and intervention
- ☐ Medical/provider training/education
- ☐ First responder training/education
- ☐ Stigma reduction/awareness messaging
- ☐ Overdose prevention supplies and training (e.g., naloxone, fentanyl test strips, syringe exchange)
- ☐ Safe smoking equipment
- ☐ STD, HIV and Hepatitis C testing and linkage to services
- ☐ Safe disposal of controlled substances
- ☐ Peer support
- ☐ Crisis intervention/linkages to care
- ☐ Referrals for help with basic needs (e.g., food, housing, healthcare)
- ☐ Mobile harm reduction services

☐

Wound care

☐

Advocacy/Community mobilization

☐

Other, please specify: \_\_\_\_\_

**2. Please share how important you think it is to provide harm reduction activities in the following settings.**

	Highly important	Somewhat important	Not that important	No opinion
During a 911 response to an overdose/post-overdose response	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At discharge from hospital or emergency room settings after an overdose event	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During treatment and transitional care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Middle and high schools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colleges and universities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Places of worship or  
cultural gatherings

☐☐☐☐

Public libraries and  
community centers

☐☐☐☐

Public safety  
buildings (i.e., fire  
stations, police  
stations)

☐☐☐☐

After-school  
programs (e.g.,  
YMCA, Boys and  
Girls Clubs)

☐☐☐☐

Street outreach

☐☐☐☐

Temporary  
housing/shelters

☐☐☐☐

Sober living and peer  
support groups

☐☐☐☐

Recovery/transitional  
living houses

☐☐☐☐

Upon release from jail  
or prison

☐☐☐☐

Home environments  
with family or others  
living in residence

☐☐☐☐

Other, please specify: \_\_\_\_\_

☐☐☐☐

**3. What are the most significant barriers that limit people from accessing, practicing, or knowing about harm reduction interventions? Select up to 5.**

☐

Don't know where/how to access

☐

Lack of available harm reduction services

☐

Lack of support from healthcare or treatment provider

☐

Lack of risk awareness/ false perception of risk

☐

Fear of criminal justice involvement/mistrust with law enforcement

☐

Financial concerns/cost

☐

Stigma against people who use drugs

☐

Lack of social support from family or others

☐

Supervised consumption sites are not legal

☐

Individual or cultural norms/beliefs

☐

Organizational policies, please specify: \_\_\_\_\_

☐

Government policies/statutes, please specify: \_\_\_\_\_

☐

Other, please specify: \_\_\_\_\_

**4. In your opinion, what are the most important harm reduction strategies to fund? Select up to 5.**

☐

Expand naloxone distribution and training to people who use drugs or are close to individuals who use drugs.

☐

Expand syringe service programs to reduce harms associated with intravenous drug use

☐

Increase community/public access points for harm reduction supplies (e.g., naloxone, fentanyl test strips, syringe access or exchange, safe smoking kits)

- ☐ Implement mobile harm reduction interventions
- ☐ Increase community-based harm reduction outreach, education and care navigation services
- ☐ Increase integration of harm reduction programs in treatment and recovery settings
- ☐ Implement pre-trial diversion and pre-arrest deflection programs
- ☐ Implement stigma reduction/awareness campaigns
- ☐ Other, please specify: \_\_\_\_\_

### **Recovery**

*Displayed to respondents selecting "Recovery" in Introduction section Q7.*

#### **1. What recovery support services does your organization provide? Select all that apply.**

- ☐ Recovery maintenance/relapse prevention and education
- ☐ Peer support
- ☐ 12-Step groups
- ☐ Crisis intervention/linkages to care & services
- ☐ Wraparound services (e.g., job skills training, housing, food assistance)
- ☐ Ancillary support services (e.g., childcare, transportation)
- ☐ Coordination of service providers/case management
- ☐ Transitional housing/sober living
- ☐ Holistic and alternative therapies
- ☐ Individual and/or family counseling
- ☐ Recreational and wellness activities
- ☐ Re-entry programs
- ☐ Telehealth services

- ☐ Naloxone distribution
- ☐ Fentanyl test strips
- ☐ Syringe exchange programs
- ☐ Other, please specify: \_\_\_\_\_

**2. What are the most significant barriers that limit people from seeking, accessing or continuing services in recovery? Select up to 5.**

- ☐ Lack of transportation
- ☐ Lack of affordable/accessible childcare
- ☐ Limited times when services are available
- ☐ Housing instability/unable to meet basic needs
- ☐ Lack of recovery support groups or services near home or work
- ☐ Sober housing availability/no beds open
- ☐ Financial/costs
- ☐ Gaps in referral systems
- ☐ Limitations/restrictions in health insurance coverage
- ☐ Limited availability of peer support
- ☐ Lack of culturally and linguistically appropriate services
- ☐ Lack of social or family support
- ☐ Not recognizing the early warning signs of relapse
- ☐ Sober housing regulations/restrictions
- ☐ Motivation for/commitment to change
- ☐ Social stigma and confidentiality concerns
- ☐ Individual/cultural norms/beliefs
- ☐ Other, please specify: \_\_\_\_\_

**3. Please indicate how much of a concern each of the following issues are in providing recovery services.**

	Not at all a concern	Somewhat a concern	Moderate concern	Serious concern
Preventing relapse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supportive transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuum of housing options	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of care coordination/continuum of care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sober living housing regulations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Licensing/monitoring of sober living homes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limited recovery housing allowing families to stay together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transitional services upon release from jail or prison	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Limited telehealth/mobile outreach services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limited recovery programs in remote communities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial/costs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community stigma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organizational policies, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Government policies/statutes, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. In your opinion, what are the most important recovery strategies to fund? Select up to 5.**

- ☐ Increase peer support specialists or recovery coaches
- ☐ Increase access to wrap-around services to individuals such as housing, healthcare, family supports, job skills training, and transportation
- ☐ Support centralized call centers that provide information and linkages to care
- ☐ Increase access to transitional, support, and recovery housing
- ☐ Implement recovery housing programs that allow or integrate FDA-approved medication with other support services
- ☐ Implement recovery focused telehealth and mobile intervention services

- ☐ Expand community-based peer-recovery centers (e.g., support groups, social events, computer access)
- ☐ Expand culturally responsive and linguistically appropriate recovery support services
- ☐ Other, please specify: \_\_\_\_\_

**Open-ended Feedback**

**Please share any additional thoughts, ideas or comments about substance use prevention and response activities in Maricopa County.**

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