



Statewide Epidemiological Outcomes Workgroup:

**Quarterly Meeting
11/19/2021**

Supported by SAMHSA PFS Grant
#6H79SP080990-01M001



Today's Agenda

- Welcome/Introductions/SEOW Mission (A. Oliveto)
- Collegiate Survey Updates (Dr. Derrick Slagle)
- SEOW Staff Updates/Data Gaps (A. Oliveto/M. Bollinger)
- Opioid Data and New HHS Overdose Prevention Strategy and AR Response (A. Oliveto/T. Barnes/L. Dickerson)
- Medical Marijuana Laws and Custody Cases (A. Oliveto)
- Substance Exposed Infants in Arkansas (C. Harper)
- Report to Congress on Prevention and Reduction of Underage Alcohol Use (A. Oliveto)
- APNA substance use data trends (J. Thostenson)
- Association of COVID-related answers with risk/protective factor answers (J. Thostenson)
- Update on temporary/permanent APNA changes (D. Kelsay)
- Me over Meth campaign updates (DAABHS/MidSOUTH)
- General Discussion/Action Plan/Wrap-Up/Next Meeting

SEOW Mission

SEOW's mission is to guide successful prevention efforts in the state of Arkansas by:

- Analyzing, monitoring and sharing data trends in substance use and other environmental, behavioral, and health-related factors.
- Informing data-driven policy and practice decision-making regarding prevention priorities at local and state levels.
- Disseminating evidence-based education and prevention materials to the larger public.

Arkansas Collegiate Survey Updates

Dr. Derrick Slagle

Director, Survey Research Center

Assistant Professor of Public Administration

University of Arkansas at Little Rock

School of Public Affairs



SEOW Staff Updates/Data Gaps

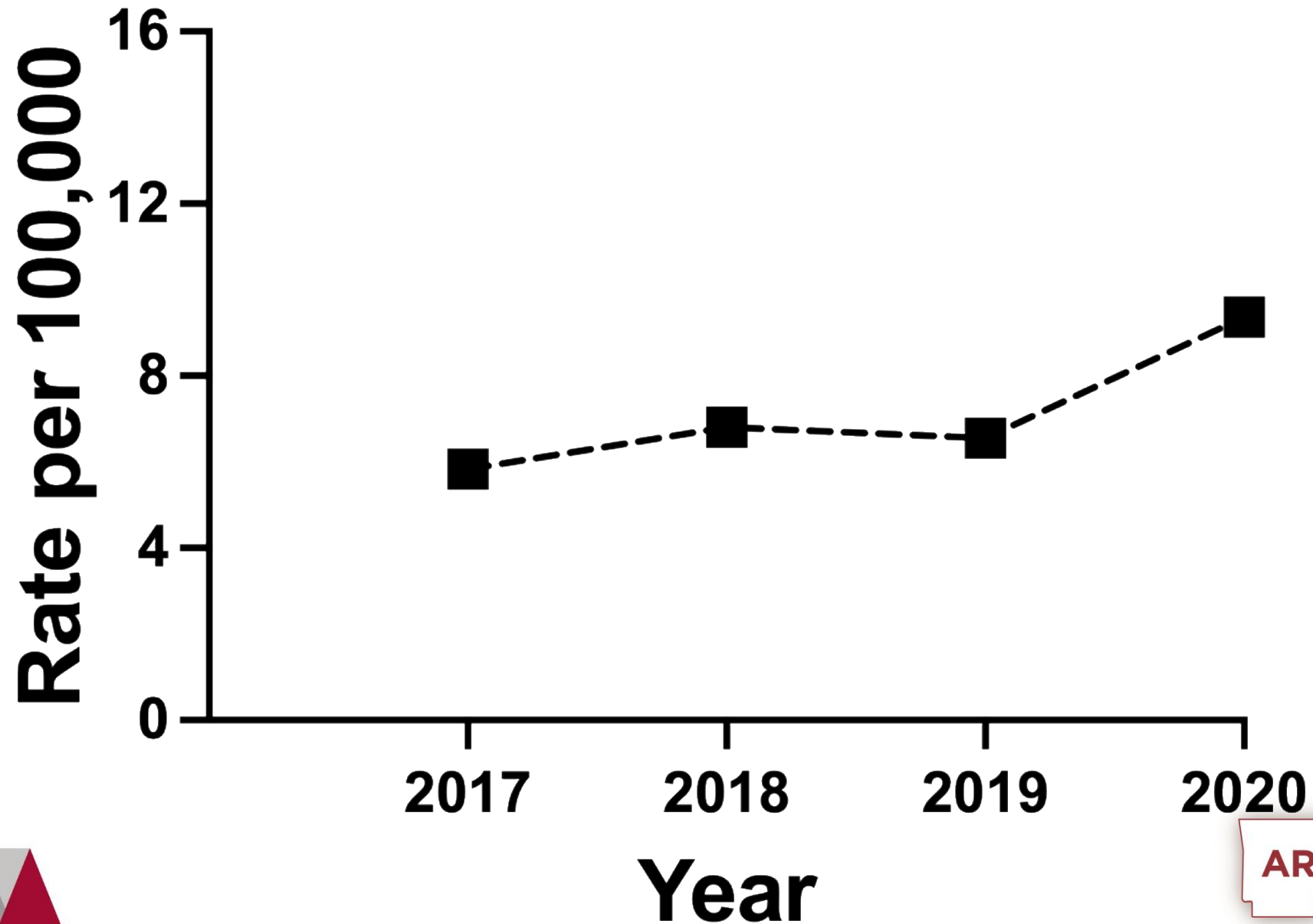
M. Bollinger/A. Oliveto

SEOW Staff

UAMS

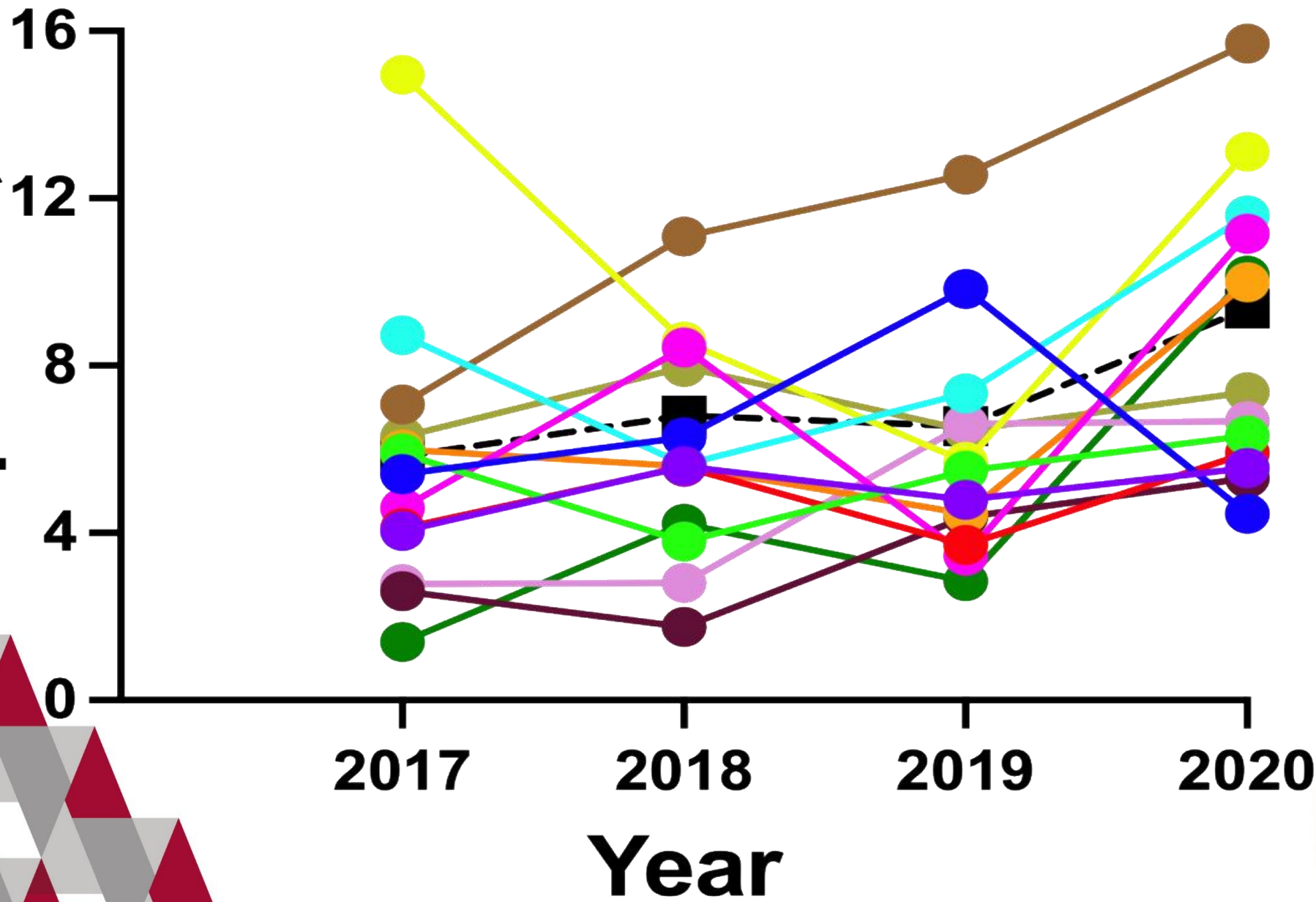


AR Opioid Overdose Deaths



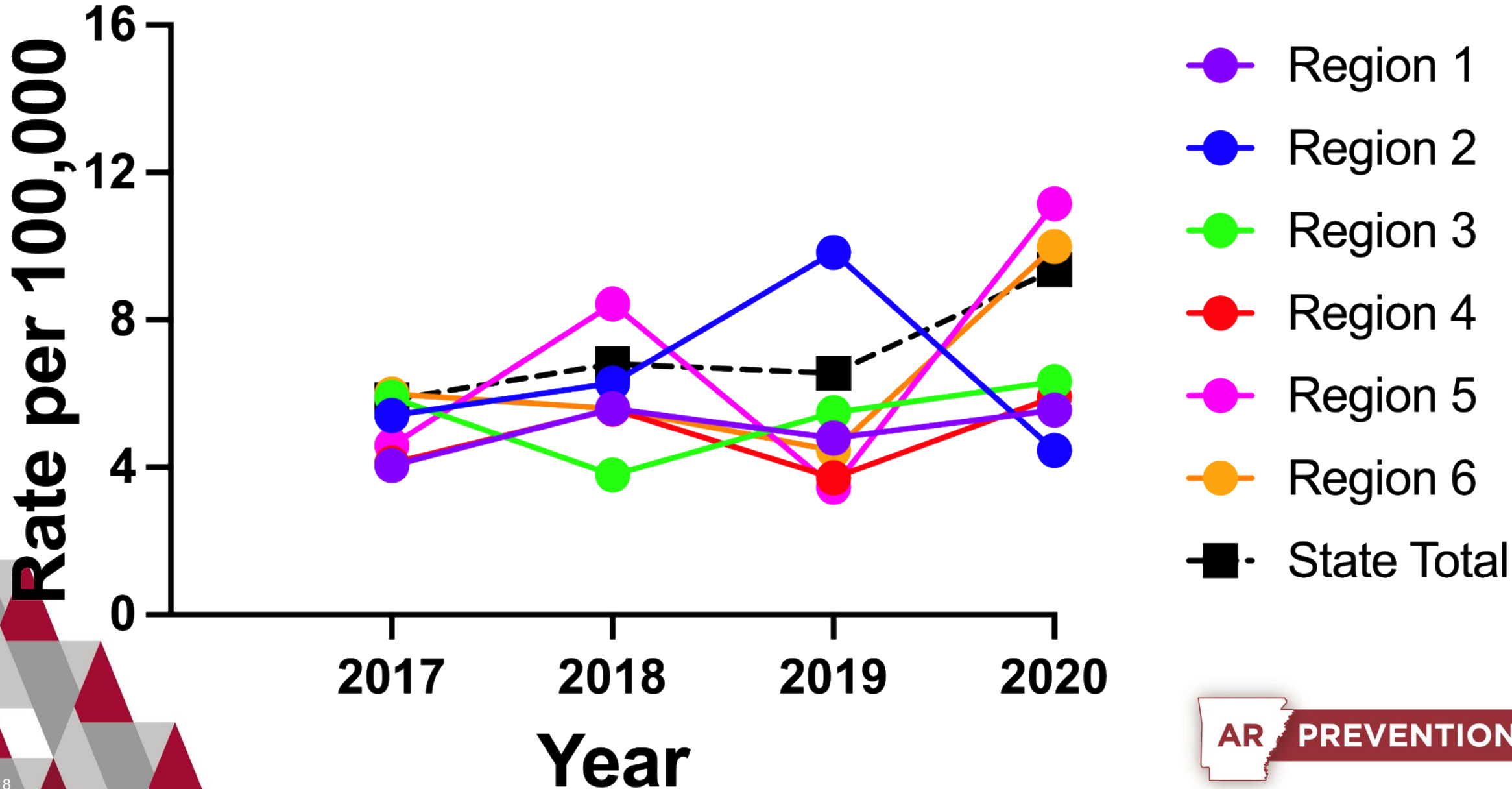
AR Opioid Overdose Deaths

Rate per 100,000

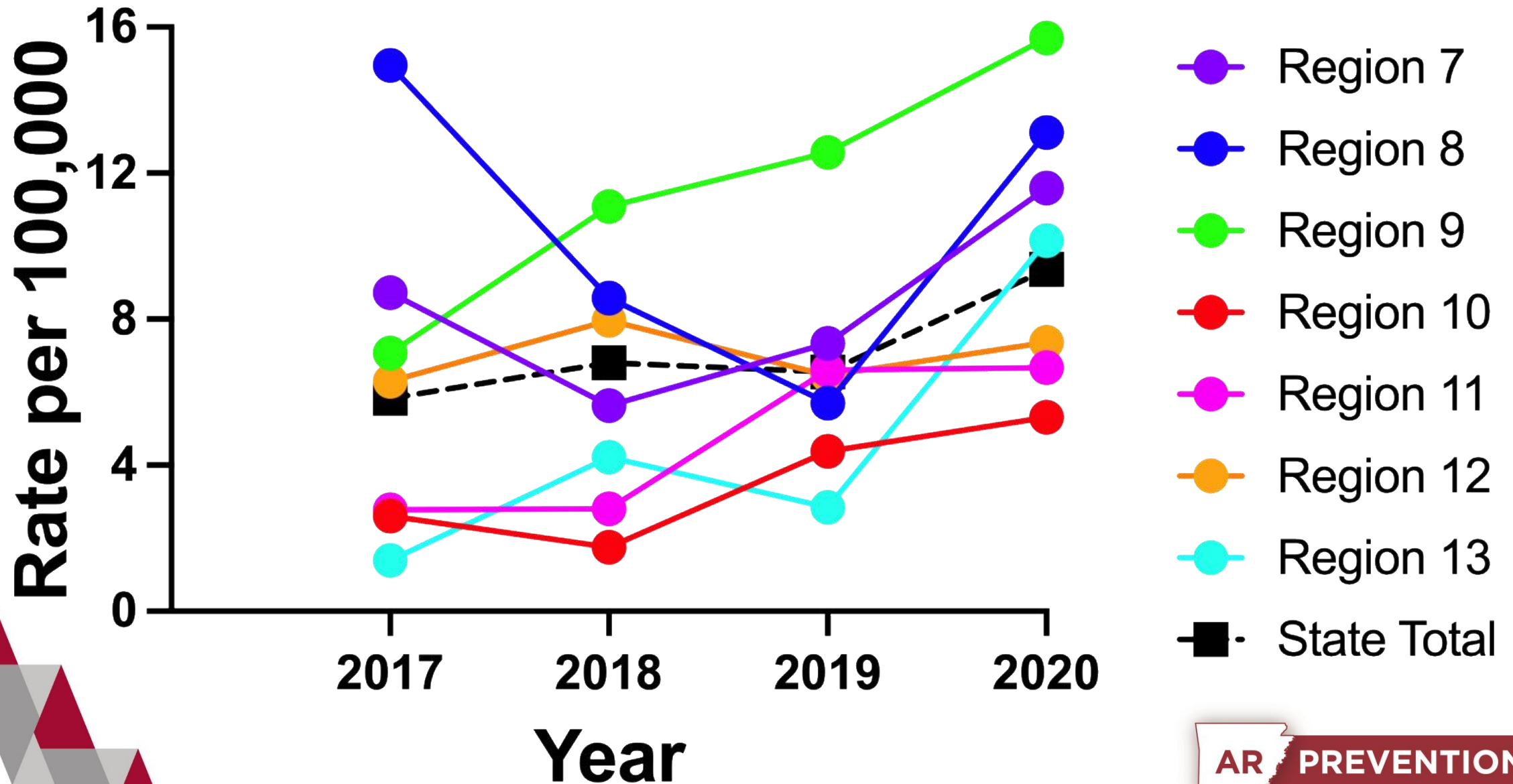


- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9
- Region 10
- Region 11
- Region 12
- Region 13
- State Total

AR Opioid Overdose Deaths

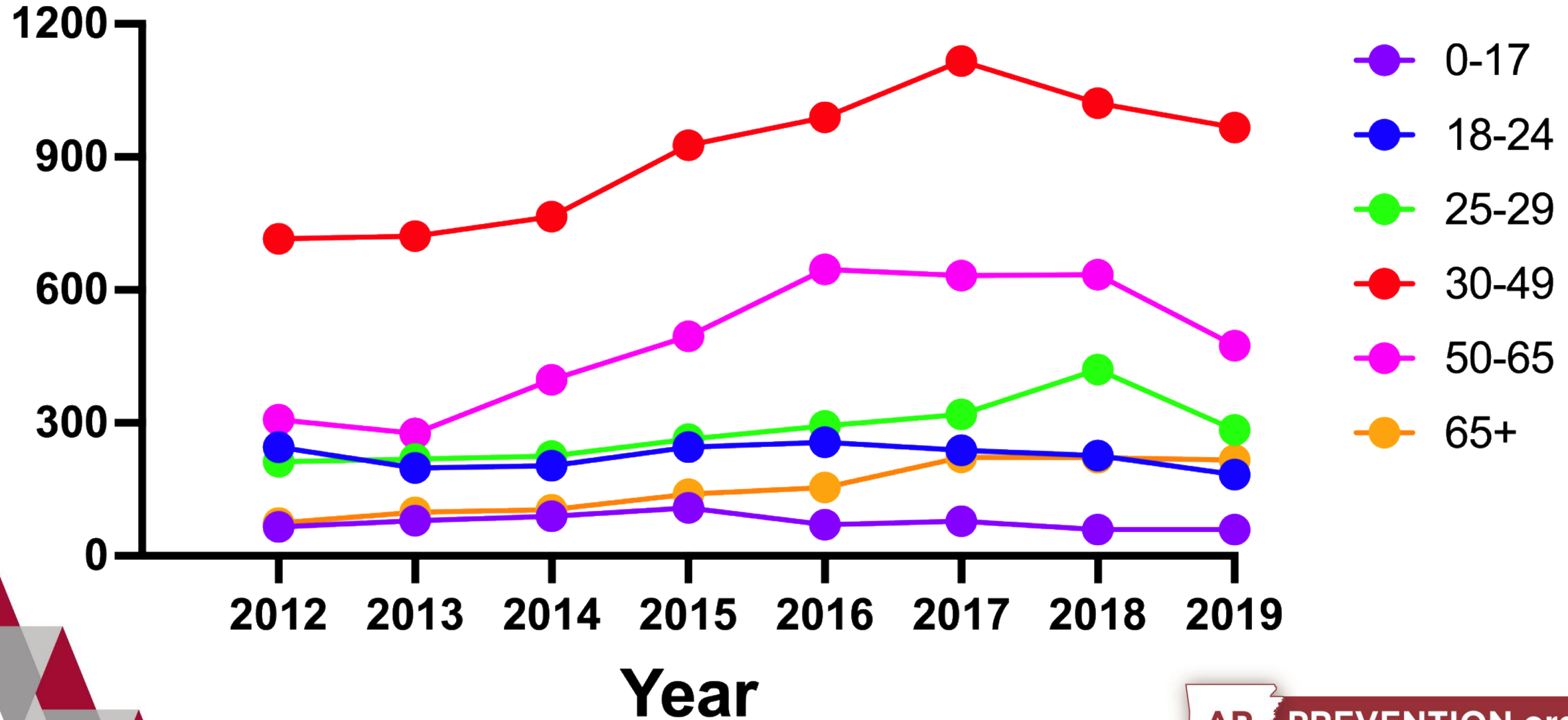


AR Opioid Overdose Deaths



ED Visits involving Opioids

Number of Admissions



Hospitalizations Involving Opioid Use

Number of Admissions

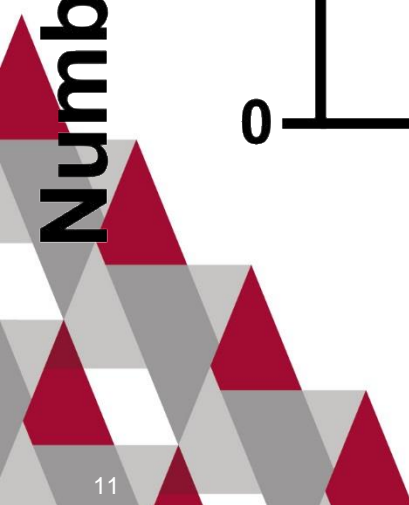
2500
2000
1500
1000
500
0

From 2010 to 2019 -
0-17: 138% ↑
18-24: 3.3% ↓
25-29: 73% ↑

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

Year

- 0-17
- 18-24
- 25-29
- 30-49
- 50-65
- 65+



HHS Overdose Prevention Strategy

- Designed to increase access to the full range of care and services for individuals who use substances that cause overdose, and their families
- Focuses on the multiple substances involved in overdose and the diverse treatment approaches for SUD
- Promote full continuum of integrated care and services to help prevent substance use, expand quality treatment, and sustain recovery from substance use disorders, all while emphasizing HHS's commitment to helping underserved populations
- Breaks new ground by providing coordinated, federal support for harm reduction and recovery support

HHS Overdose Prevention Strategy Priorities

HHS Overdose Prevention Strategy



HHS.gov

HHS OPS Priorities: Primary Prevention

- **SAMHSA's SPF for PDs:** raise community awareness and advance PD misuse prevention activities and education to schools, communities, parents, prescribers, and their patients
- **FDA regulatory work:** Updated labeling requirements about serious risks with benzodiazepines, especially when used with other medications (e.g., opioids, alcohol, etc). Consideration of mandatory prescriber education via the Opioid Analgesic Risk Evaluation and Mitigation Strategy
- **NIDA's Adolescent Brain and Cognitive Development (ABCD) Study:** Tracking biological and behavioral development of nearly 12,000 adolescents into young adulthood to produce detailed risk and protective factor profiles to improve SUD prevention

PRIMARY PREVENTION: OBJECTIVES

- Support research and surveillance to develop and improve delivery of prevention interventions.
- Facilitate the implementation of evidence-based primary prevention across the lifespan.
- Support development of and promote evidence-based treatments to effectively manage pain.
- Reduce clinically inappropriate prescribing of medications with misuse potential.

HHS OPS Priorities: Primary Prevention

Multi-Disciplinary Approaches

- **Centers for Medicare & Medicaid Services' (CMS's) Prescriber Outreach:** educates and provides outreach to prescribers around best practices for prescribing opioids and about non-opioid pain management
- **CDC's Preventing Adverse Childhood Experiences (ACEs) Data to Action program:** Designed to build state-level surveillance infrastructure that ensures the capacity to collect, analyze, and use ACEs data to inform ACEs prevention activities which may have lasting protective effects against substance use and other health-risk behaviors
- **CDC's Overdose Data to Action (OD2A) initiative:** Supports innovative and critical surveillance through the collection of comprehensive data on nonfatal and fatal overdoses to inform prevention and response efforts.

PRIMARY PREVENTION: OBJECTIVES

- Support research and surveillance to develop and improve delivery of prevention interventions.
- Facilitate the implementation of evidence-based primary prevention across the lifespan.
- Support development of and promote evidence-based treatments to effectively manage pain.
- Reduce clinically inappropriate prescribing of medications with misuse potential.

HHS OPS Priorities: Reduce Harm

- **Extends recent HHS harm reduction efforts** (e.g., SAMHSA/CDC allowing use of federal grant funds to purchase fentanyl test strips)
- **NIH Comprehensive HIV Services** in syringe services program settings
- **SAMHSA Harm Reduction Grants:** Support community-based overdose prevention programs, syringe services programs, and other harm reduction services
- **CDC Rx Awareness Campaign:** promotes awareness of the impacts of prescription opioid misuse/overdose, emphasizes that support is available for people with OUD and focuses on fentanyl as well as stigma around SUD

HARM REDUCTION: OBJECTIVES

- Advance research and demonstrations on innovative harm reduction approaches.
- Promote evidence-based harm reduction services, including those that are integrated with health care delivery.
- Expand sustainable funding strategies for harm reduction services.
- Develop educational materials and programs to reduce stigma.

HHS OPS Priorities: Evidence-Based Treatment

- **NIH Justice Community Opioid Innovation Network (JCOIN):** Seeks to advance knowledge about optimal OUD tx approaches in criminal justice settings; to sustain quality care after community reentry.
- **HRSA Rural Community Opioid Response Program:** Brings more evidence-based tx to rural communities that often lack access to high quality treatment, despite having disproportionately high need.
- **HHS Practice Guideline Changes:** Removed training, counseling, et al requirements for health care providers to treat up to 30 people at a time with buprenorphine
- **FDA/NIH initiative:** Collaborate to develop tx's for stimulant use disorder.
- **CMS Maternal Opioid Misuse demonstration model:** Advances high-quality care for participating OUD pregnant and postpartum Medicaid beneficiaries through provision of coordinated and integrated physical and behavioral health care services.
- **NIDA Medications Development Program National Drug Abuse Treatment Clinical Trials Network:** Develop tx's for stimulant use disorder

EVIDENCE-BASED TREATMENT: OBJECTIVES

- Support research on and development of new treatments and strategies to improve engagement and retention in care.
- Broaden access to evidence-based care that increases willingness to engage in treatment.
- Increase the uptake of evidence-based treatment delivery that improves engagement and retention in care.
- Promote evidence-based integrated care for people with co-occurring conditions across lines of service and care settings.

HHS OPS Priorities: Recovery Support

- **CMS Value in OUD Treatment Demonstration:** An alternative payment model that allows certain Medicare funds to be used for services not typically covered in its programs, such as peer support services, recovery housing, job training, and nutrition support.
SAMHSA Peer Recovery Center of Excellence: Provides training/technical assistance (e.g., clinical integration of peer support specialists; enhancing recovery community organization capacity)
- **HRSA Behavioral Health Workforce Education and Training Program for Paraprofessionals:** Expands recovery support services workforce by funding community-based training programs for peer support specialists and other paraprofessionals working in behavioral health.
- **NIH Research Networks for the Study of Recovery Support Services for Persons Treated with Medications for Opioid Use Disorder grants:** Supports research on topics including peer support services, recovery housing, and recovery community centers

RECOVERY SUPPORT OBJECTIVES

- Enable access to and encourage use of recovery support services.
- Improve the quality of recovery support services.
- Strengthen the recovery support services workforce.
- Research and identify best practices for recovery support services and strategies to sustain these services.

Tenesha Barnes, MA
Substance Abuse Prevention Director
Department of Human Service/DAABHS
Substance Abuse Prevention Unit
Drug Director Office

Lynette Dickerson
Substance Abuse Block Grant Program Coordinator
Department of Human Service/DAABHS

Medical Marijuana Laws Enactment Impacts: Custody Cases

Medical Marijuana Laws in Arkansas

- Arkansas Medical Marijuana Act (AMMA)
- Amendment 98 - November 8, 2016
- Allows qualifying patients to purchase and use medical marijuana (2.5 ounces/14 days) from a licensed dispensary

2.5 oz of Marijuana



EQUALS



80-220 joints



Highlights of Amendment 98

- ADH verifies with law enforcement that MM Card is valid or not.
- If MM card holder gives MM to non-qualifying person or knowingly violates any provision of the amendment 98, card is revoked and subject to any other penalties established by law.
- MM card holder can provide up to 2.5 oz MM to another qualifying person.
- ADH reports on the number of MM cards or dispensary licenses revoked in annual report to General Assembly.

Highlights of Amendment 98 (Section 6)

MM Card holder cannot:

- Undertake any task while under the influence of MM when doing so would constitute negligence or professional malpractice.
- Possess smoke, or otherwise engage in MM use:
 - On a school bus
 - On the grounds of a daycare center, primary or secondary school, college, or university
 - At a drug/alcohol treatment facility
 - At a community/recreation center
 - In a correctional facility
 - On any form of public transport
 - In a public place
 - On any property under control of the AR National Guard or US military

Highlights of Amendment 98 (Section 6)

MM Card holder cannot:

- Operate, navigate, or be in actual physical control of a motor vehicle, aircraft, motorized watercraft or any other vehicle drawn by anything other than muscle power while under the influence of MM
- Smoke marijuana:
 - In any place where tobacco smoking is prohibited by law
 - ***In the presence of anyone under 14 years of age***
 - In a motor vehicle, aircraft, motorized watercraft or any other vehicle drawn by anything other than muscle power
 - Knowingly in the presence of a pregnant woman
 - ***In a place where smoking MM will likely cause another unauthorized person to become under the influence of MM***
 - For medical use if the person is under 21 years of age

Highlights of Amendment 98 (Section 6)

The Amendment does not require:

- Government medical assistance program or private health insurer to reimburse MM use costs (unless required by federal laws)
- An employer to accommodate MM use in a workplace or an employee working while under the influence of MM
- An individual/establishment in lawful possession of property to allow anyone to use MM while on the property
- An individual/establishment in lawful possession of property to permit entry of anyone intoxicated due to MM use
- A landlord to permit MM smoking by a qualified individuals on the leased property (does not apply to edibles)

Highlights of Amendment 98 (Section 7)

Affirmative defense and dismissal for offense associated with MM use are valid when the individual is:

- A MM card-qualifying patient or designated caregiver
- Compliant with protections set forth in section 3 of the Amendment

Highlights of Amendment 98 (Section 7)

Section 3 Protections

- A qualifying patient/designated caregiver in actual possession of a MM ID card will, for the medical use of marijuana in accordance with this amendment if the qualifying patient or designated caregiver possesses not more than two and one-half ounces (2 1/2 oz.) of usable marijuana:
 - not be subject to arrest, prosecution, or penalty in any manner or
 - denied any right or privilege, including without limitation a civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau.
- A qualifying patient/designated caregiver is presumed to be lawfully engaged in the medical use of marijuana in accordance with this amendment if the qualifying patient or designated caregiver is in actual possession of a registry identification card and possesses an amount of usable marijuana not exceeding the amount allowed under this amendment.
 - Unless evidence that conduct related to marijuana was not for the purpose of treating or alleviating the qualifying patient's qualifying medical condition or symptoms associated with the qualifying medical condition in accordance with this amendment.

Highlights of Amendment 98 (Section 7)

Section 3 Protections (continued)

- A qualifying patient/designated caregiver will not, for giving, or offering to give, up 2 1/2 oz. of usable marijuana to a qualifying patient or designated caregiver for the qualifying patient's medical use when nothing of value is transferred in return, be subject to:
 - Arrest, prosecution, or penalty in any manner or
 - Denied any right or privilege, including without limitation a civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau
- A designated caregiver is not prohibited from receiving compensation or reimbursement of expenses from a qualifying patient for assisting a qualifying patient with the medical use of marijuana.

Highlights of Amendment 98 (Section 7)

Individual is not required to be in actual possession of MM ID card to raise the affirmative defense

Individual is not subject to the following for MM use, unless they do not comply with section 6 rules:

- Disciplinary action by a business, occupational or profession licensing board
- Forfeiture of any interest in or right to non-MJ licit property

2017 Legislative Session - Highlights

- **Act 5:** Defines written certification as an assessment of a qualifying patient's condition in the course of a physician-patient relationship and specifies that an application for an ID card is not considered a medical record.
- **Act 438:** Prohibits physicians from issuing certifications through telemedicine (had been relaxed temporarily during COVID).
- **Act 479:** Prevents members of the Arkansas National Guard and current members of the U.S. military residing in Arkansas from being patients or caregivers.
- **Act 545:** Requires criminal background checks for caregivers and applicants for dispensary and cultivation licenses.

2017 Legislative Session - Highlights

- Act 593: Creates protections for employees and prevents employers from taking adverse action against a patient or a caregiver solely for their status relating to medical cannabis. This bill still allows employers to create their own workplace drug policies.
- Act 670: Medical cannabis is subject to all state and local sales tax as other goods. Revenues generated shall be transferred to the Arkansas Medical Marijuana Implementation and Operations Fund.
- Act 740: Prohibits smoking in public places and other restrictions as to where individuals cannot use their medicine.
- Act 948: Requires the reporting of qualifying patients and dispensing data to the Arkansas All-Payer Claims Database.

2019 Legislative Session

SENATE BILL 440

- No applying cannabinoid concentrates or extracts to trademarked or branded food, candy, or beverages
- No foods that are likely to appeal to minors (due to shape, color, taste, or design)
 - modeled after non-cannabis products primarily consumed by/marketed to children
 - in the shape of an animal, vehicle, person, or character
 - closely resemble foods or beverages attractive to minors and commonly sold in retail establishments
 - includes candy, cookies, cakes, pastries, chewing gum, and brownies
- **ENGROSSED MARCH 14, 2019; NOW ACT 989**

2019 Legislative Session

SENATE BILL 441

- Advertising of medical marijuana may not

- Display consumption of marijuana
- Encourage or promote marijuana for use as an intoxicant
- Be reasonably considered to target children (use of cartoon characters or toys)
- Use symbols associated with medical practice (caduceus, cross of any color)

- Advertising of medical marijuana must include

- * *Marijuana is for use by qualified patients only. Keep out of reach of children*
- * *Marijuana use during pregnancy or breastfeeding poses potential harms to an unborn child or child*

- * *Marijuana is not approved by the United States Food and Drug Administration to treat, cure, or prevent any disease*

- * *Do not operate a vehicle or machinery under the influence of marijuana*

- Signage for medical marijuana cultivation/distribution sites

- Only 3 signs visible to the general public from the public right-of-way
- May not exceed 36 square feet
- May not be reasonably considered to target children (use of cartoon characters or toys)
- May not use symbols associated with medical practice (caduceus, cross of any color)

2021 Legislative Session

SENATE BILL 1525

It is unlawful for a person to knowingly:

- Use medical marijuana through inhalation in a place prohibited under the Arkansas Medical Marijuana Amendment of 2016, Arkansas Constitution, Amendment 98
- Transport medical marijuana in an amount greater than five ounces (5 oz.) unless the person is a licensed transporter, is employed by a cultivation facility or dispensary licensed by the Medical Marijuana Commission, and is in possession of a valid registration identification card issued by the Alcoholic Beverage Control Division
- Transport medical marijuana from another state into Arkansas

A violation of this section is a Class C misdemeanor.

ENCRSSED APRIL 30, 2021; NOW ACT 1062



2021 Legislative Session

SENATE BILL 1774

When a patient receives a written certification from a physician, the physician may require the patient to consult with a pharmacist consultant of a dispensary

A dispensary shall:

- Post signage at the check-in station of the dispensary notifying the qualifying patient of the availability of a pharmacist consultant;
- Provide to the new qualifying patient of the dispensary a card containing language about a consultation with a pharmacist consultant and the contact information of the pharmacist consultant; and
- Post information on the website of the dispensary regarding a consultation with a pharmacist consultant, the availability of the pharmacist consultant, and the contact information of the pharmacist consultant.

ENACTED APRIL 12, 2021; NOW ACT 666



Qualifications

Patients

- Arkansas resident with proof of residency
- *Not* a member of the National Guard or current member of the U.S. military residing in Arkansas
- **Physician's written certification** of *qualifying medical condition*
 - Signed by a medical or osteopathic physician
 - Physician licensed to practice in Arkansas
 - Physician has current DEA number

Qualifications

Caregivers

- Arkansas resident at least 21 years of age
- *Not* a member of the National Guard or current member of the U.S. military residing in Arkansas
- The individual you are providing care for must be physically disabled or a minor.
- Have not been convicted of an excluded felony offense (violence or controlled substance-related in past 10 years)
 - **Parents of a minor with a qualifying condition are not required to complete Criminal History Check.**

Qualifications

Visitors

- Has a qualifying medical condition but is not a resident of Arkansas or has been a resident of Arkansas for less than 30 days
- Posses a registry identification card or its equivalent issued under the laws of another state, district, territory, commonwealth, or insular possession of the U.S. pertaining to a qualifying medical condition under the Amendment
- Can apply for up to a 90-day MM card per application

Current Status of Medical Marijuana in Arkansas

Medical Marijuana ID Cards

- * 77,029 approved/active (as of June, 2021)
- * Distribution of physical ID cards began February 15, 2019
- * To date, only One MM ID card has been revoked

Dispensaries/Sales

- First dispensary opened: May 11, 2019 (33 now in operation, out of 38 licensed; up to 40 dispensaries can be licensed)
- Number of cultivation facilities: 5 in operation (out of 8 licensed)
- Cost of medical marijuana: \$395 - \$560 per ounce (including taxes)
- Estimated sales May 2019 - May 2021: \$330.4M (48,914 lbs or 24.5 tons)

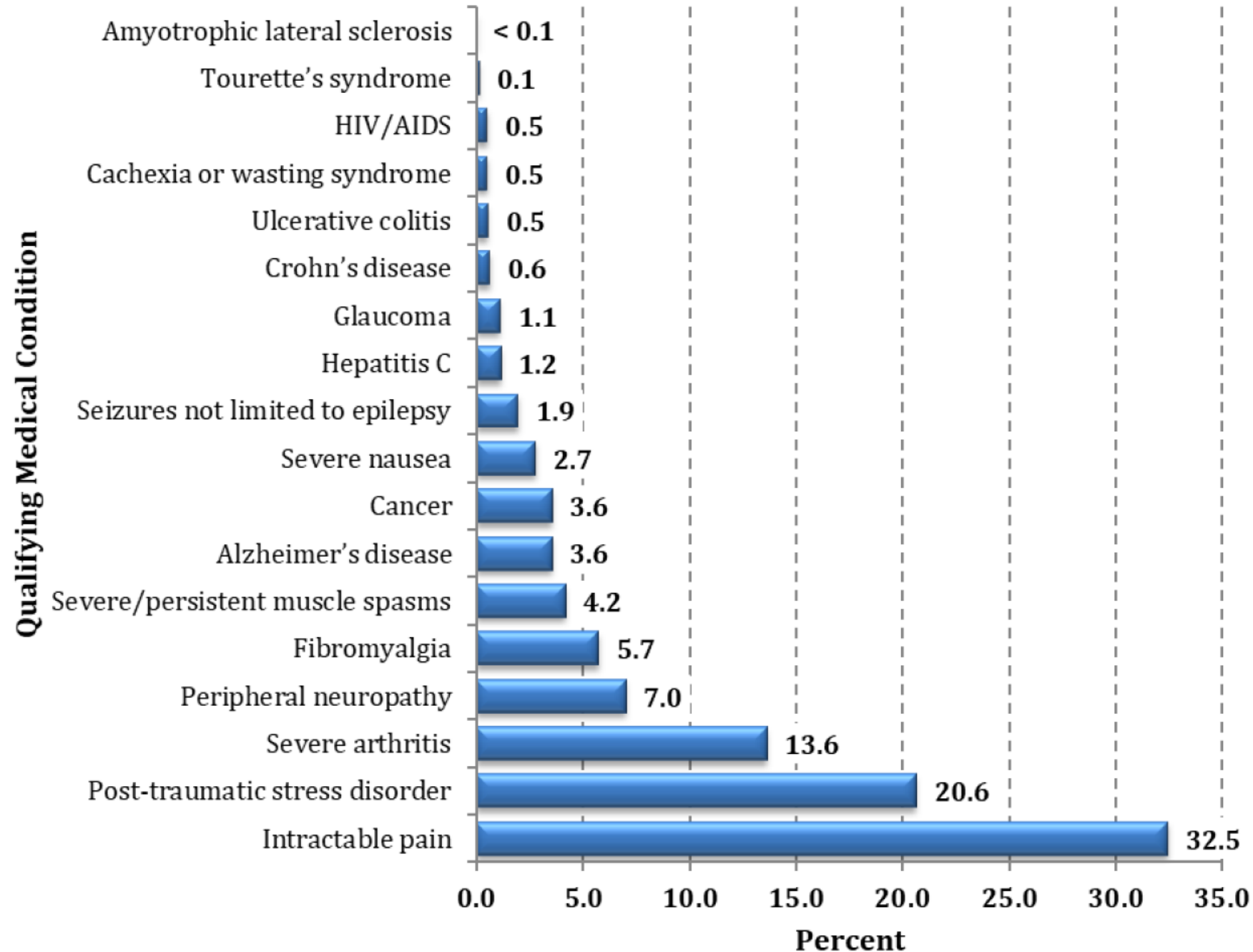
Current Status of Medical Marijuana in Arkansas

Procedure for Informing ADH when someone has violated MM use restrictions:

- ❖ No formal process
- ❖ Individual/organization contacts ADH using ADH's main number (501-682-4982)

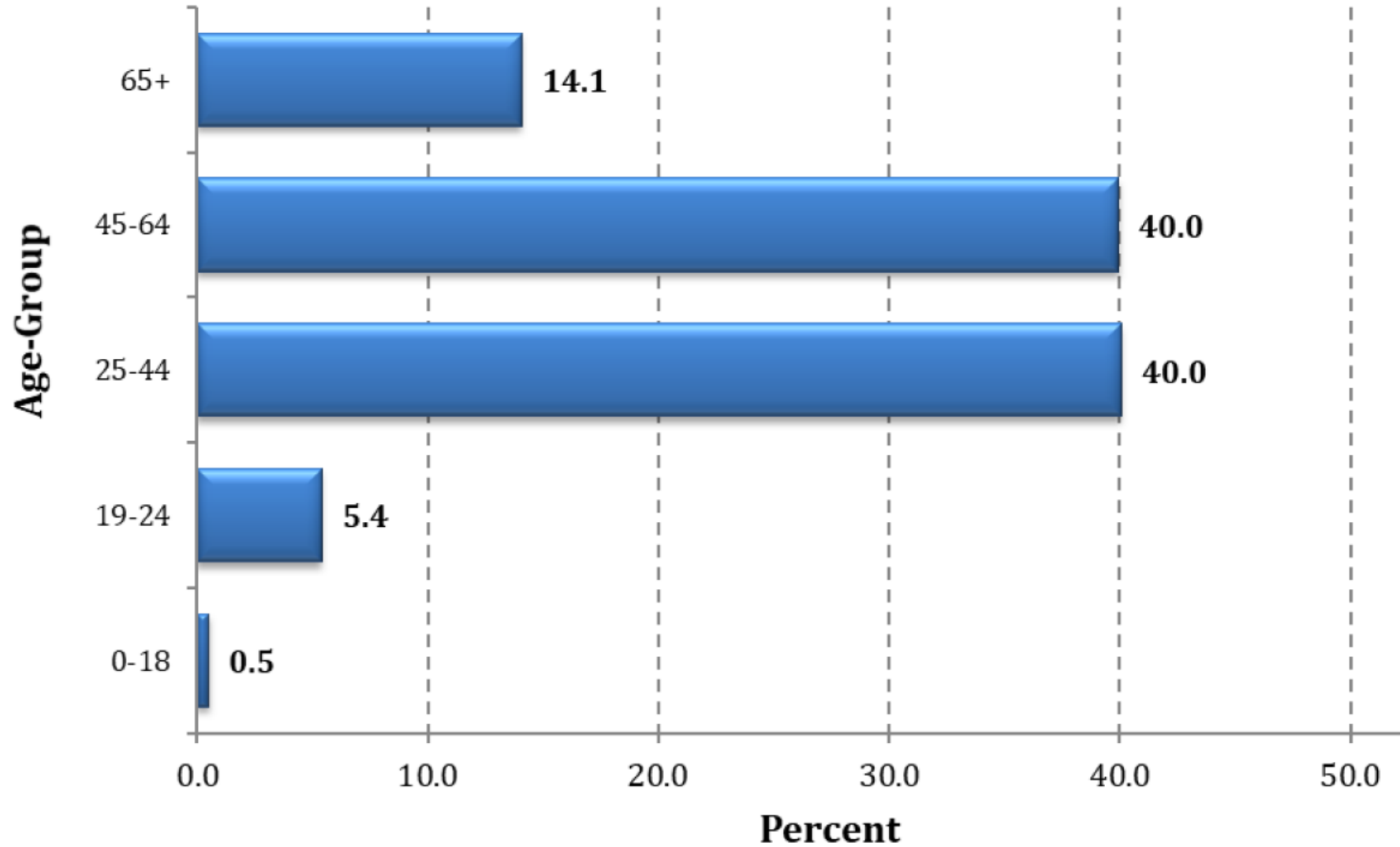
Medical Marijuana ADH FY 2020 Annual Report

MM Card Holders by Qualifying condition

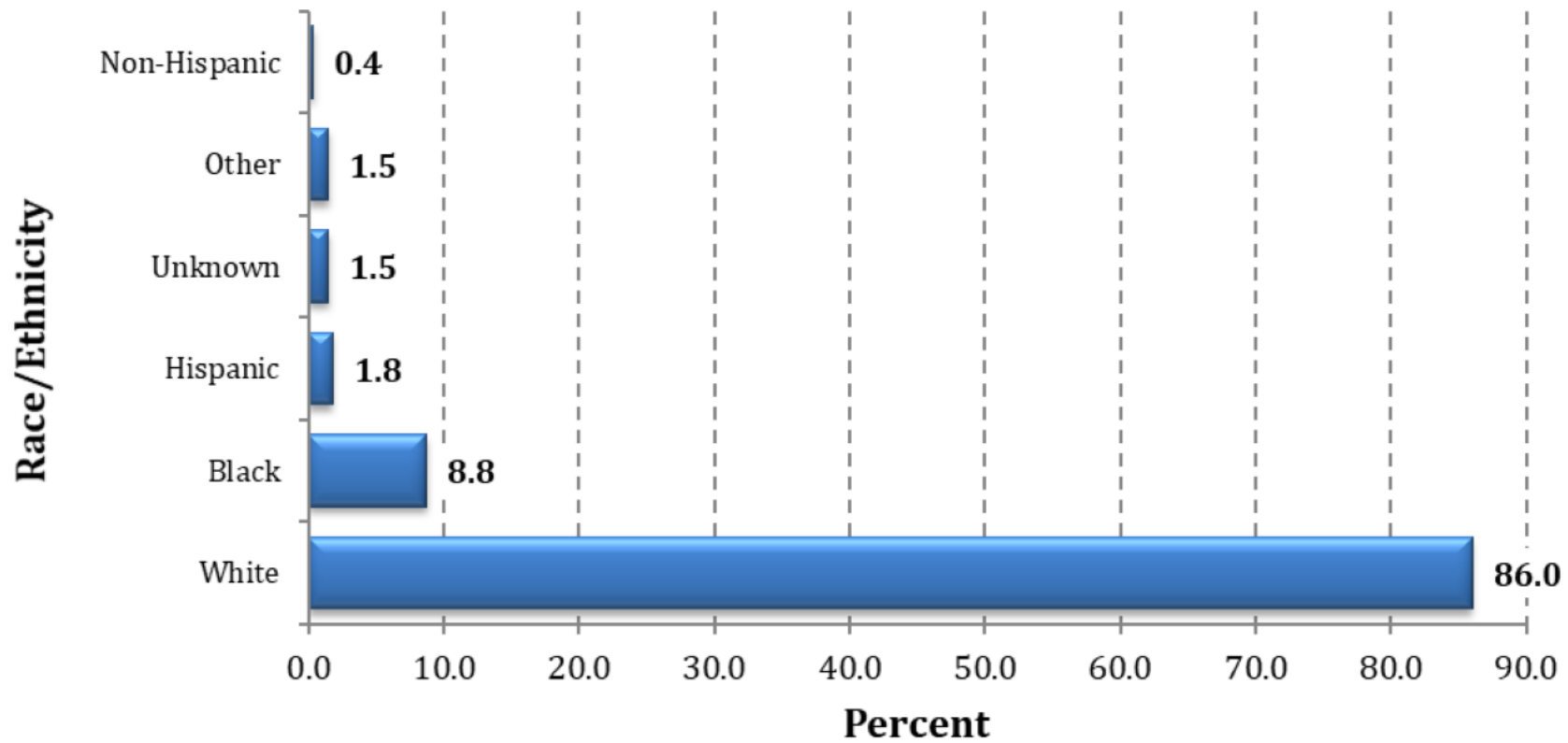


Medical Marijuana ADH FY 2020 Annual Report

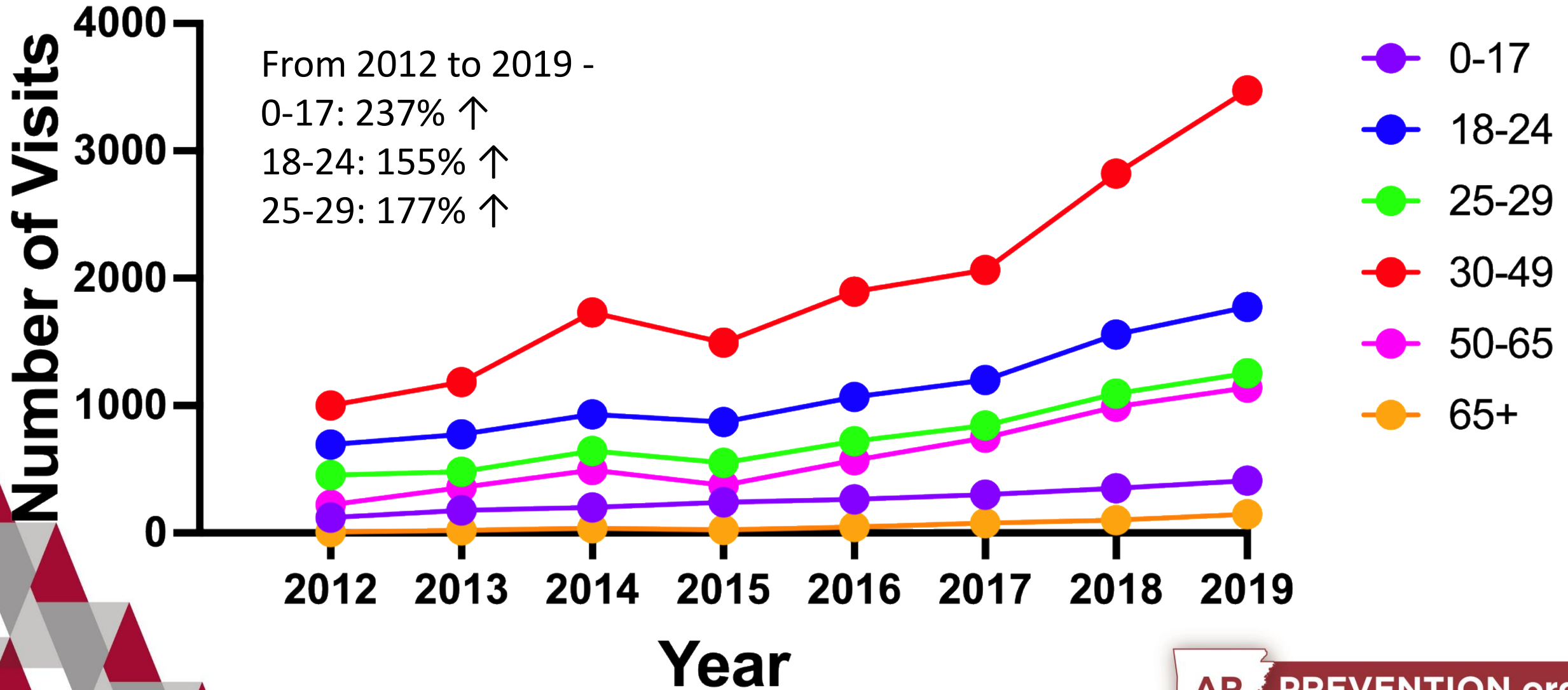
MM Card Holders by Age Group



Medical Marijuana ADH FY 2020 Annual Report



ED Visits Involving Marijuana



Real-Life Impacts: Common Scenario's

An approved MM Card Holder is stopped for allegedly DUI:

- Can affirmative defense and dismissal occur given violation of section 6 of amendment 98?
- If marijuana was involved and person is convicted, the person has violated rules regarding MM use and their MM ID Card can be revoked

An approved MM Card Holder is arrested for allegedly purchasing illicit marijuana:

- Can affirmative defense and dismissal occur given allegedly illegal act?
- If convicted, then their MM ID Card can be revoked

An approved MM Card Holder has a history of substance use disorder or criminality:

- This does not impact their card approval as long as they comply with rules and regulations

Real-Life Impacts: Common Scenario's (continued)

An approved MM card holder shares some of their medical marijuana with another qualified MM card holder:

- Can affirmative defense and dismissal occur?

An approved MM card holder is caught possessing more than 5 oz of marijuana:

- Can affirmative defense and dismissal occur?
- If convicted, then their MM ID Card can be revoked

An approved MM Card Holder shares their MM with a person who does not hold a MM ID card:

- Can affirmative defense and dismissal occur?
- If convicted, then their MM ID Card can be revoked

Real-Life Impacts: Common Scenario's (continued)

A caretaker has a history of substance use disorder:

- Is eligible for a caretaker MM ID Card, assuming all eligibility criteria are met

A caretaker was convicted of a violent felony offense 25 years ago:

- Is eligible for a caretaker MM ID Card, assuming all eligibility criteria are met

A caretaker of his/her minor children who qualify for patient MM ID card was convicted of controlled substance-related offense in the past 10 years

- No criminal check is done for a caretaker during application process
- If convicted of a controlled substance-related offense while being an approved caretaker, approval may be revoked

Real-Life Impacts: Common Scenarios (cont)

SCIENTIFIC REPORTS

A hair sample of a child in the custody of an approved MM ID Card Holder tests positive for cannabinoids

OPEN Finding cannabinoids in hair does not prove cannabis consumption

Bjoern Moosmann, Nadine Roth & Volker Auwärter

Paper reports on two studies conducted to clarify the main routes of incorporation for THC, THC-COOH and THCA-A into human hair and to provide a valid basis for correct interpretation of hair analysis results

- **Detection of THC, THC-COOH and THCA-A in human hair cannot be regarded as a proof of cannabis consumption or being present while marijuana is smoked**

Moosmann, B., Roth, N. & Auwärter, V. Finding cannabinoids in hair does not prove cannabis consumption. *Sci Rep* 5, 14906 (2015).



Health Effects of Passive Cannabis Exposure Among Children

Indoor cannabis smoke and children's health

Alexander Posis^{a,*}, John Bellettiere^{a,b,**}, Sandy Liles^a, John Alcaraz^c, Benjamin Nguyen^a, Vincent Berardi^{a,d}, Neil E. Klepeis^a, Suzanne C. Hughes^a, Tianying Wu^c, Melbourne F. Hovell^a

^a Center for Behavioral Epidemiology and Community Health (C-BEACH), Graduate School of Public Health, San Diego State University, San Diego, CA, USA

^b Department of Family Medicine and Public Health, University of California San Diego, La Jolla, CA, USA

^c Graduate School of Public Health, San Diego State University, San Diego, CA, USA

^d Department of Psychology, Chapman University, CA, USA

Odds of reporting a greater number of child adverse health outcomes were 1.83 times higher for children of families with indoor cannabis smoking (N=29) vs families without cannabis smoking (N=163).

Results were not statistically significant.

More studies are needed.

- 1) Past year use of an ED for coughing or difficulty breathing, and
- 2) Whether in the past year the child had a physician-diagnosed:
 - Ear infection
 - Bronchitis or bronchiolitis
 - Asthma
 - Skin conditions (e.g., eczema or atopic dermatitis)

Real-Life Impacts: Common Scenario's

A child of an approved MM ID Card Holder accidentally ingests MJ and ends up in ED:

- No specific rule in Amendment 98 about proper storage of MM
- Can a case be made for negligence or reckless endangerment?
 - Any precedents with other legal controlled substances?

Are parents negligent merely due to medical marijuana use?

Freisthler B, Gruenewald PJ, Wolf JP. ***Examining the relationship between marijuana use, medical marijuana dispensaries, and abusive and neglectful parenting.*** *Child Abuse Negl.* 2015;48:170-178. doi:10.1016/j.chiabu.2015.07.008

In CA, 3,023 parents or legal guardians of children 12 and younger surveyed (March 2009 through October 2009)

Results showed:

- 1) Parents with past-year marijuana use were almost 3 times more likely to engage in physical abuse than those who did not
- 2) Past-year marijuana use was unrelated to supervisory neglect
- 3) Parents with past-year marijuana use were less likely to engage in physical neglect than those who did not

May need to focus more on/monitor incidence of physical abuse rather than neglect.

Considerations

Policy considerations

- Should caregivers of minors be qualified to hold a Medical Marijuana card?
- Should caregivers of minors be allowed to smoke in front of teens?
- Should caregivers of minors with qualifying condition for MM card undergo a criminal history check?
- Should a history of substance use be an exclusion for caregivers?
- Should a provision around secure storage be added?
- Would a formal process for reporting offenses to ADH be useful?

Data Monitoring

- Any systematic data on MM impacts on custody cases?
- Any way to understand relationship between MM and child abuse?
- Are we monitoring impacts of MM in household on youth perceptions, etc.?

Substance Exposed Infants in Arkansas

Christin Harper

Assistant Director

Division of Children and Family Services
Arkansas Department of Human Services

Recent SAMHSA Reports

**New Publications:
October 14, 2021**

[Report to Congress on the Prevention and Reduction of Underage Drinking](#)

[Drinking 2020](#)

An annual report containing national data on underage drinking patterns, the federally coordinated approach on underage drinking prevention and treatment, and information on the National Media Campaign "Talk. They Hear You."

[State Performance & Best Practices for the Prevention and Reduction of Underage Drinking 2020](#)

This document evaluates states' use of best practices in preventing underage drinking, as required by the STOP Act.



Alcohol Metrics

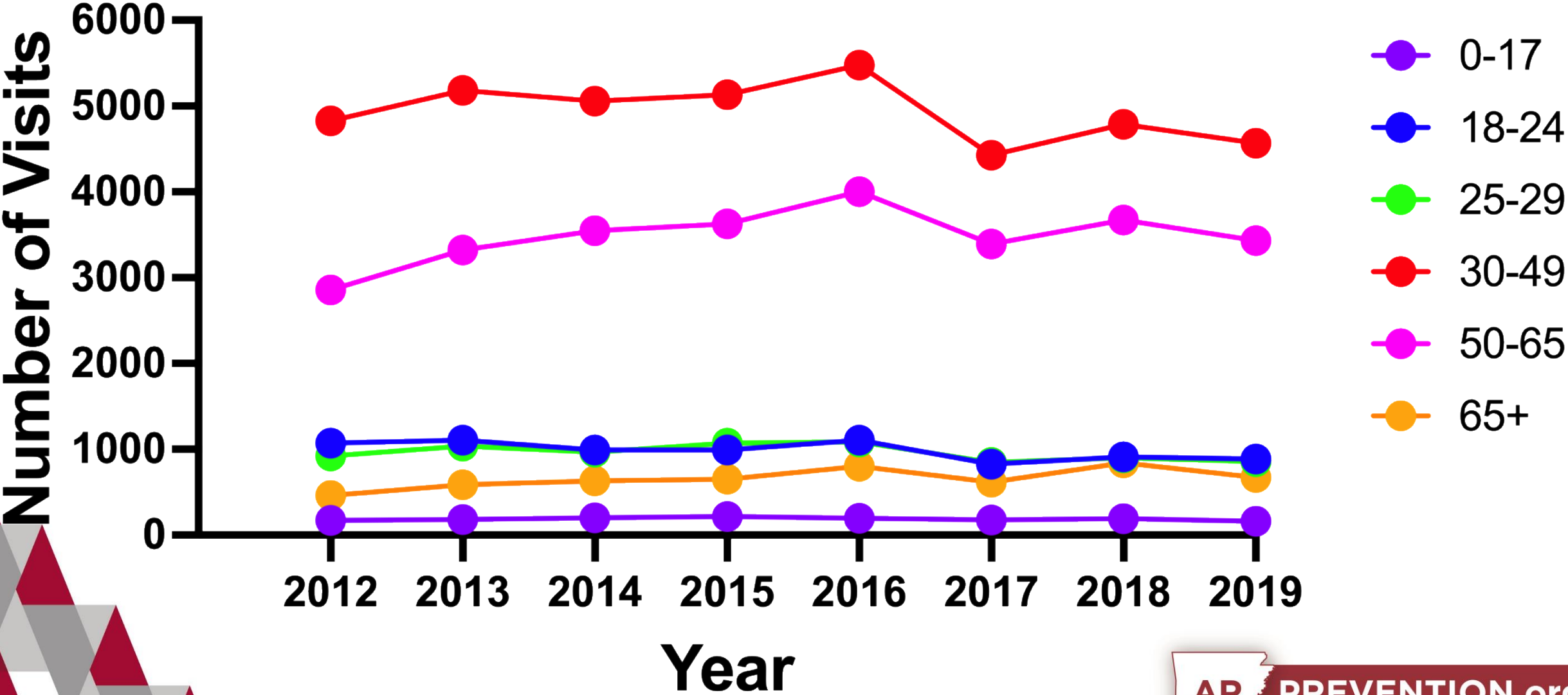
Measure	Arkansas (%)	US (%)
Alcohol Use (past 30 days): 12-20 yrs	16.8	19.3
Binge Drank (past 30 days): 12-20 yrs	10.1	11.7
Perceive no great risk of binge drinking 1-2 times/wk: 12-17 yrs	56.7	56.6
Meet DSM-IV Alcohol Use Disorder: 12-17 yrs	2.0	1.7
Needed but did not receive Tx for AUD: 12-17 yrs	2.0	1.7
Crash Deaths Involving Driver With a BAC \geq 0.01: 15-20 yrs	28.0	19.0

SAMHSA, State Performance & Best Practices for the Prevention and Reduction of Underage Drinking Report. 2020.

Based on 2017-2018 data

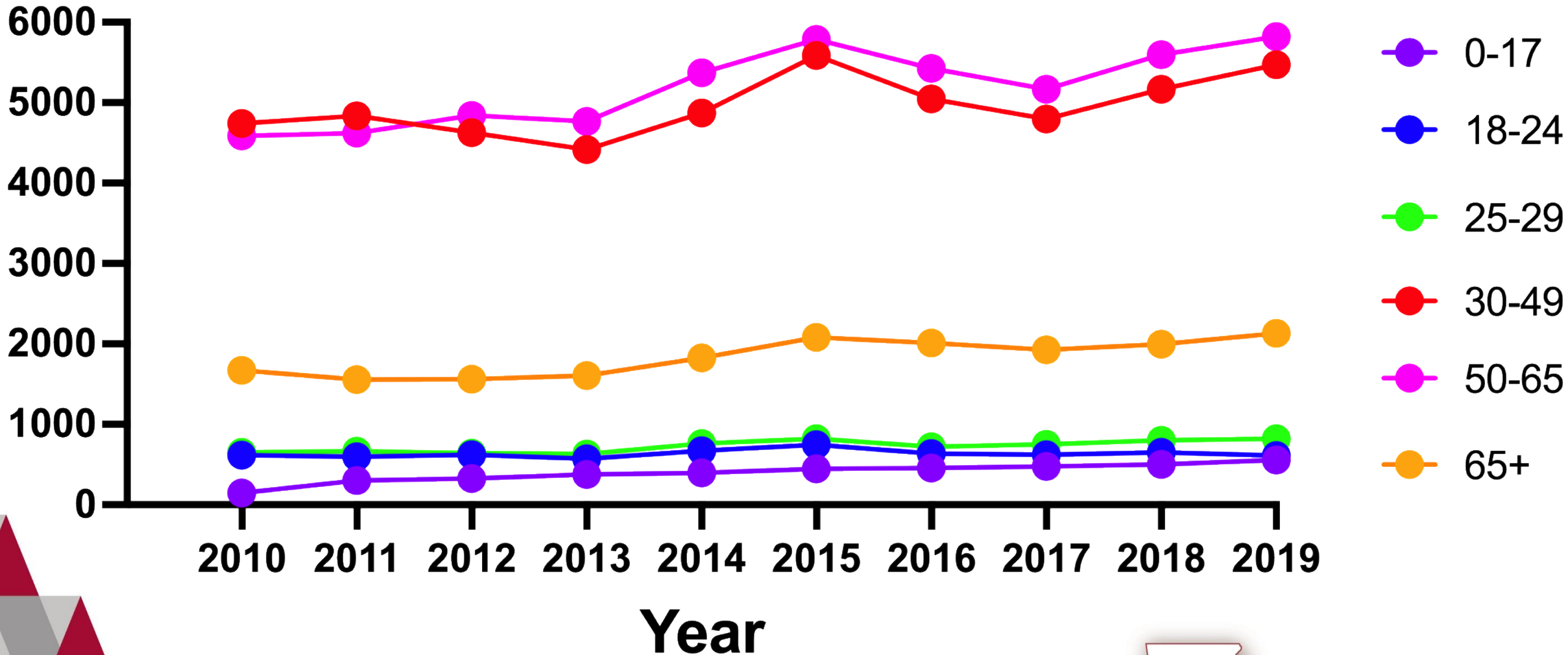


ED Visits Involving Alcohol



Hospitalizations Involving Alcohol

Number of Admissions



Jeff Thostenson

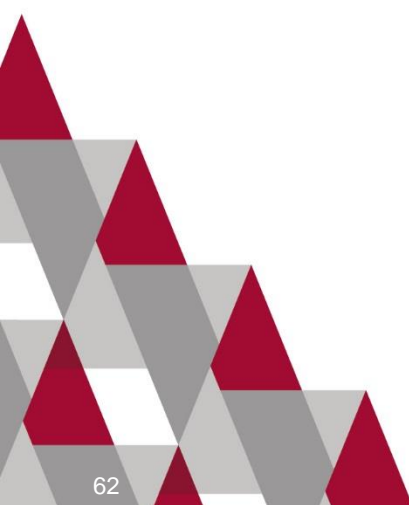
APNA Substance Use Data Trends

Association of COVID-Related Answers with Risk/Protective
Factor Answers

Darla Kelsay
Substance Abuse Prevention Coordinator
University of Arkansas at Little Rock
MidSOUTH Center for Prevention and Training

APNA Changes: Updates

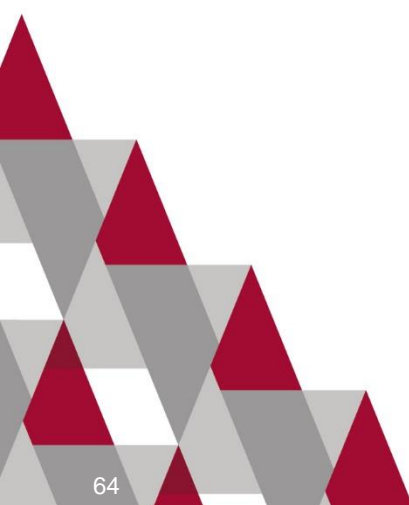
Me Over Meth Campaign: Updates



Discussion



Action Plan/Wrap-Up/Next Meeting





We CAN make a difference!

Thank you!

