Arizona Healthcare Cost Containment System Prevention Needs Assessment

Evaluation Report

May 2025

AHCCCS Prevention Needs Assessment

May 2025

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About LeCroy & Milligan Associates:

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 level with a broad spectrum of social services, criminal justice, education, and behavioral health programs. This report was prepared by Liz Hardesty, MPH; Steven Wind, PhD; Nancy Hankel, EdD; Tracey Thomas, DrPH; Natalie Long, MSW; Mireilys Ramirez, MPA; Julia Garcia, MSW; Karla Galindo, BSW; Tiffany Sais, MSW; Kara Jones, MA, MLIS; Nora Carrillo, MBA.

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EXECUTIVE SUMMARY

In response to evolving substance use trends and emerging public health challenges, the Arizona Health Care Cost Containment System (AHCCCS) contracted with LeCroy & Milligan Associates (LMA) to conduct a comprehensive statewide needs assessment. Guided by SAMHSA's Strategic Prevention Framework (SPF), this initiative assessed the scope of substance use prevention needs across Arizona.

The primary objectives were to evaluate existing prevention efforts, identify gaps and disparities, elevate community voices—particularly from underserved populations—and recommend evidence-based, culturally responsive strategies to inform future funding and policy. This assessment was grounded in a strengths-based, mixed-methods approach, incorporating input from more than 400 stakeholders, including youth, parents, tribal representatives, educators, and prevention professionals.

Data Collection Methods included a literature review, secondary data sources for Arizona and National Data (AYS, ADHS, AHCCCS, IHE, NSDUH, YRBS, CDC and more), a Workforce Survey, Listening Sessions, and Interviews.

The literature reviewed in the needs assessment highlights several significant trends shaping substance use in Arizona and nationally. **Cannabis use has increased steadily in recent years**, with national prevalence rising from 7.6% in 2013 to over 15% in 2022. Notably, marijuana use is now higher among young adult women than men for the first time, and LGBTQIA+ and female high school students also report higher rates of current marijuana use.

Vaping remains a key concern, especially among youth; while national use among middle and high school students declined to 5.9% in 2024, vaping is still widespread, fueled by discreet devices and appealing flavors. Among adults, e-cigarette use is highest in the 18–24 age group and more prevalent among LGBTQIA+ individuals.

Alcohol use shows mixed trends—while national binge drinking has declined slightly, Arizona's rates remain above average, with 19% of adults reporting binge use.

Fentanyl continues to be the most lethal substance nationally and in Arizona, contributing to over 74,000 overdose deaths in 2023, with increasing presence in counterfeit pills and significant seizure increases across the western U.S. These findings point to an urgent need for prevention approaches that address evolving patterns of normalization, shifting risk perceptions, and rising synthetic drug threats.

Key Findings

1. Evolving Substance Use Patterns

- Marijuana, vaping, and alcohol are the most commonly used substances among Arizona youth. Use often begins in middle or high school and is heavily influenced by peer networks and family norms.
- Marijuana use has become increasingly normalized since recreational legalization in 2021. Youth often perceive it as low-risk, and daily use is common in some peer groups.
- Vaping, particularly of flavored nicotine and THC, is rampant among youth and difficult to detect in schools. Devices are small, odorless, and often resemble everyday objects.
- Alcohol use remains widespread among high school and college students. Though national binge drinking rates are decreasing slightly, Arizona still reports high rates, especially in rural and border counties.
- Fentanyl is perceived as the most dangerous substance, despite low direct use among youth. Many are aware of its presence in counterfeit pills (e.g., fake Xanax or Percocet), and stakeholders express urgent concern about unintentional ingestion and overdose risk.
- Polysubstance use, especially combining alcohol with prescription medications or other drugs, was noted as an emerging issue.

2. Regional and Population-Based Disparities

- Access to prevention is highly uneven. Urban counties like Maricopa and Pima have well-established coalitions and access to school-based programs, while rural, tribal, and border regions often report limited funding, staff, and programmatic infrastructure.
- Counties with high poverty and unemployment rates—like Apache, Navajo, and Santa Cruz—experience elevated risk factors and higher reported youth use but lack the same volume of prevention programs found in urban areas.
- Tribal communities often lack infrastructure to host outside-led prevention programs due to sovereignty considerations, space limitations, or competing priorities.
- Transportation, weather, and social stigma are additional barriers to accessing prevention in more isolated areas.

3. Gaps for Underserved Populations

- LGBTQIA+ youth, Spanish-speaking families, youth of color, out-of-school youth, and individuals living in rural areas are significantly underrepresented in current prevention efforts.
    - LGBTQIA+ youth are at elevated risk due to minority stress, social isolation, and lack of affirming spaces or messaging.

- Youth in non-English-speaking households, especially Spanish-speaking homes, may lack access to culturally relevant materials and programs.
- Youth not enrolled in school, including those in juvenile detention, foster care, or alternative education, are often unreachable by traditional school-based prevention efforts.
- Rural areas continue to have access to fewer programs and positive activities for youth.

4. Prevention System Strengths and Opportunities

- Arizona has dedicated coalitions, engaged educators, and proactive tribal and public health partners who are committed to prevention.
- Programs such as *The Buzz* and *Belief in Bloom* successfully engage college students with creative, pro-social programming.
- Narcan training, marijuana prevention education, and vaping awareness initiatives are expanding, particularly on college campuses and in some school districts.
- Many local coalitions are incorporating mental health education, trauma-informed practices, and peer-led interventions to increase effectiveness.

5. Workforce Capacity and Readiness

- The Workforce Survey (N=314) revealed that while most prevention professionals are passionate and experienced, many feel undertrained in key areas such as:
  - LGBTQIA+ affirming practices
  - Cultural responsiveness
  - Trauma-informed care
  - Emerging drug trends (e.g., fentanyl, cannabis concentrates)
- Many rural and tribal prevention staff are managing large geographic areas with minimal support, leading to burnout and inconsistent service delivery.
- Only 37% of survey respondents reported feeling adequately prepared to address new challenges like youth vaping or the impact of social media on substance use behaviors.

6. Risk and Protective Factors

- Risk factors identified include:
  - Trauma and adverse childhood experiences (ACEs)
  - Peer pressure and social media influence
  - Early access to substances through friends and/or family
  - Social normalization of use in the home or community
- Protective factors include:
  - Strong family communication

- Pro-social engagement opportunities (e.g., sports, clubs)
- Culturally affirming environments and mentors
- Access to mental health services and trusted adults

- Youth and adult stakeholders consistently emphasized that building trust, offering safe spaces, and incorporating youth leadership are critical to increasing protective factors.

Recommendations

Expand and Diversify the Prevention Workforce

- Offer competitive salaries, rural and tribal service stipends, and clear career pathways.
- Provide training in prevention science, trauma-informed care, cultural humility, and substance use trends.
- Support community health workers and peer-led models, especially in tribal and bilingual settings.
- Establish regional training collaboratives to share knowledge and build capacity.

Strengthen Equity and Program Reach

- Fund prevention initiatives tailored to underserved groups, including LGBTQIA+ youth, Indigenous youth, and disconnected youth.
- Develop flexible, youth-centered programming in nontraditional settings, such as juvenile justice, afterschool spaces, and digital platforms.
- Expand bilingual and culturally specific resources and integrate Indigenous healing practices where appropriate.
- Incorporate youth voice through participatory program design and evaluation.

Enhance Prevention Messaging and Education

- Launch a statewide campaign focused on vaping, marijuana, alcohol, and fentanyl risks, modeled after successful public health campaigns.
- Develop parent toolkits for addressing substance use at home and strategies for early conversations.
- Support youth-developed social media content and peer campaigns to increase relevance and reach.
- Train school personnel to recognize and respond to new substance use trends and devices.

Promote Systemic Coordination

- Convene interagency planning groups across sectors such as education, public health, and juvenile justice.
- Integrate prevention into school wellness efforts, behavioral health screenings, and higher education programming.
- Partner with tribal governments, colleges, and community-based organizations to co-create innovative, place-based prevention approaches.

Advance Early Intervention and Mental Health Supports

- Embed substance use prevention in behavioral health screenings and restorative school practices.
- Fund early childhood and parenting programs that build protective factors early in life.
- Expand access to pro-social youth development opportunities statewide.

Invest in Data and Evaluation

- Provide TA and mini-grants to expand local data collection capacity and analysis.
- Promote community-based participatory research (CBPR) to elevate local voices and ensure relevance.
- Disseminate findings through dashboards, infographics, and briefs tailored for different audiences.

Arizona's substance use prevention system faces urgent challenges but also tremendous opportunities. **The findings of this needs assessment point to clear priorities: deepen equity, modernize the workforce, engage youth meaningfully, and scale what works.** With strategic investment and bold coordination, AHCCCS can build a stronger, more inclusive prevention infrastructure that protects the health and potential of all Arizonans.

Substance Use Trends & Prevention

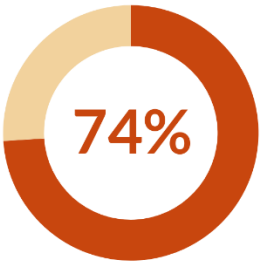
School-Age Youth (Ages 12-17)

15% Youth reported using e-cigarettes once or more in their lifetime.

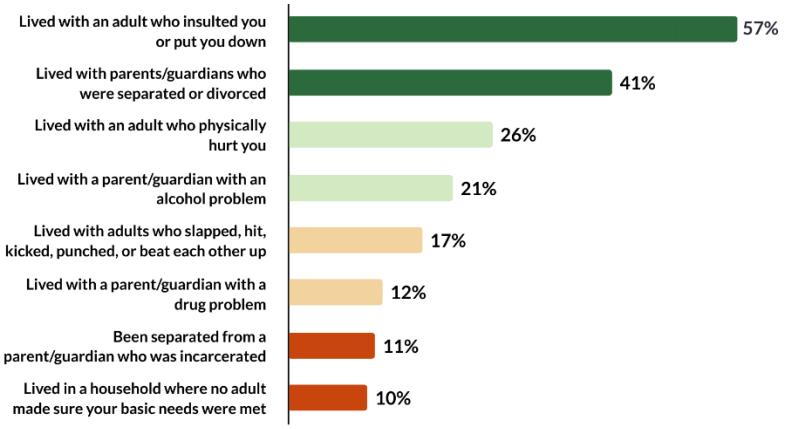
15% Youth reported using marijuana* once or more in their lifetime.
*Marijuana edibles (**11.8%**) and marijuana concentrates (**11.2%**) reported separately.

27% Youth reported using alcohol once or more in their lifetime.

Adverse Childhood Experiences (ACEs) Among Arizona Students



of Arizona Youth Survey (AYS) respondents reported having **at least one** ACE



Thoughts from Community Members Across Arizona

"Instead of using their prescription drugs, they are looking for that euphoric high to take them out of whatever they're feeling."
- Student Listening Session Participant

"There's some really good programs going on, but some people lack transportation. Transportation would be good."
- Student Listening Session Participant

"I'm sure [substance use] has a lot to do with numbing pain. And I'm not talking physical pain, but I'm sure that there is mental-emotional pain that people just don't want to feel. They would rather go around and be numb."
- Parent Listening Session Participant

"Because we're a border city, we can get ahold of fentanyl and marijuana. It's easy to get stuff like that. Someone could just cross and get drunk."
- Student Listening Session Participant

Risk Factors

64% AYS respondents reported **low commitment to school.**

26% Students with high risk.*

22% AYS respondents reported a perceived **availability of drugs** in their community.

17% AYS respondents reported their parents/guardians have attitudes **favorable to drug use.**

17% AYS respondents reported **attitudes favorable to antisocial behavior.**

Protective Factors

70% AYS respondents reported **opportunities for prosocial involvement** in school.

66% Students with high protection.**

58% AYS respondents reported **family attachment.**

50% AYS respondents reported **interaction with prosocial peers.**

*Students who reported more than eight risk factors (8th grade) or more than 9 risk factors (10th & 12th grade) in their lives.
**Students who reported four or more protective factors (all grades) in their lives.

Prevention Needs and Recommendations

Needs		Recommendations
In more rural areas, youth and parents report few safe spaces or activities for youth, as well as inconsistent access to programming.	**Youth Programming**	Invest in physical infrastructure such as youth centers and community gyms to provide safe alternatives and pro-social environments.
Staff capacity to provide services was highlighted as a concern.	**Staff Capacity**	Support prevention workforce development, particularly in rural and tribal areas, by funding full-time roles and providing ongoing training in trauma-informed practice and fentanyl awareness.
LGBTQ+ youth and Spanish-speaking families are frequently underserved due to language barriers, stigma, or lack of targeted outreach.	**Care for High-Risk Subpopulations**	Develop culturally and linguistically tailored content, especially for high-risk populations.
Some participants reported that prevention is largely absent in school systems.	**Prevention in Schools**	Expand school-based and peer led programs that speak to youth realities and normalize help-seeking.

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Unless otherwise noted, all quantitative data comes from the 2024 Arizona Youth Survey (AYS). Data is collected every two years by the Arizona Criminal Justice Commission's Statistical Analysis Center. In 2024, just over 42,000 8th, 10th & 12th graders completed the survey, or about 18% of the student population in these grades statewide. Qualitative data comes from listening sessions conducted with school-age youth across Arizona.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Substance Use Trends & Prevention

College Students & Transition-Age Youth (Ages 18-26)

22%

of college students reported there is "no risk" or "slight risk" in using e-cigarettes daily.

15% reported that there is "no risk" or "slight risk" in smoking one or more packs of cigarettes per day.

67%

of college students reported there is "no risk" or "slight risk" in using marijuana once or twice/week.

26%

of college students reported there is "no risk" or "slight risk" in consuming one or two alcoholic drinks daily.

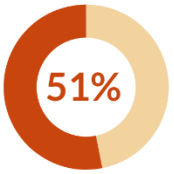
17% reported that there is "no risk" or "slight risk" in consuming five or more alcoholic drinks in a row once or twice per week.

Past 30-Day Reported Substance Use

Alcohol: 53% **Marijuana: 28%** **E-Cigarettes: 19%** **Tobacco: 8%** **Cocaine: 2%**

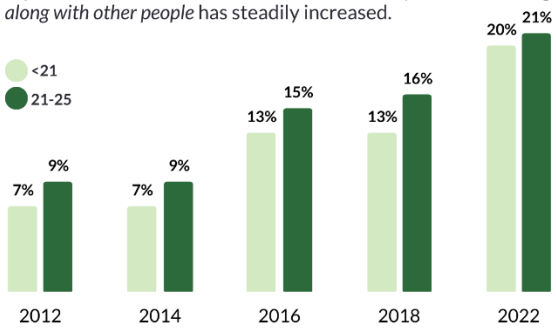
Mental Health & Substance Use

A little **more than half** of all students surveyed reported that they **received information from their college or university on alcohol and other drug use**



Approximately the same number of students indicated that they **received information regarding depression & anxiety**

Since 2012, the percentage of young adults saying that *anxiety or depression made it difficult for them to work, study, attend class or get along with other people* has steadily increased.



College students from around Arizona share their thoughts on experiences with mental health and substance use:

"My friends describe [marijuana] as kind of being a reward...throughout the day they've experienced stressful stuff, but they say, ok, well, I get to go home tonight and smoke. So, it's ok."

"Students are lonely. They are struggling to connect with the people around them."

"I feel like a lot of people just struggle to not be anxious and to have a good time in public."

"There's never social activities to actually go out and do together, so I think that would be helpful to have something we can look forward to doing that doesn't involve [substances]."

"We need more mental health support, because I think we know that's kind of the root cause of a lot of substance use...there are so many people here who can't access therapy and can't afford it."

Risk and Protective Factors Identified by Participants

Risk Factors

- Normalization of substance use
- Negative influence by peers
- Stress
- Lack of social involvement
- Family norms
- Parental influence

Protective Factors

- On-campus counseling
- Supportive resident assistants for students living on campus
- Increased focus on mental health
- Pro-social groups and events (athletics and clubs)
- Parental influence

Prevention Needs and Recommendations

Needs		Recommendations
More relevant messaging about prevention.	**Messaging**	Support social media micro-campaigns developed by college students to increase relevance and engagement.
Partnerships, planning groups, and initiatives embedded in institutions of higher education.	**Systemic Coordination**	Convene interagency planning groups to coordinate funding, training, and messaging. Embed substance use prevention into initiatives, establish state-supported partnerships to pilot prevention models.
LGBTQ+ teens, tribal youth, Spanish-speaking families, and individuals in rural areas are underserved.	**Care for High-Risk Subpopulations**	Develop culturally and linguistically tailored content, especially for high-risk populations.
College students do not always have the funding to access behavioral health care.	**Access to Care**	Education about what free or low-cost services are available to students through their school and community.

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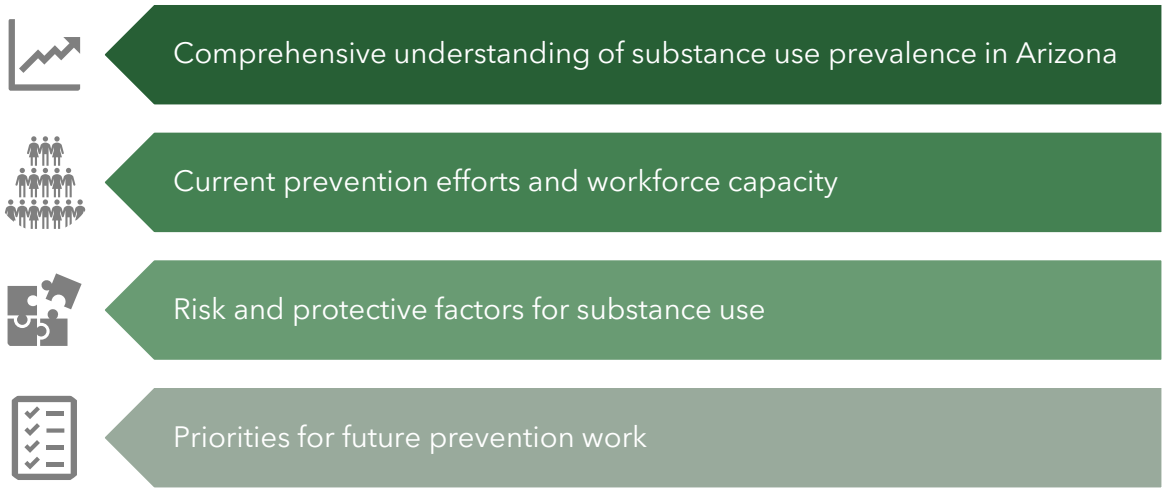
Unless otherwise noted, all quantitative data comes from the 2022 Arizona Institutes for Higher Education (AZIHE) survey. This survey is administered every other year to students attending Arizona State University, Embry Riddle Aeronautical University, Northern Arizona University, Pima Community College, the University of Arizona, and Yavapai College and is comprised of a random sampling of undergraduate students from each institution. Qualitative data comes from listening sessions conducted with college students and transition-age youth across Arizona.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency, providing health care coverage to low-income residents. As Arizona's single state agency for substance use treatment, AHCCCS also plays a significant role in addressing substance use disorders through multiple grant sources and initiatives.

In 2024, AHCCCS contracted with LeCroy & Milligan Associates (LMA) to conduct a 7-month Statewide Substance Use Prevention Needs Assessment to identify and prioritize key issues related to substance use prevention across the state. This assessment is designed to support AHCCCS in identifying and funding future primary prevention strategies. To inform strategies, the assessment provides the following:



AHCCCS SUBG Prevention Program

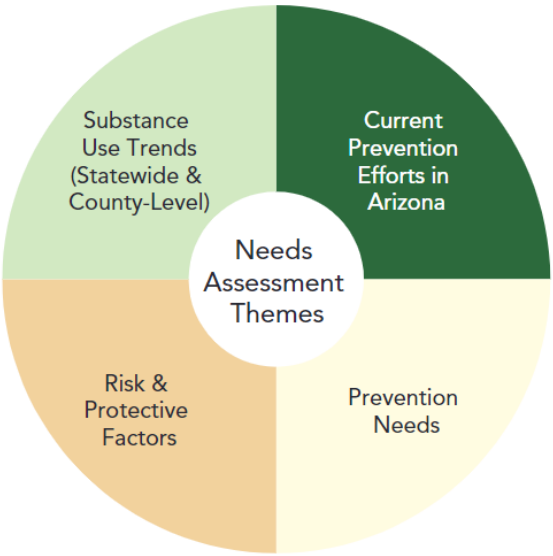
The Arizona Health Care Cost Containment System (AHCCCS) receives Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funding from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) for planning, implementing, and evaluating substance use disorder (SUD) services throughout Arizona. The SUBG Prevention program specifically allocates resources for primary SUD prevention efforts. AHCCCS' SUBG grant administration aims to identify needs for substance use prevention throughout the state, as well as disparities in physical or cultural access to prevention programs. The needs assessment results will assist AHCCCS in determining prevention priorities, identifying effective prevention strategies, and making informed funding decisions.

Assessment Framework

The assessment was guided by the Strategic Prevention Framework (SPF), which is widely recognized for its emphasis on evidence-based decision-making, stakeholder engagement, and community context. The SPF is a planning process designed to guide communities in developing effective SUD prevention strategies tailored to their specific needs and context.

The SPF recognizes that substance use is influenced by a wide variety of factors, including **demographic factors** (e.g., age, income, and education levels); **cultural factors** (e.g., norms within different racial/ethnic groups); **economic factors** (e.g., availability of resources, access to services); **geographic factors** (e.g., rural vs. urban disparities); and **political factors** (e.g., local policies, state initiatives). This recognition provides a comprehensive understanding of substance use patterns and their underlying factors, including risk and protective factors, which inform targeted prevention strategies. By addressing the root causes of substance use, communities can influence both consumption patterns and consequences of substance use.

Guided by the SPF, this needs assessment is organized around four major themes: 1) substance use trends in Arizona and at the county level; 2) current prevention efforts in Arizona; 3) risk and protective factors; and 4) prevention needs. Additionally, the assessment included a review and comparison of SUBG prevention allocation models to recommend one that best aligns with the state's substance use priorities and goals. The needs assessment's multi-dimensional approach offers an in-depth view of substance use in the state, informing future prevention efforts.



METHODOLOGY

AHCCCS contracted with LeCroy & Milligan Associates (LMA) to conduct the assessment using a mixed-methods approach based on the SPF. This section describes the methods LMA used to carry out the needs assessment.

Whenever possible, LMA attempted to recruit participants in higher-risk subgroups, including rural and urban populations, racial/ethnic minorities, LGBTQIA+ individuals, and other marginalized communities. AHCCCS provided a list of stakeholders that included representatives from government agencies, prevention coalitions, community-based organizations, healthcare providers, and tribal authorities to ensure all relevant voices were included to effectively address Arizona's diverse needs.

The inclusion of diverse perspectives was critical to answering the key assessment questions below, which relate to the assessment's four major themes:

I. Substance Use Trends

- What is the current prevalence of substance use among different demographic groups and geographic populations in Arizona?

II. Current Prevention Efforts

- What are best practices in substance use prevention?
- What prevention efforts are implemented in the state, and how do they differ by county or region?
- What populations are served by current prevention efforts, and where are the gaps?
- What are the key barriers to implementing primary prevention efforts for substance use?
- What is Arizona's primary prevention workforce capacity, and how does it vary by county or region?

III. Risk & Protective Factors

- How do various factors (e.g., demographic, geographic, cultural) affect substance use trends in Arizona and in specific counties or regions of the state?

IV. Prevention Needs

- What are the strengths and gaps in existing resources, policies, programs, and interventions for substance use prevention?
- What prevention strategies are needed to address the factors influencing substance use in Arizona, particularly in high-need geographic regions and demographic groups?
- What are the training needs for the primary prevention workforce?

To answer these questions, the assessment used a combination of primary and secondary data collection and analysis. Exhibit 1 lists the data sources used in this assessment, along with a brief description of each source's purpose in advancing the needs assessment. The assessment also included a literature review of current best practices in primary prevention education for youth and adults. When possible, the literature included in this assessment focused on the past five years (2019-2024) to ensure the information was both current and applicable in practice.

Exhibit 1. Data Collected, Purpose, and Analytic Method

Data Source	Purpose/Construct	Method of Analysis	Sample Size
Arizona Data (AYS, ADHS, AHCCCS, IHE, etc.)	Identify incidence, prevalence, and contributing factors to substance use across different populations in Arizona.	Descriptive Statistics	N/A
National Data (NSDUH, YRBS, CDC, etc.)	Identify incidence, prevalence, and contributing factors to substance use across different populations in Arizona.	Descriptive Statistics	N/A
Workforce Survey	Elicit feedback about primary prevention workforce capacity and priorities from individuals engaging in prevention-related work across Arizona. The survey was shared with two distinct populations doing prevention work: substance use prevention coalitions & organizations, and school mental health professionals & school nurses.	Descriptive Statistics; Thematic Analysis	N=314 (207 prevention specialists & 107 school MHPs & nurses)
Listening Sessions	Elicit feedback from various coalitions and organizations throughout the state on current prevention efforts, strengths, and barriers with a focus on rural and young adult/college populations.	Thematic Analysis	N=10 (91 total participants)
Interviews	Elicit feedback from various stakeholders and SMEs throughout the state on current prevention efforts, strengths, and barriers with a focus on rural and young adult/college populations.	Thematic Analysis	N=8
Literature Review	Research on current and best practices in the field of substance use prevention.	--	N/A

Secondary Data Sources

The following secondary data sources were consulted for this needs assessment, and a brief description of each source is included below. Please note that throughout this report, there are discrepancies in the number of decimal places reported for numeric data. This is due to the way data are reported in secondary sources. We included decimal places where provided and appropriate to be as accurate as possible in our reporting.

Arizona Institutes for Higher Education Network (AZIHE)

The AZIHE online survey is coordinated by the Arizona Board of Regents as well as individual colleges and universities across the state and is administered every other year to students attending Arizona State University, Embry Riddle Aeronautical University, Northern Arizona University, Pima Community College, the University of Arizona, and Yavapai College. It is comprised of a random sampling of undergraduate and graduate students (ages 18-24) from each institution. The survey collects data on student health behaviors, academic performance, mental health, substance use, and academic engagement. Only two institutions completed the survey in 2020 due to the COVID-19 pandemic; therefore, data from this year is unavailable.

Arizona Youth Survey (AYS)

The AYS is sponsored by the Arizona Department of Health Services (ADHS) Bureau of Population Health & Vital Statistics and gathers data on substance use, mental health, attitudes towards prevention, and risk behaviors among middle—and high-school-aged youth in grades 8-12 across the state. This survey is conducted every two years.

Arizona Department of Health Services (ADHS), Bureau of Population Health and Vital Statistics

ADHS operates programs throughout the state in the following areas: disease prevention and control, health promotion, community public health, environmental health, maternal and child health, emergency preparedness, and the regulation of various centers across the state (childcare, assisted living, etc.). The Bureau of Population Health and Vital Statistics provides information on patterns and trends in the health status of all Arizonans, with up-to-date information available on their website.

Arizona Department of Public Safety (DPS), Arizona Crime Statistics

DPS collects data on crime statistics that are submitted by local law enforcement agencies across the state and publishes them on a website[1] for the public to access.

High School Youth Risk Behavior Survey (YRBS)

The YRBS is sponsored by the Centers for Disease Control and Prevention (CDC) and collects data on risk behaviors among high school students, including substance use, sexual behaviors, physical activity, and mental health. The survey is conducted every two years among high school students in grades 9-12, typically ages 14-18.

[1] https://azcrimestatistics.azdps.gov/tops

National Survey on Drug Use and Health (NSDUH)

The NSDUH is a national survey conducted by SAMHSA annually, with a focus on drug use, mental health issues, and access to treatment. The survey is conducted among individuals aged 12 and older, and data is grouped by categories of youth ages 12-17 and adults 18 and older.

Treatment Episode Data Set (TEDS)

The TEDS is a national data system under the umbrella of SAMHSA that tracks admissions and discharges from licensed substance use treatment facilities nationwide. The data collected consists of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of individuals aged 12 and older who are receiving services.

Workforce Survey

The Workforce Survey was designed to be completed by individuals throughout the state who are actively involved in primary prevention-related activities in either a paid or volunteer position. AHCCCS provided LMA with a list of stakeholders and contacts that do prevention work, and LMA also reached out to active coalitions and community organizations listed on the *Substance Awareness Coalition Leaders of Arizona* (SACLAz) website.[2] Since some of the information on this website was out of date, LMA reached out to all of the listed coalitions and organizations to determine their status. A table of **active** coalitions pulled from the SACLAz website is in Appendix A.

Since a large amount of prevention work also occurs in the K-12 school setting, LMA connected with the Arizona Department of Education to request that the survey be shared with School Mental Health Professionals (MHPs) and School Nurses in districts across Arizona. Incentives in the form of a $15 e-gift card were offered to survey participants. Due to a limit on the number of incentives that could be provided, the survey was first distributed to rural and tribal organizations/coalitions and then to the remainder of the state, as well as School MHPs and School Nurses, two weeks later. This was one strategy implemented to help ensure that groups often underrepresented in these types of needs assessments had the opportunity to complete the survey first and be guaranteed an incentive for doing so. The full survey is available in Appendix D.

Listening Sessions

LMA conducted ten listening sessions throughout the state to gain a better understanding of substance use trends, current prevention efforts, and protective factors across individual communities. Many of these sessions were held in rural parts of the state, as these communities are more often underrepresented in large, statewide needs assessments. AHCCCS also

[2] https://saclaz.org

requested that LMA focus on college students' perspectives on substance use, so three groups were held in three different counties with community college students (Arizona Western College & Yavapai College) as well as 4-year university students (Northern Arizona University). Listening sessions were all conducted in person and lasted approximately 1.5 hours, and incentives in the form of a $25 gift card were offered to participants at the end of each session. Details on the participating organizations are listed below in Exhibit 2.

Exhibit 2. Needs Assessment Listening Sessions Participating Organizations

Organization	City / County	Population (# in attendance)
Mohave Substance Treatment Education & Prevention Partnership (MSTEPP)	Kingman / Mohave	Coalition and community members (9)
Copper Canyon Coalition	Superior / Pinal	Coalition and community members (10)
Yuma County Anti-Drug Coalition (YADC)	Yuma / Yuma	Coalition and community members (8)
Arizona Western College	Yuma / Yuma	College students (12)
Be Awesome Coalition	Maricopa / Maricopa	Parents & Educators (9)
Yavapai College	Prescott / Yavapai	College students (8)
Northern Arizona University	Flagstaff / Coconino	College students (3)
Circles of Peace*	Nogales / Santa Cruz	Coalition and community members (13); Youth (7)
Guadalupe Prevention Partnership	Guadalupe / Maricopa	Tribal community members (12)

Note: Organizations are listed in the order in which the session occurred. *Circles of Peace held two separate sessions: one for adults and one for youth.

Interviews with Stakeholders & Subject Matter Experts

In addition to listening sessions, LMA conducted eight interviews with stakeholders and subject matter experts across the state to gain additional insights into prevention work that is happening in Arizona, what is currently working well/improvements that could be made, and where participants felt future funding should be directed. Interviews were conducted with four coalition directors (two of whom worked primarily with tribal populations); two prevention directors who primarily work with college students, one tribal health program director, and one prevention specialist with the Arizona Department of Education. Interviews lasted between 45 minutes to one hour and were conducted via Zoom. Interviewees received a $25 e-gift card as an incentive at the end of each session.

Limitations

While LMA sought to be as inclusive as possible of all groups when scheduling listening sessions, we had limited success engaging tribal populations. Early in the project, AHCCCS shared news of the assessment with their tribal work group and liaisons, but many contacts we outreached did not have the time to assist in the recruitment of participants or the space available to host a listening session. There are also strict rules to which tribes must adhere when an outside entity conducts data collection activities, and the short timeline for this project made it difficult to complete these requirements in a timely fashion. In lieu of listening sessions, we focused our efforts on conducting individual interviews with tribal members who are involved in prevention work, as well as disseminating the workforce survey to tribes and rural areas in Arizona two full weeks before a wider release to the remaining coalitions and organizations in the state.

When scheduling listening sessions, LMA asked coalitions to recruit as diverse a group as possible to ensure a wide range of thoughts and opinions from participants. Since coalitions had the freedom to choose which individuals they invited to these sessions, LMA had minimal oversight in the process, other than being able to review a list of attendees in advance for some sessions; for others, a review of the list in advance was not possible.

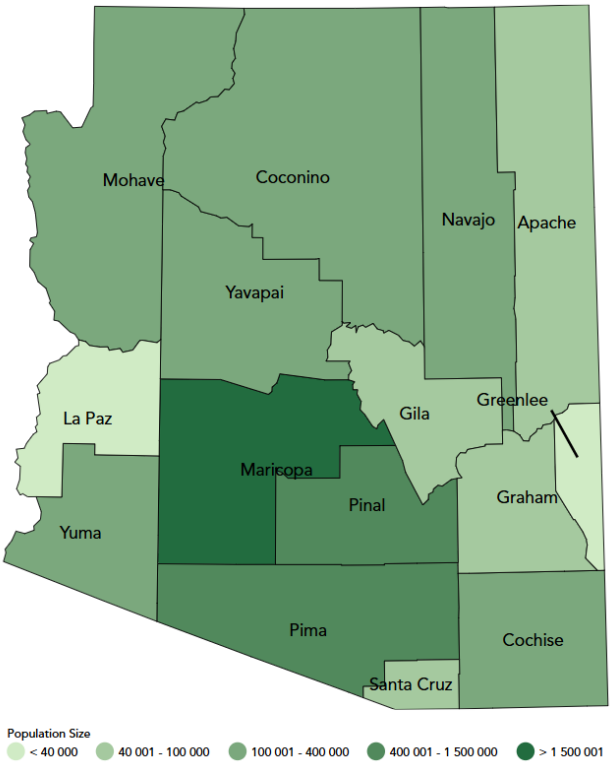
Regarding secondary data limitations, this needs assessment includes federal and state data collected since 2018, which covers the period of time when the COVID-19 pandemic occurred. For some sources, there is a gap in data collection and reporting from 2020-2021, and when possible, this is documented in a note beneath individual exhibits.

ARIZONA DEMOGRAPHICS

Understanding the demographic context of the state and its distinct regions is essential to designing and implementing effective substance use prevention efforts. Population characteristics such as age distribution, poverty rates, and employment status provide important insight into the underlying social and economic conditions that may influence substance use risk and protective factors. By examining who lives in a community and the challenges they face, prevention programs can be better tailored to address disparities, allocate resources strategically, and support high-needs populations across the state. The following exhibits show the most up-to-date information available at the time of reporting on Arizona's population distribution, race/ethnicity/age group breakdown, as well as poverty and unemployment rates statewide.

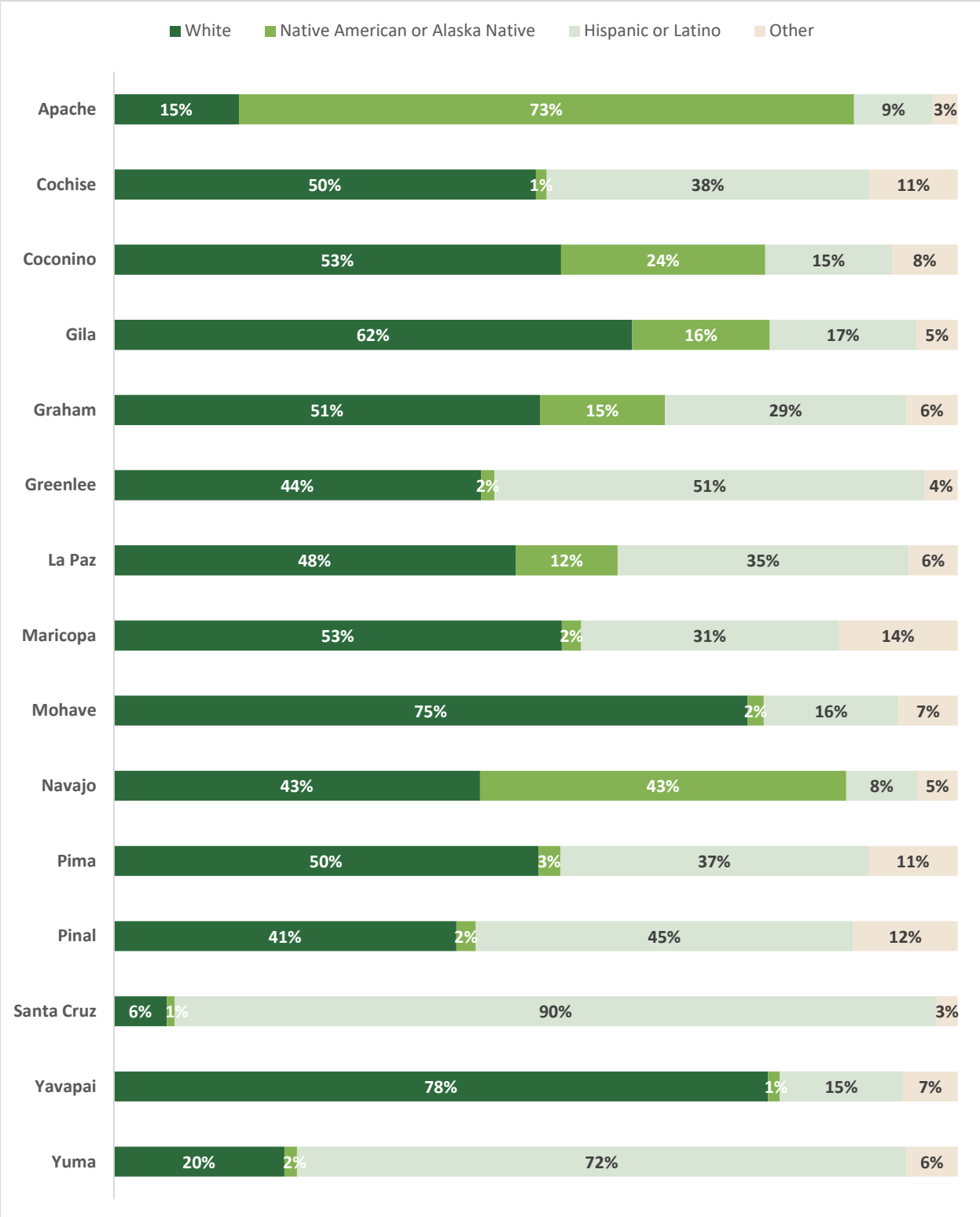
Exhibit 3. Population by Arizona County, 5-Year Estimates, 2020-2024

Rank	County	Population
1	Maricopa	4,673,096
2	Pima	1,080,149
3	Pinal	513,862
4	Yavapai	252,013
5	Mohave	226,479
6	Yuma	220,310
7	Coconino	145,161
8	Cochise	125,773
9	Navajo	109,516
10	Apache	64,800
11	Gila	54,073
12	Santa Cruz	50,508
13	Graham	40,242
14	La Paz	16,992
15	Greenlee	9,410



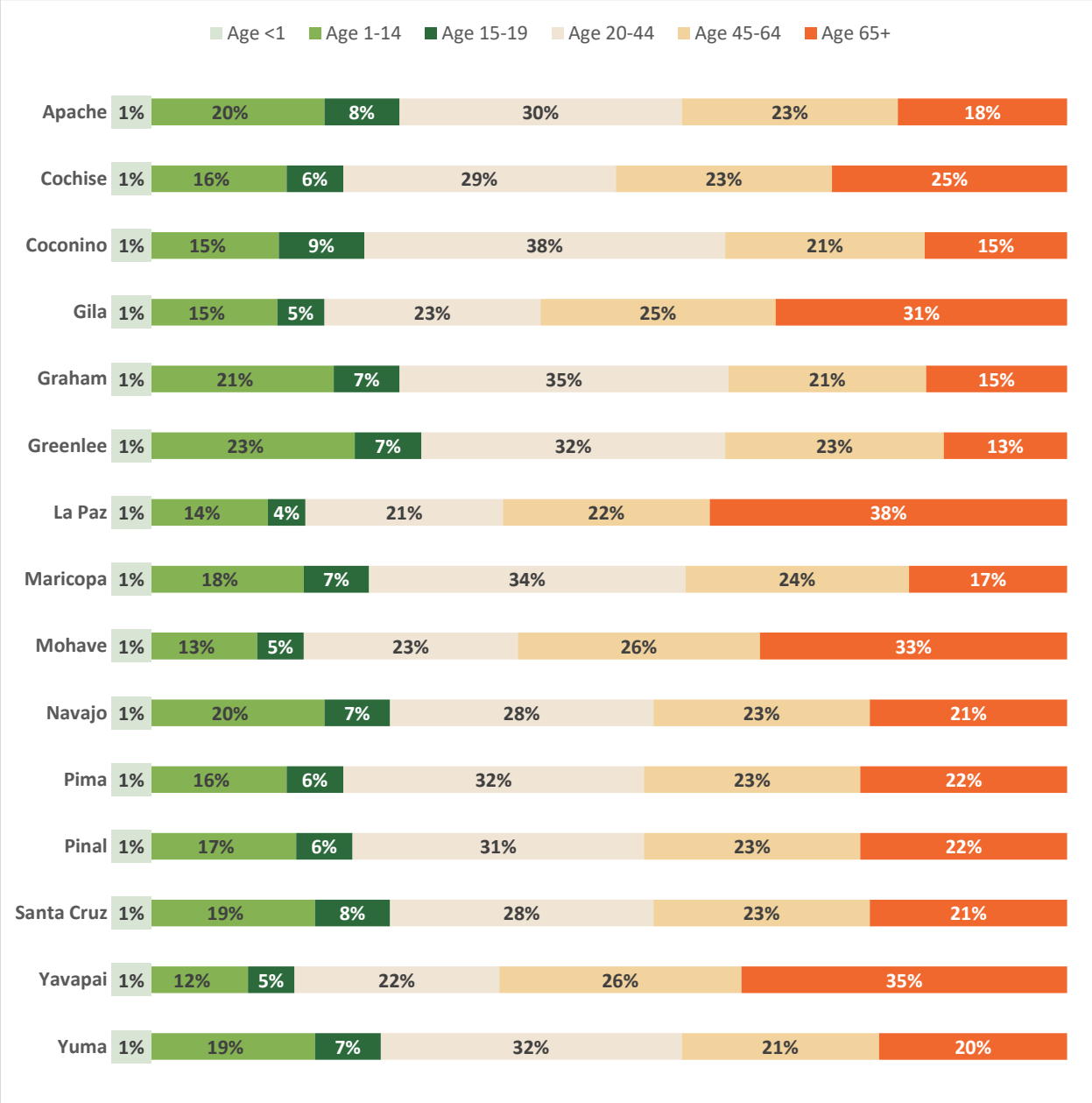
Source: U.S. Census Bureau, 2020-2024, American Community Survey 5-Year Estimate

Exhibit 4. Percent Race/Ethnicity by Arizona County, 5-Year Estimates, 2020-2024



Source: U.S. Census Bureau, 2020-2024, American Community Survey 5-year estimates. Note: "Other" in this chart includes Asian, Black or African American, Native Hawaiian or Pacific Islander, Other Race, and Mixed-Race categories.

Exhibit 5. Age Breakdown by Arizona County, 2024

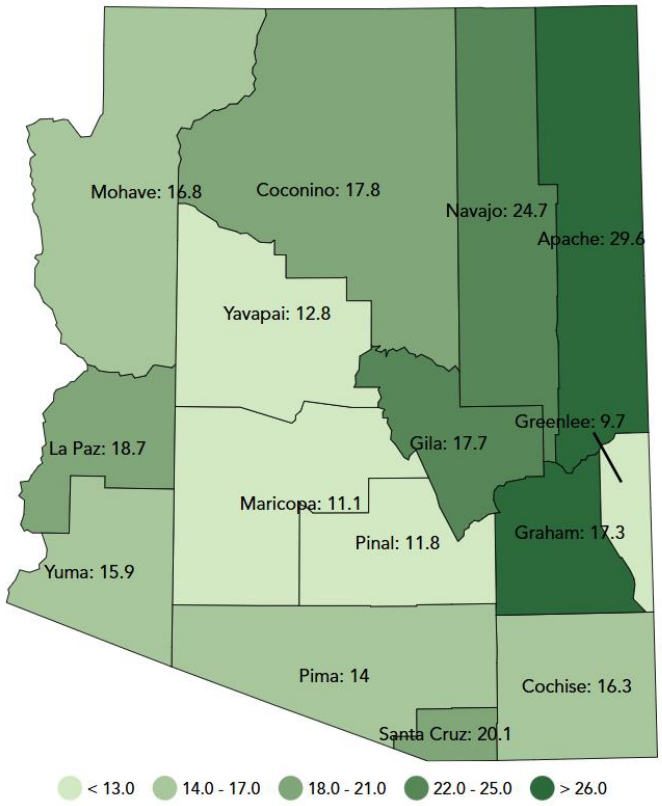


	Yuma	Yavapai	Santa Cruz	Pinal	Pima	Navajo	Mohave	Maricopa	La Paz	Greenlee	Graham	Gila	Coconino	Cochise	Apache
Age <1	2,673	1,786	605	4,818	10,065	1,324	1,743	50,371	134	122	534	447	1,326	1,275	735
Age 1-14	41,690	29,898	9,850	84,648	168,510	21,845	29,268	834,843	2,378	2,198	8,478	8,279	22,840	20,756	13,150
Age 15-19	15,442	12,370	3,885	29,962	69,840	7,764	10,561	318,146	706	702	2,914	2,880	14,144	7,743	5,075
Age 20-44	70,263	54,782	14,114	147,782	350,510	31,117	52,163	1,603,36	3,627	3,122	14,001	12,510	57,031	36,834	20,115
Age 45-64	45,059	64,298	11,675	110,475	248,321	25,792	59,195	1,125,36	3,831	2,246	8,335	13,349	32,147	29,842	15,430
Age 65+	42,851	88,634	10,451	106,259	239,388	23,004	75,177	794,154	6,452	1,283	5,845	16,541	22,387	31,803	12,052

Source: Arizona Department of Health Services, Population Health & Vital Statistics, 2024

Exhibit 6. Percent Living in Poverty by Arizona County, 2023

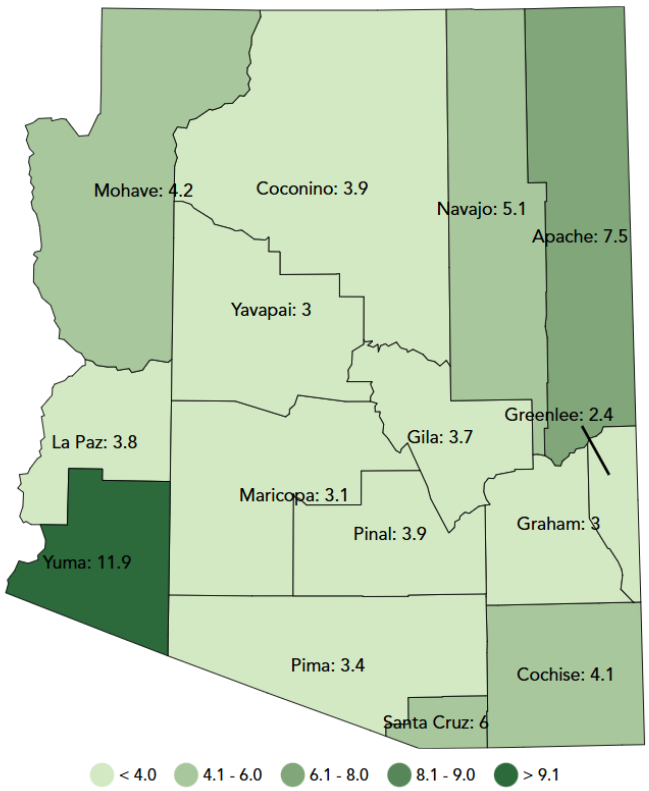
Rank	County	Poverty Rate (%)
1	Apache	29.6
2	Navajo	24.7
3	Santa Cruz	20.1
4	La Paz	18.7
5	Coconino	17.8
6	Gila	17.7
7	Graham	17.3
8	Mohave	16.8
9	Cochise	16.3
10	Yuma	15.9
11	Pima	14.0
12	Yavapai	12.8
13	Pinal	11.8
14	Maricopa	11.1
15	Greenlee	9.7



Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, 2023

Exhibit 7. Percent Unemployed by Arizona County, 2024

Rank	County	Unemployment Rate (%)
1	Yuma	11.9
2	Apache	7.5
3	Santa Cruz	6.0
4	Navajo	5.1
5	Mohave	4.2
6	Cochise	4.1
7	Coconino	3.9
8	Pinal	3.9
9	La Paz	3.8
10	Gila	3.7
11	Pima	3.4
12	Maricopa	3.1
13	Graham	3.0
14	Yavapai	3.0
15	Greenlee	2.4



Source: Arizona Office of Economic Opportunity, 2024

CURRENT SUBSTANCE USE TRENDS

This section of the report explores current substance use trends across Arizona through a review of secondary data from both national datasets and state-specific sources, a review of relevant literature, as well as primary data collected via the Workforce Survey, listening sessions, and individual interviews with subject-matter experts and stakeholders working in the field of substance use prevention. Segments are organized by substance (alcohol, vapes/nicotine, marijuana, and illicit drugs, including fentanyl). While some graphs and charts are woven throughout this section, many have been moved to the appendix to improve flow and readability. Please refer to Appendix F for additional information. Unless otherwise noted, "youth" refers to individuals aged 12-17; "transition-age youth" or "college students" refers to individuals aged 18-26.

Substance use patterns have shifted significantly over the past decade, shaped by evolving societal norms, policy changes, and the unprecedented impact of the COVID-19 pandemic. Understanding these trends is critical for tailoring effective prevention strategies that reflect the realities faced by society today.

Exhibit 8. Major Substance Use Issues & Trends Identified by Listening Session Participants

Substance Use Issue	Identified Trend
Alcohol	Socially accepted; frequent binge use in college and tribal contexts
Cocaine	Used in college parties and pressured by peers to try; growing visibility
Fentanyl	High potency; increased overdose deaths; powder form replacing pills
Marijuana	Normalized among youth and college students; daily use is common; low perceived risk
Prescription Drugs	Polydrug use with alcohol; misuse of ADHD meds, Xanax
Vaping (including nicotine and marijuana)	Rampant in schools; flavored and easy to conceal

Alcohol

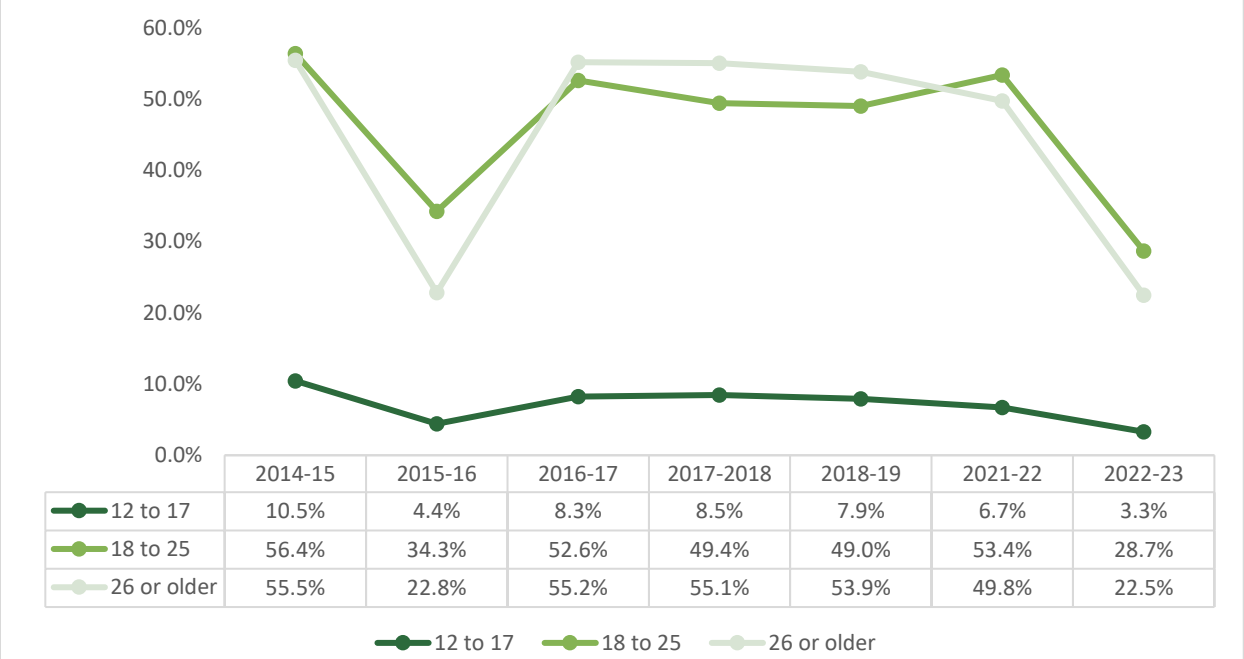
Trends show that alcohol consumption remains widespread across all age groups, though emerging data points to a slight national decline. The State Health Access Data Assistance Center (2024) reports that in 2023, 16.4% of U.S. adults reported binge or heavy drinking, a decrease from 17.9% in 2022 (Gowlovech, 2025). Binge drinking is defined as consuming five or more drinks for men and four or more drinks for women on an occasion. However, data from

the Centers for Disease Control and Prevention (CDC) for 2021–2022 show that **Arizona reports a higher percentage of adults engaging in binge drinking compared to the national average**—19% versus 17%, respectively (CDC, 2024). Alcohol consumption also varies significantly across demographic groups.

According to the *Monitoring the Future* survey, alcohol use significantly declined in both twelfth and tenth grades. From 2000 to 2024, the past 12-month prevalence decreased from 73% to 45% in twelfth graders, from 65% to 26% in tenth graders, and from 45% to 13% in eighth graders (Miech et al., 2024). Despite these national improvements, Arizona continues to experience a substantial impact from alcohol misuse. The state has a high number of alcohol-related deaths compared to its population, and the rate of alcohol-related deaths attributed to chronic causes, like alcohol use disorder, is well above the national average (National Center for Drug Abuse Statistics, 2023).

Data from the most recent NSDUH (Exhibit 9) shows that nearly 29% of transition age youth in Arizona ages 18-25 reported alcohol use in the past month, though this figure has declined from previous years.

Exhibit 9. Trends in Prevalence of Past Month Alcohol Use in Arizona by Age Group, 2014-2023

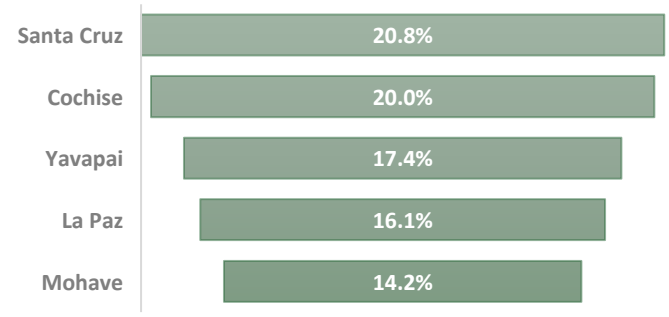


	2014-15	2015-16	2016-17	2017-2018	2018-19	2021-22	2022-23
12 to 17	10.5%	4.4%	8.3%	8.5%	7.9%	6.7%	3.3%
18 to 25	56.4%	34.3%	52.6%	49.4%	49.0%	53.4%	28.7%
26 or older	55.5%	22.8%	55.2%	55.1%	53.9%	49.8%	22.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014-2023; data unavailable for 2019-2020

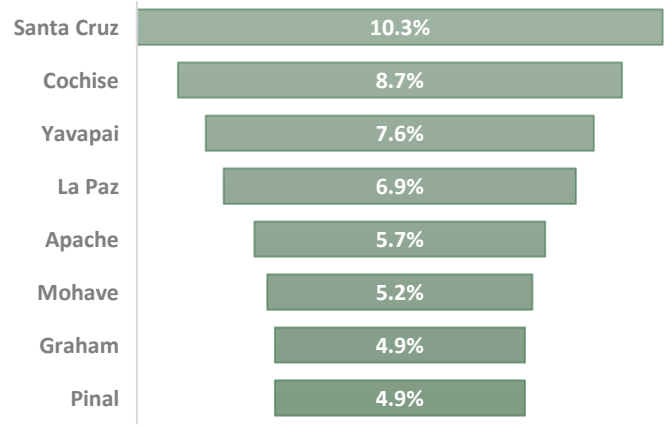
The 2024 Arizona Youth Survey (AYS) asked students to report alcohol use in the past 30 days as well as lifetime use on one or more occasions (Arizona Criminal Justice Commission, 2024). While the statewide average for **30-day use** is 12.3%, Cochise, La Paz, Mohave, Santa Cruz, and Yavapai counties had rates of use that were above this average (Exhibit 10).

Exhibit 10. 30-Day Alcohol Use by County



The average rate of **binge drinking reported in the past 30 days** was 4.5% statewide, with Apache, Cochise, Graham, La Paz, Mohave, Pinal, Santa Cruz, and Yavapai counties reporting above average rates (Exhibit 11).

Exhibit 11. 30-Day Binge Drinking by County



The statewide average for **lifetime alcohol use** was 27.1%, with Cochise, La Paz, Mohave, Santa Cruz, and Yavapai counties reporting higher than average rates (Exhibit 12).

According to the 2024 AYS, students who reported consuming alcohol in the past 30 days provided additional information on how they acquired it. Most of the time (41%), students got it at a party, while they got it from a relative over 21 years old 32% of the time (Exhibit 13).

Exhibit 12. Lifetime Alcohol Use by County

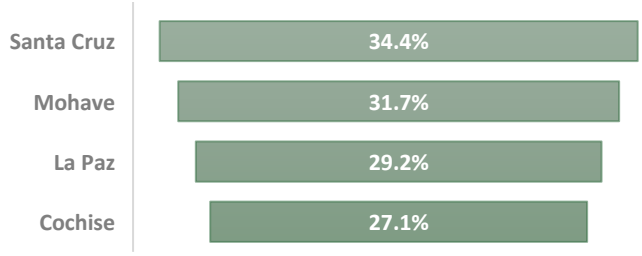
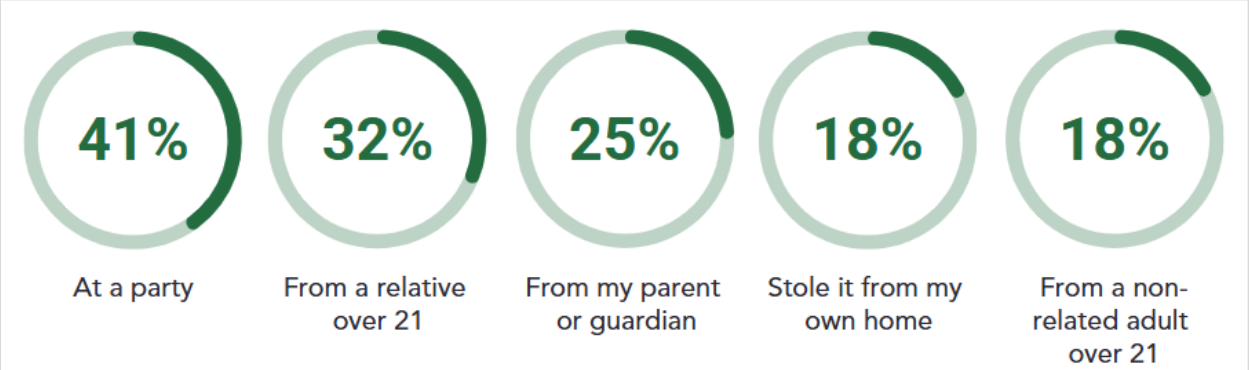


Exhibit 13. Top Five Sources from Which Middle and High School Students Acquire Alcohol



Source: Arizona Youth Survey, 2024

The ways in which college students acquire alcohol are somewhat similar, but the primary source differs. In 2014, 2016, and 2018, the Arizona Institutes for Higher Education (AZIHE) survey included a question that asked college students how they obtained alcohol. For students under 21, "friends" was the most common response, with students reporting they acquired alcohol from them around 53% of the time. This was followed by "house parties" (37%) and "family members" (23%) as typical sources for acquiring alcohol.

Alcohol emerged as a widely discussed substance across all listening sessions—youth/college students, parents, educators, and coalition members. While it is legal and culturally normalized, participants expressed concern about **alcohol's widespread use, early initiation, and underestimated risks.**

Youth described alcohol use as a common part of social experiences, particularly in high school and college settings. Some youth reported starting to drink in middle or high school, often introduced by older friends or siblings. Multiple youth across listening sessions noted that alcohol often acts as a social lubricant of sorts, allowing students to feel more comfortable in group settings. Many noted that alcohol is widely available at parties, and participants in one listening session discussed **how common it is in Greek life on their college campus, specifically binge drinking, blackouts, and poly-substance use**.

> "A lot of people I know drink because when they're drunk, it's easier to be yourself and not feel socially anxious and insecure. I feel like a lot of people struggle to not be anxious and to have a good time in public."
>
> – Listening session participant

Parents shared concerns about **early exposure to alcohol and its normalization within households**. Some expressed fears about youth drinking and driving or accessing alcohol while unsupervised. Some parents also reflected on their own history with alcohol or growing up in households where drinking was common.

Educators and coalition members emphasized that **alcohol is often the most damaging but overlooked substance**. It was described as "culturally romanticized," with its use deeply embedded in many families. Several noted its role in intergenerational trauma, family disruption, and long-term health problems.

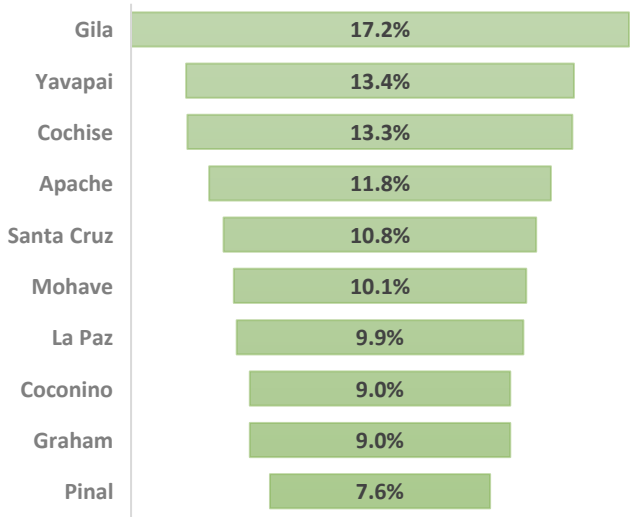
Stakeholders and subject matter experts participating in interviews identified alcohol as one of the two most widely used substances in their communities, along with marijuana. They described alcohol as a particularly common substance used among youth and college students. One interviewee noted that "alcohol has been number one forever," emphasizing that this is not a new issue in their community. Like listening session participants, interviewees noted a concern regarding drinking and driving in their communities.

Vapes / Nicotine

Literature shows that vaping and nicotine use have declined among youth but remain a concern. In 2024, 5.9% of U.S. middle and high school students reported using e-cigarettes in the past 30 days, a decrease from 7.7% the prior year (Jamal et al., 2024). Among adults, e-cigarette use is most common among those aged 18–24 and declines steadily with age (CDC, 2024). E-cigarette use is also higher among adults who identify as lesbian, gay, or bisexual than among adults who identify as heterosexual. The introduction of e-cigarette products with features that appeal to youth may reignite interest and even increase interest among youth (U.S. FDA, 2024). While state-specific vaping trends for Arizona are limited, it was found that **in 2019, Arizona reported a rate of 48.4% of high school students who reported using electronic vapor products at least once in their lifetimes, lower than nationwide,** which was 50.1% (Del Campo-Carmona, 2023).

The 2024 Arizona Youth Survey (AYS) asked students to report e-cigarette use in the past 30 days as well as lifetime use on one or more occasions. Statewide, the average 30-day use was 7.1%, with Apache, Cochise, Coconino, Gila, Graham, La Paz, Mohave, Pinal, Santa Cruz, and Yavapai counties reporting higher than average rates (Exhibit 14).

Exhibit 14. Vaping/Nicotine 30-Day Use by County



Lifetime use of e-cigarettes on one or more occasions was 15.3% statewide, with Apache, Cochise, Coconino, Gila, Graham, La Paz, Mohave, Pima, Pinal, Santa Cruz, and Yavapai counties reporting higher than average lifetime use (Exhibit 15).

According to the 2024 AYS, students who reported vaping in the past 30 days provided additional information on how they acquired the vape device. Most of the time (51%), students got it directly from a friend, while they got it from a smoke shop 28% of the time (Exhibit 16).

Exhibit 15. Vaping/Nicotine Lifetime Use by County

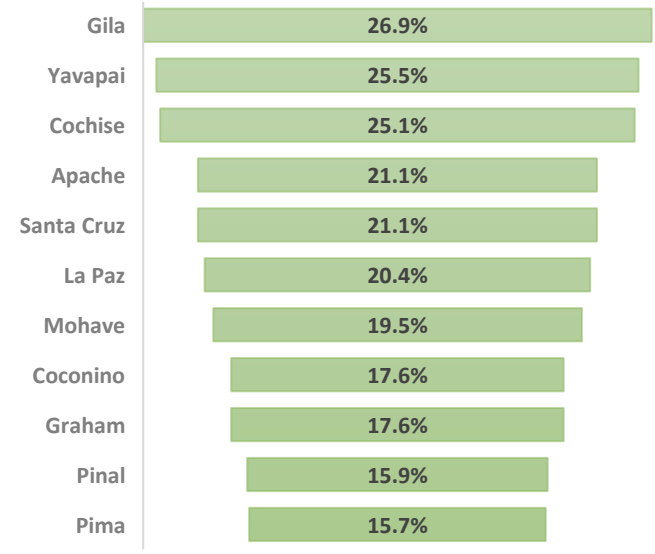
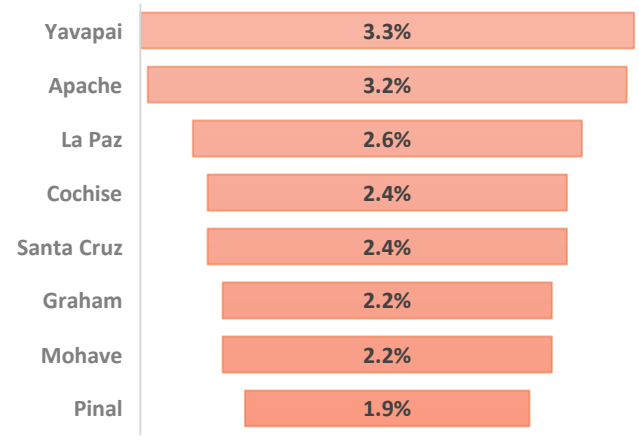


Exhibit 16. Top Five Sources from Which Students Acquire Vape Devices

Source: Arizona Youth Survey, 2024

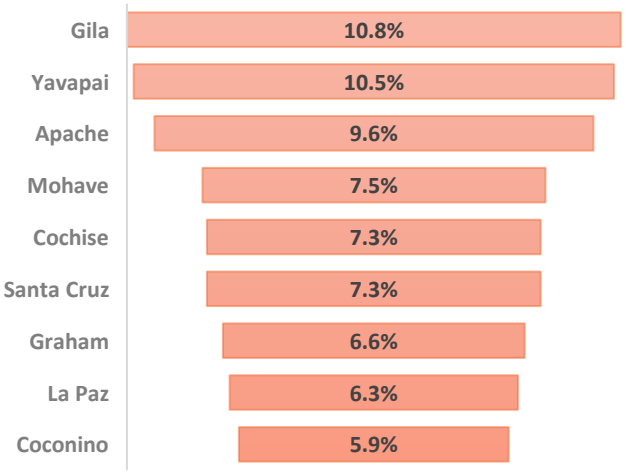
In general, traditional cigarette use among students who completed the AYS is significantly less than that of vape devices, with the statewide average for past 30-day use reported at 1.5% and lifetime use at 5.4%. However, as reported above, rates of traditional cigarette usage remain high in the same counties as rates of e-cigarette usage. Students in Apache, Cochise, Graham, La Paz, Mohave, Pinal, Santa Cruz, and Yavapai counties reported higher than average 30-day use of cigarettes (Exhibit 17).

Exhibit 18. 30-Day Cigarette Use by County



Students in Apache, Cochise, Coconino, Gila, Graham, La Paz, Mohave, Santa Cruz, and Yavapai counties reported higher than average lifetime use (Exhibit 18).

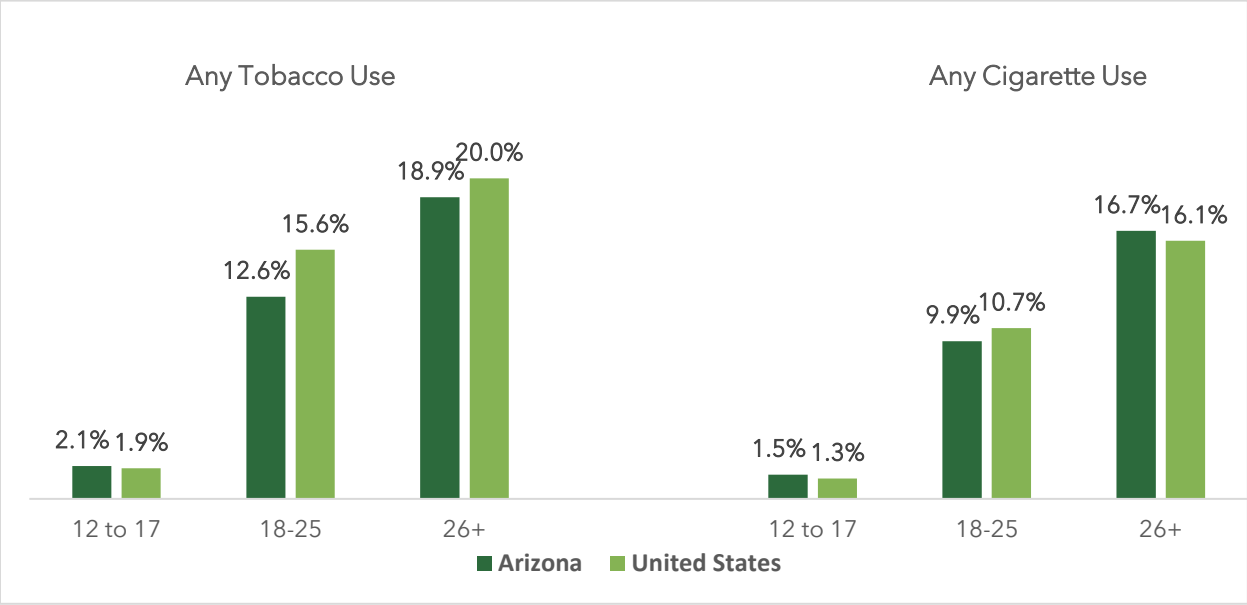
Exhibit 17. Lifetime Cigarette Use by County



In the most recent AZIHE survey, college students across Arizona were asked about their risk perception for daily e-cigarette use**.** In 2018, 34% of all students surveyed reported there was no risk or slight risk; 66% felt there was moderate or great risk. In 2022, 21% of all students surveyed reported there was no risk or slight risk; 79% felt there was moderate or great risk. This suggests an increasing awareness of the risks associated with e-cigarette use.

According to the NSDUH, across Arizona, 30-day use of any kind of tobacco product is slightly below the US average for individuals aged 18 and older, and slightly higher than the national average for youth aged 12-17. For cigarettes specifically, Arizona rates are lower than the national average for transition-age youth aged 18-25, while rates are slightly higher than the US average for those aged 12-17 and those aged 26 and older (Exhibit 19).

Exhibit 19. Prevalence of Past Month Tobacco and Cigarette Use by Age Group in the U.S. and Arizona, 2022-2023



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

Youth across all listening sessions reported that vaping is extremely common among their peers. Devices are often used in schools, bathrooms, or in social settings, with abundant flavor options and colorful packaging making them more appealing. **Participants described how normalized vaping has become—it is viewed not only as socially acceptable but, in many cases, as a status symbol or trend.** Vape devices are easy for youth to access and conceal, sometimes resembling items like USB drives or highlighters, which makes them hard for teachers and parents to detect.

> "They hold onto [the vape] like it's a blanket. The flavors taste so good."
>
> – Listening session participant

During listening sessions, **youth reported obtaining vapes from older friends, siblings, or even directly from stores by using fake IDs**. While some youth acknowledged health risks, many noted that their peers were not concerned. In some cases, youths reported that they began vaping because their parents also vaped or viewed it as a safer alternative to smoking. Some parents even purchased vape products for their children, believing they were promoting a safer behavior than illicit drug use.

Parents and educators highlighted a **lack of parental awareness about vaping**, with some parents underestimating the risks or even supplying vapes to their children. According to one school staff member, "Three out of five times, I could verify that the parent was the one vaping in the home and that's where [the student] got it from." Others noted that youth were mimicking parental behavior when they vaped at home.

Parents and educators also expressed concern that vape products are designed to appeal to youth through a variety of flavors and sleek, inconspicuous packaging. Some equated this trend to targeted advertising akin to tobacco campaigns of the past. According to one participant, "Kids think it's cool now because it doesn't look like a cigarette."

> "We've seen students get anxious without [their vape] – they're physically attached."
>
> – Listening session participant

Beyond concerns about product appeal, coalition and school staff participating in listening sessions emphasized the addictive nature of vaping, particularly due to high nicotine content. They described youth showing signs of dependency and needing frequent access to their devices.

Stakeholders and subject matter experts participating in interviews also identified vaping as a significant concern in their communities. While some interviewees were more focused on nicotine use, others emphasized marijuana consumption through vape devices. Like parents and educators in listening sessions, interviewees noted the **growing normalization of vaping in home settings**. One interviewee reported that students as young as first grade had tried vaping, describing it as the norm because "their parents are doing it." There was also concern that youth lack awareness of vaping's potential harms, including overconsumption due to high potency and exposure to unknown substances in the devices.

> "I've had a lot of instances where kids will just end up with a vape, and it's because it was found at their house, and they don't know what substance is in the vape, which is also scary."
>
> – Interviewee

Marijuana

Cannabis remains the most used psychoactive drug in the United States. Its use increased from 7.59% to 11.48% in 2013–2019, was 11.54% in 2020, and increased again from 13.13% to 15.11% in 2021–2022. Additionally, in 2022, use was highest among individuals aged 18–34, male, non-Hispanic multiracial, and generally lower SES adults (Mattingly et al, 2024). **It is also the most commonly used federally illicit drug among adolescents in the nation** (Hammon et al., 2020). According to the *Monitoring the Future* survey, 44.1% of women aged 19-30 reported cannabis use compared to 40.3% of men, marking the first time that cannabis use was higher among women in this age group (Patrick et al., 2024). According to the Youth Risk Behavior Survey (YRBS) results from 2023, the same was reflected in high school students, where female students were more likely than male students to use marijuana currently. LGBTQIA+ students were also more likely than cisgender and heterosexual students to use marijuana currently. In Arizona, analysis of 18 million hospital records revealed a 20% increase in cannabis-related

hospital visits between 2016 and 2021, with notable rises among adolescents and adults aged 65 and older (Meier et al., 2024).

The 2024 Arizona Youth Survey (AYS) asked students to report marijuana use in the past 30 days as well as lifetime use on one or more occasions. Marijuana is reported on its own, as well as by two additional categories – concentrates and edibles. For information on concentrates and edibles, as well as additional rates from other counties, please see Exhibits 80 & 81 in Appendix E.

The statewide average for 30-day use of marijuana on one or more occasions was 7.4%; lifetime use was 15.2%. Counties that reported higher than average 30-day use of marijuana were Apache, Cochise, Coconino, Gila, La Paz, Mohave, Pima, Pinal, and Yavapai (Exhibit 20). Counties that reported higher than average lifetime use were Apache, Cochise, Coconino, Gila, Graham, La Paz, Mohave, Pima, Pinal, and Yavapai (Exhibit 21).

Exhibit 20. 30-Day Marijuana Use by County

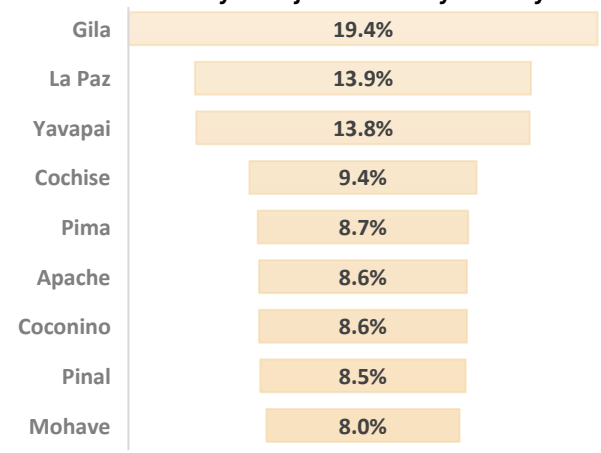
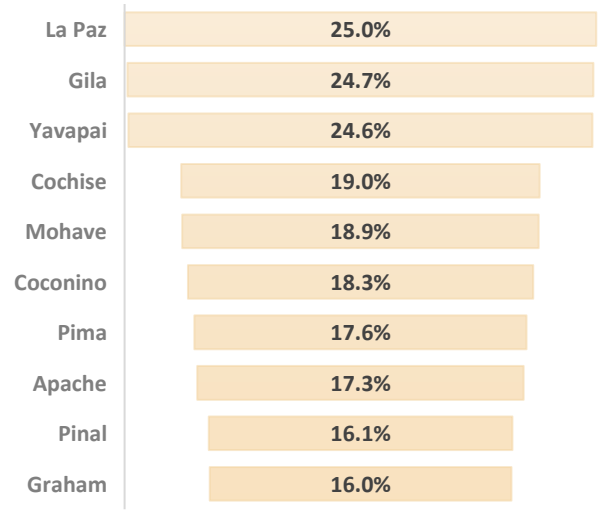
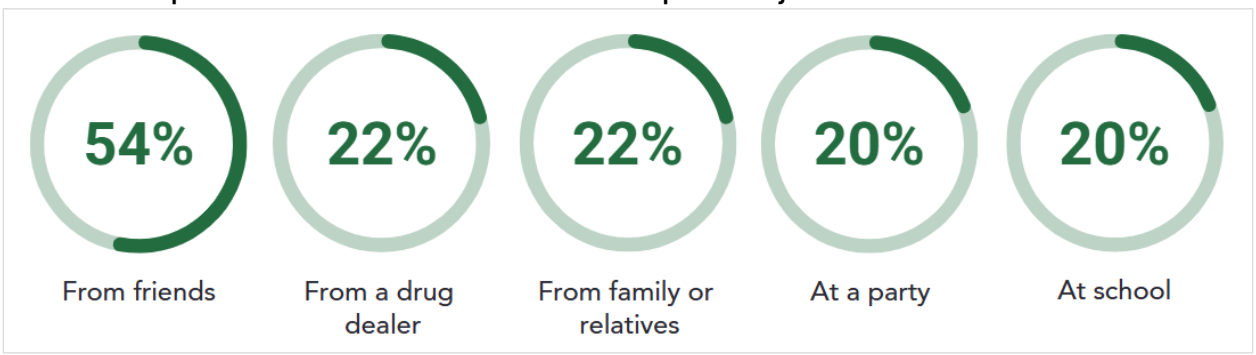


Exhibit 21. Lifetime Marijuana Use by County



According to the 2024 AYS, students who reported using marijuana in the past 30 days provided additional information on how they acquired it. Most of the time (54%), students got it directly from a friend, while they got it from a drug dealer 22% of the time (Exhibit 22).

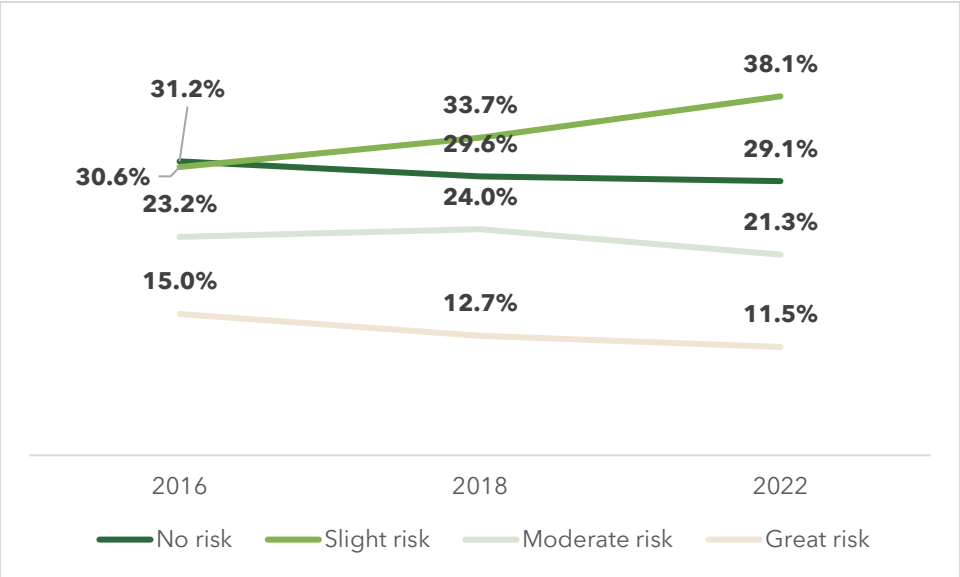
Exhibit 22. Top Five Sources from Which Students Acquire Marijuana



Source: Arizona Youth Survey, 2024

In 2016, 2018, and 2022, college students who completed the AZIHE survey were asked about their perception of risk for marijuana use once or twice per week. There has been a decline each year in the percentage perceiving this usage as posing a "great risk." Results are shown below in Exhibit 23.

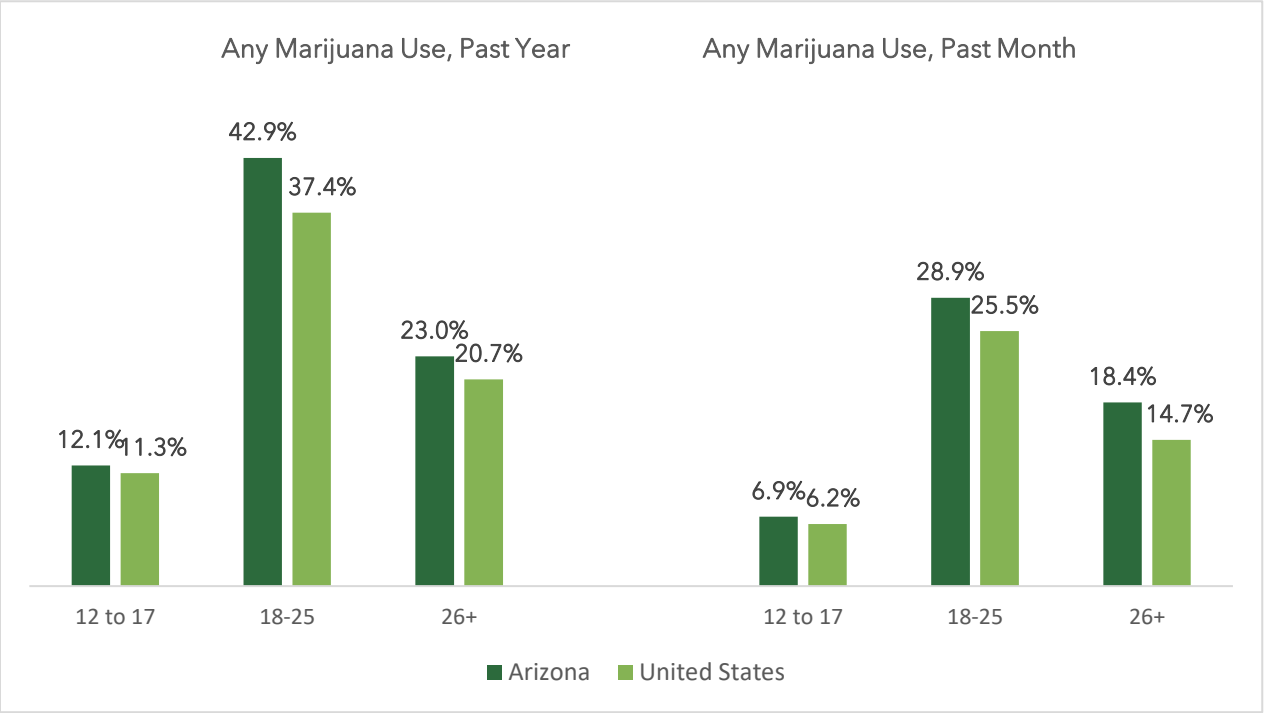
Exhibit 23. Perceived Risk of Marijuana Use Once or Twice Per Week (2016 – 2022)



Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 24 shows data collected by the NSDUH on marijuana use for different age groups in 2023, both for previous-month use and previous-year use. Across all age groups, average use is higher for Arizona than in the US.

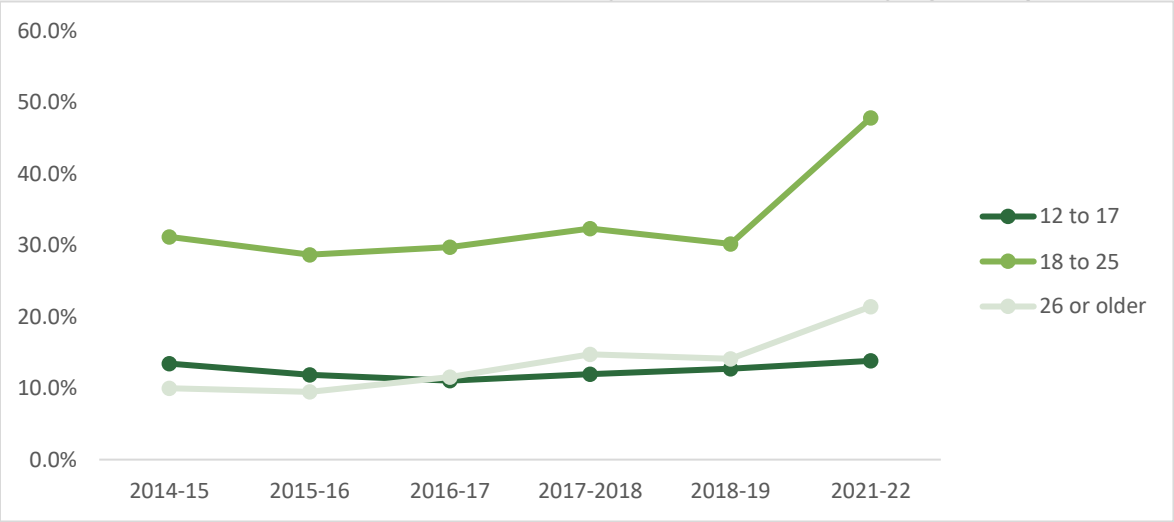
Exhibit 24. Prevalence of Past Year and Past Month Marijuana Use by Age Group for the U.S. and Arizona, 2022-2023



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

Exhibit 25 looks at NSDUH data on trends in marijuana use over the previous decade. From 2018 to 2022, all age groups showed an increase in marijuana use, with the largest increase occurring for individuals between the ages of 18-25. This increase also coincides with the legalization of recreational cannabis in the state of Arizona in 2020 and the first state-licensed sales of recreational cannabis in Arizona in 2021.

Exhibit 25. Trends in Prevalence of Past Year Marijuana Use in Arizona by Age Group, 2014-2022



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021-2022

Marijuana use across the state has been steadily increasing among all age groups since becoming recreationally legal in 2021. It was consistently **identified in listening sessions as one of the most normalized and widely used substances among youth and young adults**. Youth reported frequent use of marijuana in the form of THC vapes and edibles. Many expressed that marijuana use is perceived as safe, relaxing, or even beneficial for managing stress or anxiety. Daily use was described as common among peers, with some youth referencing its medicinal or legal status as justification.

> "Everyone I know smokes daily…it's just what we do to relax."
>
> – Listening session participant

Parents expressed concern over youth underestimating the risks of marijuana, particularly newer forms with higher potency. They highlighted the normalization of use within households, where some adults use edibles or vape THC openly. Some parents noted challenges in communicating with teens about marijuana when it is legalized or used by family members.

Educators and coalition members raised concerns about the invisibility of THC use on school campuses due to odorless cartridges and edibles. They noted an **increase in marijuana-related disciplinary incidents** and a shift in attitudes where students are no longer hiding their use. There were also discussions around how legalization has weakened prevention messaging. Exhibit 26 shows major themes that arose during listening sessions, along with illustrative quotes.

Exhibit 26. Marijuana Themes Identified Across Listening Sessions and Illustrative Quotes

Theme	Quote
Normalization and Perception of Risk	"Marijuana is very, very common and accessible now. I feel like I kind of grew up being told weed is not addictive…a lot of people I know are addicted to weed but are able to function." – College student
	"There is a normalization of cannabis…it's just too normal. The parents could be eating gummies, and the kids are like, 'Okay, that's not a big deal.'" – Coalition member
	"They say, 'Oh, it's medicine.' That's how they think it's safe. They're not seeing the new stuff coming out. The synthetic stuff is not…it's too strong." – Coalition member
Edibles and Overconsumption	"A lot of the kids doing edibles think it's a chocolate bar. So they eat the whole bar. Next thing you know, they did 100 milligrams when they should've done five." – Coalition member
	"In high school, I had friends who greened out and would be throwing up because they had too many edibles." – College student

Theme	Quote
Increased Potency and Access	"We're not dealing with your grandma's marijuana…it's chemically reconfigured to make it far more potent." – Coalition member "You're seeing younger and younger cases… they're just grabbing it from their parents and not thinking it's harmful." – Coalition member
Use Among Youth and College Students	"A lot of the people I know that smoke weed are smoking every single day…they say they're not addicted but are doing it every night." – College student "The more common form, like indoors and on campus, is carts or edibles–it's easier to hide." – College student "It's very difficult for our security teams to determine if it's being used. One device looked like a highlighter pen, but it was a vape." – School staff
Legalization and Youth Messaging	"When it was legalized, [my friend] just said, 'Well, they legalized it, so obviously it's not that bad.' It became another excuse." – College student "Legalizing marijuana is probably going to make more people be more open about it… but it doesn't necessarily mean they'll smoke more." – College student

> "[I'm] very concerned about what's happening with marijuana. We're seeing a decrease in perception of risk and more social acceptance. That's a huge concern."
>
> – Interviewee

During interviews, stakeholders and subject matter experts also discussed how marijuana use had increased due to greater accessibility and social acceptance. One interviewee explained that in their community, marijuana becomes the "drug of choice" as youth get older. The increasing use of marijuana has led to growing concern among interviewees about serious health and safety risks, including psychosis, Cannabinoid Hyperemesis Syndrome, dependency, and driving under the influence.

Illicit Drugs and Fentanyl

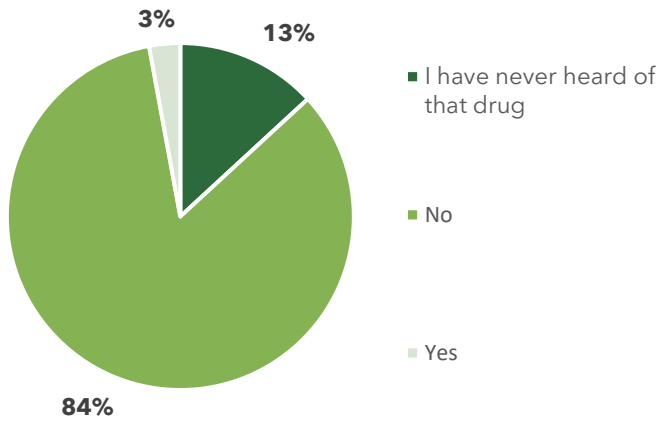
Illicit drug use among adolescents and young adults is an ongoing concern. According to the YRBS results from 2023, female and LGBTQIA+ high school students were more likely than their peers to engage in most substance use behaviors, and LGBTQIA+ students were about twice as likely as cisgender and heterosexual students to have ever used select illicit drugs and prescription opioids (CDC & Prevention, 2024).

According to the Arizona Department of Health Services (ADHS), more than five people die every day from opioid overdoses in Arizona. This equates to over 1,800 opioid-related deaths annually, underscoring the severity of the opioid crisis in the state.

Fentanyl remains the most lethal drug threat both nationally and in Arizona. Although overdose deaths began declining in 2023, percentages in the western region of the country increased from 48.5% to 66.5% (Tanz et al, 2024). In 2023, synthetic opioids like fentanyl contributed to over 74,000 overdose deaths, though for the first time in years, overall overdose deaths declined slightly (CDC & Prevention, 2024). The number and size of fentanyl seizures is increasing nationwide compared to previous years (Palamar, 2025). The total weight of fentanyl seized increased the most in western states. In Arizona, fentanyl overdose deaths have risen nearly 5,000% since 2015, with Maricopa County alone seeing multiple deaths daily (Maricopa County, 2024).

The 2024 AYS asked students if they had ever used fentanyl, with 3% saying "yes," 84% saying "no," and the remaining 13% saying they had never heard of fentanyl (see Exhibit 27). Complete data from the 2024 AYS on students' reported use of illicit substances is included in Appendix E. Statewide averages are shown below in Exhibit 28, while Exhibit 29 includes illicit drug use by age group for the U.S. and Arizona.

Exhibit 27. Have you ever used fentanyl?



Source: Arizona Youth Survey, 2024.

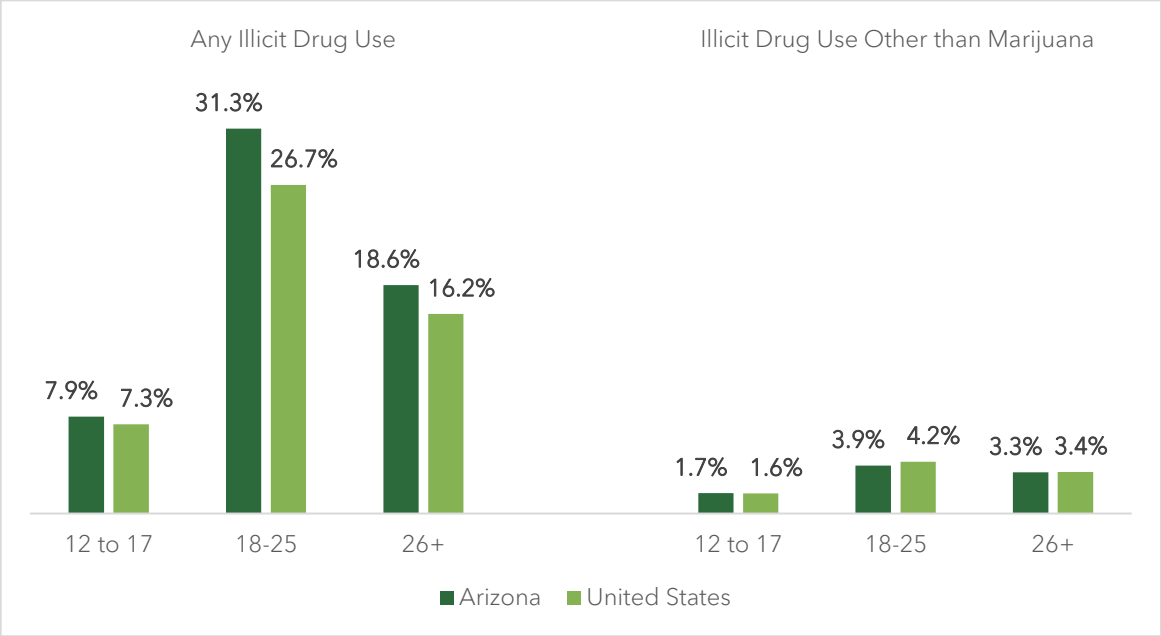
Exhibit 28. Statewide Averages of Student Illicit Substance Use

Substance	Statewide Average (%)
Polydrug use	5.8
Inhalants	3.6
Prescription pain relievers	3.2
Hallucinogens	3.1
Over-the-counter drugs	2.9
Prescription stimulants	1.9

Prescription sedatives	1.2
Steroids	0.9
Cocaine	0.9
Ecstasy	0.8
Synthetic drug users	0.6
Methamphetamines	0.5
Heroin	0.4

Source: Arizona Youth Survey, 2024

Exhibit 29. Prevalence of Past Month Illicit Drug Use and Illicit Drug Use Other than Marijuana by Age Group for the U.S. and Arizona, 2022-2023



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

Listening session participants identified concerns related to fentanyl, as well as methamphetamine and cocaine use. Although less commonly used than alcohol, marijuana, or vaping products, these substances were described as increasingly visible and dangerous, particularly among vulnerable populations.

Youth participants reported limited direct use of fentanyl, meth, or cocaine themselves, but demonstrated increasing awareness of their dangers. Fentanyl was widely recognized due to news of overdose deaths in their communities, especially involving counterfeit pills. One youth in a border town noted that "You can die from one fake pill. Everyone knows someone who overdosed." While less frequently discussed, cocaine was noted primarily in college settings,

particularly within party and Greek life cultures. Some college students also mentioned using Adderall for studying and Xanax for stress relief, often mixing these substances with alcohol.

Parents described fentanyl as their greatest fear, often prioritizing fentanyl prevention messaging over other substances. Many voiced concern that youth could unknowingly ingest fentanyl through counterfeit Xanax or Percocet pills. Methamphetamine was discussed less frequently by parents of younger youth, but more commonly among families affected by homelessness or trauma.

Educators and coalition members highlighted fentanyl as a rapidly escalating crisis, especially in border communities and among reentry populations. They noted increased training around naloxone (Narcan) administration. Methamphetamine was described as persistently destructive in rural and tribal communities, often tied to cycles of trauma, homelessness, and family breakdown.

Stakeholders and subject matter experts participating in interviews also identified fentanyl as a significant issue in their communities. Interviewees acknowledged fentanyl's potential for fatal overdoses, making it perceived as especially harmful in their communities, even though it was not identified as the most prevalent. A few interviewees also mentioned that cocaine, prescription opiates, and methamphetamines are a concern in their communities, though to a lesser degree.

> "Use of substances like cocaine, prescription opiates, and obviously fentanyl is a little bit everywhere, unfortunately. So, we're seeing a lot of that occurring in our community."
>
> – Interviewee

Substance Use Disparities

Understanding disparities in substance use is critical for informing targeted prevention efforts. Substance use patterns vary widely across demographic groups, revealing key inequities that public health strategies must address. These disparities persist along racial, ethnic, and gender lines, and research continues to highlight these gaps. For example, sexual and gender minority people face greater challenges with alcohol use, hazardous drinking, alcohol use disorder (Mereish, 2024), and substance use and misuse (Mereish, 2019). This points to the unique stressors this group experiences. Understanding these specific vulnerabilities can help shape more targeted prevention strategies for the different groups who are disproportionately affected by substance use.

Demographic Disparities

1

Age

Young adults (18-25) are more likely to initiate or increase substance use than any other age group (Lu, et al, 2023). Binge drinking also peaks in late adolescence. Cannabis vaping is on the rise among youth and young adults and has become more prevalent in settings where recreational use for adults has been legalized (Harrell et al, 2022). However, almost one million adults aged 65 and older live with a substance use disorder. It may be due to a number of different factors including their susceptibility to the effects of drugs, unintentional misuse of medicines, and/or taking substances to cope with life changes, amongst other reasons (NIDA, 2018).

2

Gender

Gender differences show that men are more likely to use almost all types of illicit drugs and develop substance use disorders. Men also show higher rates of use or dependence on illicit drugs and alcohol than do women. Women, though less likely to use, face higher relapse rates. Trends also show women face unique barriers to accessing treatment, including stigma, childcare responsibilities, and fear of losing custody of children (NIDA, 2020). Interestingly, some stakeholders in Arizona reported that they are beginning to see higher rates of substance use among women, so this is a trend that should be monitored closely.

3

Race / Ethnicity

Racial disparities persist in substance use patterns. For example, White Americans report the highest overall rates of substance use (especially opioids and methamphetamines), but Black and Latinx communities have lower rates of use overall while facing harsher criminal penalties and lower access to treatment. Substance use disorder has an impact on the health of certain minority groups, including more severe alcohol use among American Indians, and disproportionately high rates of alcohol-related injury and mortality for Blacks and Latinos. Additionally, these communities also have lower access to substance-use-related treatment (Acevedo et al, 2018).

Stakeholder Perspectives

Stakeholders and subject matter experts participating in interviews were asked about the differences in substance use patterns across populations. They identified several groups at higher risk and offered various reasons for this increased vulnerability based on the specific group (Exhibit 30).

> "Females are using alcohol, marijuana, and vaping at higher rates than males, and that's something that I think we need to take a good, hard look at."
>
> – Interviewee

Exhibit 30. High-Risk Populations for Substance Use and Contributing Factors Identified by Stakeholders and Experts

High-Risk Population	Contributing Factors
Historically marginalized populations, specifically Native Americans and other racial minorities, and LGBTQIA+ populations	Coping strategy (e.g., using alcohol to cope with racial discrimination)
School-age female youth	Social pressure to fit in; social influence from social media
Socially disconnected youth	Lack of positive social group & social involvement
College-student athletes	Stress; social pressure & social media influence

CURRENT PREVENTION EFFORTS IN ARIZONA

Review of Best Practices in Prevention

As substance use patterns continue to shift, effective prevention efforts are more essential than ever. These efforts should be grounded in evidence-based strategies that target risk and protective factors across multiple levels, including individual, family, school, and community environments. Current best practices emphasize implementing a combination of universal, selective, and indicated prevention approaches tailored to diverse populations and local conditions to achieve the greatest impact.

Core Prevention Strategies

Universal Prevention: Universal programs target the general population regardless of individual risk level, with the goal of shifting social norms and promoting healthy behaviors across broad groups. School-based programs like *Life Skills Training* have been widely implemented in schools to build personal and social competence, resulting in decreased substance use initiation rates (SAMHSA, 2019; Botvin et al, 2014).

Selective Prevention: Selective interventions focus on groups at heightened risk, such as youth with adverse childhood experiences (ACEs), children of parents with substance use disorders, Indigenous youth, or LGBTQIA+ youth. Programs like *Project Venture*, designed specifically for Indigenous youth, integrate cultural values and have shown success in reducing substance use. (SAHMSA, 2019; SAHMSA, 2024; Carter, Straits, & Hall, 2007).

Indicated Prevention: Indicated strategies are designed for individuals showing early signs of problematic behaviors. Brief interventions like SBIRT (Screening, Brief Intervention, and Referral to Treatment) in healthcare and school settings have demonstrated effectiveness in reducing use among adolescents (SAHMSA, 2019; Babor, 2007).

In Arizona, these models have increasingly been implemented through initiatives such as the Arizona Youth Partnership's substance use prevention programs, which combine school-based curricula with community outreach (Arizona Youth Partnership, n.d.).

The key principles for effective prevention practices, listed below, are drawn from a seminal resource in the field of prevention. The National Institute on Drug Abuse (NIDA) published the second edition of Preventing Drug Abuse among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders in 2003. The principles outlined in the guide remain steady over time, showing their continued potency and relevance.

Key Principles for Effective Prevention

Cultural Relevance

Programs must be culturally adapted and inclusive to resonate with diverse populations, including racial/ethnic minorities and LGBTQIA+ communities (NIDA, 2003).

Early Intervention

Prevention efforts are most effective when initiated early, particularly during critical developmental windows such as early adolescence (NIDA, 2003).

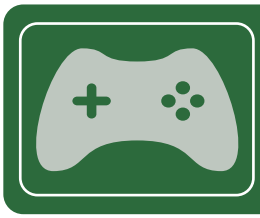
Family Engagement

Family-centered approaches foster protective factors such as parental monitoring and positive communication (NIDA, 2003).

Community Collaboration

Multi-sector coalitions involving schools, healthcare providers, law enforcement, and community organizations enhance the reach and sustainability of prevention efforts (NIDA, 2003).

Emerging Trends in Prevention



Technology-Based Interventions: Mobile apps and online platforms like "smokeSCREEN" are being developed to engage youth in substance use prevention through gamified learning and digital skill-building. An evaluation study found that the videogame effectively changed beliefs and knowledge about smoking and nicotine vaping in a positive direction (Sweileh, 2024; Heftje, 2021; SAHMSA, 2020).

Trauma-Informed Approaches: Recognizing the link between adverse childhood experiences (ACEs) and substance use, programs are increasingly incorporating trauma-informed care principles (SAHMSA, 2023).

Policy and Environmental Strategies: Efforts such as regulating retail cannabis access, implementing pricing strategies, and zoning laws are critical components of comprehensive prevention frameworks.

Addressing Disparities through Prevention

Successful prevention efforts must prioritize addressing existing disparities by ensuring equitable access to programs and tailoring interventions to meet the unique needs of marginalized populations. Culturally competent workforce development, resource allocation to underserved areas, and inclusive community engagement are pivotal in bridging prevention gaps.

Prevention Efforts and Gaps

Prevention education programs are a critical tool in reducing the initiation and escalation of substance use among youth (Van Ryzin & Chirimwami, 2024). School-based initiatives have traditionally focused on raising awareness about the risks of substance use and teaching refusal skills (Bell, 2021; Van Ryzin & Chirimwami, 2024). Screening and psychological interventions in schools, such as Cognitive Behavioral Therapy and interventions that integrate mental health screening with behavioral supports—like Screening, Brief Intervention, and Referral to Treatment (SBIRT), have demonstrated strong efficacy in preventing mental disorders in youth, with parenting interventions also showing positive effects for mental health promotion. (Bell, 2021; Fisher et al., 2024). Programs such as *Life Skills Training*, *Project ALERT*, and the *Good Behavior Game* incorporate cognitive-behavioral approaches that promote self-regulation, problem-solving, and healthy decision-making (Le et al., 2021). These interventions are most effective when they also address broader social determinants, such as trauma, isolation, and mental health challenges (Van Ryzin & Chirimwami, 2024).

Evidence shows that early intervention during adolescence is key (Bell, 2021; Van Ryzin & Chirimwami, 2024). Targeted prevention efforts, particularly those focused on children, adolescents, and adults at high risk, have been found to be more cost-effective than universal approaches. In the adult population, workplace interventions targeting employees have been shown to be particularly effective, though the effectiveness of prevention efforts for older adults remains inconclusive (Le et al., 2021). However, barriers such as a lack of trained personnel and stigma remain obstacles to implementation, particularly in underserved communities.

Data from Arizona indicates an increasing investment in school-based and community-driven prevention programs, reflecting national trends. For example, the state has recently increased its funding for youth prevention education, resulting in more widespread access to interventions like cognitive-behavioral therapy (CBT) and trauma-informed care in schools (Governor's Office of Youth, Faith, and Family, 2023).

Prevention efforts and programs are often aimed at adolescents, young adults, and communities with higher risk profiles. Adolescents aged 12–18 remain the primary target of prevention strategies due to their heightened vulnerability to early substance use. State and

federal-level interventions primarily focus on these groups, with some initiatives targeting high-risk youth in rural and urban areas.

However, certain groups continue to be underserved. Marginalized racial and ethnic communities, such as Black, Hispanic, and Indigenous populations, face significant barriers to accessing these programs due to systemic inequities in healthcare and educational access. LGBTQIA+ youth, particularly those in non-affirming environments, also experience high rates of substance use and mental health challenges, but often lack adequate, culturally competent prevention services. For instance, **motivational interviewing** has shown promise in reaching **Latinx youth** (Moreno et al., 2024), offering a culturally specific intervention that may be more effective than traditional approaches. **Barriers** such as **fear of deportation** among Hispanic adolescents (Cox et al., 2024) highlight challenges that disproportionately affect certain groups, indicating the need for policies that address these fears. **School-based programs**, such as those involving **technology-supported cooperative learning**, have proven effective (Van Ryzin & Chirimwami, 2024), yet there is a need to expand these programs to underserved regions. Finally, **young adults' pathways to opioid misuse** should be incorporated into prevention efforts, especially in communities where opioid misuse is rising (Ballard et al., 2024).

Prevention Efforts in Arizona Communities

Interviewees provided several examples of prevention activities in their communities. **Many of the identified efforts were pro-social activities and events** that were specifically focused on substance use prevention, while others aimed to create social spaces for young people to engage in activities together. These activities were offered for both school-aged and college-aged populations. There were, however, more examples offered at the college level. Interviewees identified pro-social prevention programs, including "The Buzz" and "The Belief in Bloom," which bring college students together to engage in pro-social activities as they learn about substance use prevention. Another pro-social activity listening session attendees identified included team sports (both school-connected and other).

Across the state of Arizona, listening session participants emphasized **the value of upstream efforts** (those that address broad social and economic factors) focused on increasing awareness, early intervention, and building protective environments/factors. These include education campaigns on fentanyl, alcohol, and marijuana use risks, integration of prevention content in schools (starting with age-appropriate content in elementary schools), and expansion of youth-centered pro-social activities and programming.

Community coalitions and schools are spearheading local efforts, with more activity in urban regions. Programs range from fentanyl awareness workshops in college settings to coalition-led parent education sessions. However, implementation is inconsistent across the state. Additionally, **prevention messaging related to marijuana and vaping is an uphill battle.** Particularly, it is challenging for school administrators to manage the volume of disciplinary issues tied to vaping and marijuana. As noted previously, many young people are provided with vapes and marijuana from their parents or at home. Consequently, it is very difficult to try to help youth understand the serious risks of using these substances when their parents or others seemingly approve of them in their home setting.

> "I know that… marijuana use is very low perceived risk since it was legalized… schools are finding a lot of vape devices containing marijuana now."
>
> – Listening session participant

Despite regional differences in delivery and volume of programming**, listening session participants across all groups called for expanded school-community partnerships, early education, and targeted outreach** that can address both curiosity-driven experimentation and coercion-based drug involvement.

Schools and colleges in Arizona are offering an assortment of prevention activities to students. Interviewees gave examples of several prevention education programs delivered in schools and college campuses. Additionally, social media is being used on college campuses to promote healthy behaviors, and there are also some statewide campaigns focusing on prevention for various age groups. Exhibit 31 provides examples of some of the prevention efforts taking place in communities.

Exhibit 31. Examples of Current Prevention Efforts Identified by Stakeholders and Subject Matter Experts

Location/Population	Prevention Activities & Programs
College Campus/College Students	*The Buzz*, a pro-social, game-oriented and interactive alcohol education/prevention program developed by the University of Arizona for college students
College Campus/College Students	Creation of prevention space on campus for college students to congregate and engage in activities including arts and crafts
College Campus/College Students	*Belief in Bloom*, a pro-social cannabis prevention program where college students participate together in prevention activities and learn healthy ways to cope
College Campus/College Students	Petting zoo event with alcohol prevention activities held on college campus
College Campus/College Students	Narcan training and education

Location/Population	Prevention Activities & Programs
K–12 School/Elementary-, Junior High-, and High School-Age Youth	Various education in-school education programs are offered on topics including over-the-counter medicine safety (elementary students), dangers of vaping (junior high), fentanyl education (junior high and high school students), and marijuana prevention (high school students)
K –12 Schools/Elementary-Age Youth	Lions Quest program focuses on anti-bullying, pro-social engagement, and substance use prevention.
K–12 School/Junior High-Age Youth	Catch My Breath educates on the dangers of vaping and marijuana.
Statewide Web-Based Campaign/Youth and Young	Talk NOW Az Campaign (talknowaz.com) provides education to parents and caregivers on talking with young people about substance use.
Community Youth Center/Youth	Various programming for youth to provide a safe space and pro-social environment after school

Generally, these programs were delivered to a general population of youth and young people, using a universal approach. One exception was for a program called "Catch My Breath," being offered specifically to students in junior high who had been caught with a vaping device at school so that they could avoid suspension.

One interviewee doing prevention work in K–12 schools recognized a need for more targeted strategies, meeting the needs of specific students, such as Native Americans, and better responding to trends in the data; however, they found it difficult to identify strategies tailored for specific groups. At the college level, an interviewee also suggested that some colleges and universities need assistance with implementing more selective strategies tailored to the needs of specific populations.

Listening session participants indicated Arizona's prevention efforts have succeeded in reaching school-connected youth, especially in urban districts, and parents who are engaged in coalition or school activities. However, **critical populations remain underserved**. These include out-of-school youth, LGBTQ+ teens, tribal youth, Spanish-speaking families, and individuals in rural or unincorporated areas.

> "They're coming from homes where parents are abusing cannabis, alcohol… and they allow their kids to do it… the perceived risk is, like, zero."
>
> – Listening session participant

One educator remarked on the importance of early and accessible education: "Once they know how bad [drugs] are for them, they can stop… but many are forced [into it]… I've heard that many are forced into getting involved in the mafias." Youth who are

disconnected from supportive adults or systems often fall outside the reach of standard programming.

Parental attitudes and peer influence also contribute to gaps in impact. As one coalition representative described, "They're coming from homes where parents are abusing cannabis, alcohol… and they allow their kids to do it… the perceived risk is, like, zero." These norms reinforce disengagement from formal prevention messaging, particularly among middle and high school students who see substance use as normalized or condoned. An additional consideration is the legalization of cannabis in the state of Arizona. A study by Park and Yoo (2022) shows that the effect of legalization of cannabis has a greater effect on use rates in areas without pre-existing availability (i.e., typically more rural regions). This has implications for Arizona's rural communities, which face higher rates of cannabis use, compounded by a lack of access to prevention programs.

Barriers to Prevention Efforts

In general, there are several barriers to the implementation of prevention efforts. One major barrier is the **lack of trained personnel**. School systems, particularly in rural areas, often lack the necessary resources to implement and sustain prevention programs effectively. Similarly, **social stigma** surrounding substance use and mental health issues continues to be a significant impediment, preventing many individuals from seeking or accessing help.

Resource allocation is another key challenge. While urban areas tend to receive more funding and support for prevention programs, rural areas frequently lack the infrastructure and resources needed to run these initiatives effectively. Disparities in funding, as seen in regions like Arizona's rural counties, limit the scope and impact of existing programs. Local government efforts, such as those from county health departments in Arizona, focus on education campaigns, but resources remain limited in rural areas. These areas often face staffing shortages and inadequate funding for community coalitions, which are vital for long-term prevention success. Addressing these disparities is key to bridging the gap in prevention efforts across regions.

Lastly, there is a growing recognition of the **need for greater cultural competence** in prevention strategies. Indigenous communities, for instance, face unique challenges due to historical trauma, and culturally tailored programs that integrate these communities' traditional healing methods could improve engagement and outcomes.

Transportation and weather were additional barriers identified to bring young people together for more pro-social events in communities, along with **resistance to participating due to discomfort in social settings**. For example, one interviewee noted that post-COVID, young people have experienced greater difficulty communicating with each other, which can be a barrier to participating in pro-social activities. When discussing spaces for youth to gather, such

as teen centers, other barriers mentioned were liability concerns and securing long-term funding. In a listening session, youth also cited a lack of safe spaces and recreational opportunities, which leaves them vulnerable to influence. As one person stated, "There's a lot of gang violence due to drugs in the community… that just happens very frequently."

To overcome these barriers, interviewees discussed the importance of meeting youth and young people and their parents where they are, which includes going where they already are. That may mean leveraging social media for prevention activities since, as one interviewee noted, "We've become a generation who relies on our phones too much, but that's where the students are."

Interviewees also suggested the importance of **making these activities and events enjoyable**, with one interviewee explaining to get school-age youth and their parents to attend events, "We meet them with fun and then deliver information, so they feel like they get more than just a lecture from the event."

> "We've done a lot more events and activities within the dorms. Going to the rec center, going to colleges, because [students] don't want to leave. We have to meet them where they're at, and I think that's been really, really successful."
>
> – Interviewee

Listening session participants identified additional barriers. These included unstable funding sources, insufficient staffing, and a lack of program infrastructure, particularly in rural and tribal communities. Prevention professionals in these areas often juggle multiple responsibilities with little specialized support. Parents and educators also raised the issue of inadequate training and messaging alignment, specifically for messages youth receive from home and messages youth receive at school.

Listening session participants also identified physical and social infrastructure. Logistical constraints such as transportation barriers, rigid eligibility rules, and limited awareness of programs also disproportionately affect low-income and immigrant families.

Prevention Workforce Capacity

Effective substance use prevention relies on a well-trained, supported workforce capable of delivering evidence-based interventions. However, challenges related to workforce capacity are widespread.

Nationally, many substance use prevention programs face significant challenges due to workforce shortages and high turnover rates, particularly in rural and underserved areas. According to SAMHSA, rural communities often struggle with limited access to behavioral health services, exacerbated by a lack of trained professionals and resources. (SAHMSA, 2023) However, workforce challenges can vary significantly across regions.

To address workforce gaps in the field of substance use prevention, SAHMSA offers various training programs aimed at increasing the number of qualified prevention specialists. The Prevention Technology Transfer Center (PTTC) Network provides education and resources to enhance the skills of prevention professionals (SAMHSA, n.d.). However, ongoing professional development opportunities are often underfunded, limiting the ability of specialists to stay current with best practices and emerging trends (SAMHSA, 2023). Other barriers to expanding the prevention workforce may include insufficient funding for training and recruitment incentives, as well as limited access to culturally competent training for staff working with marginalized populations (SAMHSA, 2014). A focus on building a more diverse and well-equipped workforce is critical to addressing these disparities.

In Arizona, these challenges are especially pronounced in rural regions. The Arizona Department of Health Services has identified shortages of certified prevention specialists in several counties, which impact the delivery and effectiveness of prevention programs. To mitigate these issues, the state offers programs such as the State Loan Repayment Program, which provides loan repayment assistance to professionals who work in underserved areas, including rural communities (ADHS, n.d.).

The prevention workforce in Arizona varies significantly by region. Urban counties such as Maricopa and Pima have more comprehensive staffing structures, with coalition coordinators, school prevention specialists, and youth advocates often working together. In contrast, rural counties rely heavily on part-time or multi-role staff.

In tribal, border, and frontier communities, the lack of locally trained, culturally competent staff compounds the problem. Listening session attendees in these areas expressed an urgent need for investment in the local prevention workforce, including bilingual professionals and those with lived experience. Training was frequently cited as a need across all regions in trauma-informed care, emerging drug trends, and culturally responsive communication.

Participants advocated for more integrated systems, stating that often school personnel, behavioral health providers, law enforcement, and coalitions operate in silos. “We need more training and shared strategies so we’re not duplicating efforts or leaving people behind,” summarized one listening session participant, echoing the call for a systems-oriented workforce approach.

Workforce Survey Results

The Workforce Survey (WFS) was designed to be completed by individuals throughout the state who are currently involved in prevention-related activities. A number of questions contained in the survey assisted in adding insights into what current prevention efforts are occurring in Arizona and described the background and expertise of this workforce. There were 314 respondents to the WFS. Although it is not possible to determine the formal generalizability of

these findings without knowing the degree to which this number represents the entire substance use prevention workforce, this number is substantial and includes one or more individuals representing every county in Arizona, making the results a useful resource to guide planning. Note that since the survey was shared separately with both prevention workers in coalitions and community organizations ("workforce") as well as school MHPs and nurses working directly with K-12 students, results are categorized by each group.

Demographics

Exhibit 32 illustrates the distribution of education levels among coalition and community organization (workforce) respondents and school setting respondents (school MHPs and nurses). Almost half of all respondents (47%) had a post-graduate education.

Exhibit 32. Distribution of Education Levels

Level of Education	Workforce	School MHPs & Nurses	Total
Post-graduate (masters, doctorate)	84	37	47%
College graduate (2 or 4-year degree)	64	30	37%
Some college	19	3	9%
Technical school or certificate program	5	5	4%
High school graduates (including GED)	8	0	3%

(N=255)

Exhibit 33 shows the length of time respondents have worked in substance use prevention when they responded to the survey. It shows a balanced distribution of newer to experienced employees.

Exhibit 33. Length of Time Working in Substance Use Prevention

Employment Status	Workforce	School MHPs & Nurses	Total
1 year or less	20	20	16%
2 - 4 years	59	21	31%
5 - 7 years	29	7	14%
8 - 10 years	13	9	9%
More than 10 years	59	18	30%

(N=255)

Exhibit 34 shows the work status of respondents. Most (82%) reported being employed full-time, with a small portion contributing as part-timers, volunteers, or interns.

Exhibit 34. Employment Status of Respondents

Employment Status	Workforce	School MHPs & Nurses	Total
Full-time (35 hours or more per week)	149	61	82%

Part-time (less than 35 hours per week)	15	3	7%
Volunteer	11	11	9%
Intern	5	0	2%

(N=255)

Exhibit 35 illustrates the counties in which respondents reported working. Respondents could report more than one county, and several reported working in more than one county (n=28); most respondents reported working in only one county (n=277). Representatives were reported in every Arizona county, with the largest representations serving the two counties with the largest urban centers—Maricopa (n=140) and Pima (n=57).

Exhibit 35. Counties Where Respondents Engage in Substance Use Prevention Activities

County	Workforce	School MHPs & Nurses	Total
Apache	10	2	4%
Cochise	14	3	6%
Coconino	9	4	4%
Gila	18	2	7%
Graham	14	1	5%
Greenlee	6	1	2%
La Paz	24	2	9%
Maricopa	83	57	46%
Mohave	14	6	7%
Navajo	16	5	7%
Pima	38	19	19%
Pinal	33	11	14%
Santa Cruz	8	3	4%
Yavapai	9	7	5%
Yuma	12	8	7%

(N=305)

Exhibit 36 illustrates the type of communities served by respondents' organizations: rural and urban. Respondents could report more than one type of community, and some respondents (n=26) reported their organization works in both types of communities; most respondents (n=279) reported their organization only works in one type of community. More than half (59%) responded to serving rural communities.

Exhibit 36. Types of Communities Served

Type of community	Workforce	School MHPs & Nurses	Total
Rural (fewer than 500,000 people)	126	54	59%

Urban (500,000 or more people)	89	62	50%

(N=305)

Exhibit 37 illustrates the languages used to provide services by respondents' organizations. Most organizations provide services in English. Native American languages (n=10), including Apache, Tohono O'odham, and Navajo, were reported most often in the "other" category.

Exhibit 37. Languages Used to Provide Services

Language	Workforce	School MHPs & Nurses	Total
English	196	103	98%
Spanish	111	80	63%
Other	18	10	9%
External interpretation service	22	22	14%

(N=305)

Qualifications

Exhibit 38 shows the training respondents reported receiving to help them be more prepared to support substance use prevention efforts. Respondents could report having received more than one kind of training. The most frequently identified training type was Motivational Interviewing, which 51% of respondents reported they had received.

Exhibit 38. Trainings Respondents Have Received

Training Type	Workforce	School MHPs & Nurses	Total
Motivational Interviewing / Techniques	92	25	51%
Suicide Alertness for Everyone (safeTALK)	68	40	47%
Cognitive Behavioral Techniques	62	24	37%
QPR (Question, Persuade, Refer)	59	24	36%
Applied Suicide Prevention Intervention Skills Training	58	19	33%
Cultural Competency 101	57	13	30%
Strategic Prevention Framework: Introduction to the Strategic Prevention Framework	59	3	27%
Strategic Prevention Framework: Strategic Planning / Logic Models	45	3	21%

Substance Abuse Prevention Specialist Skills Training	45	2	20%
Strategic Prevention Framework: Conducting a Community Needs Assessment	43	4	20%
Prevention Ethics	41	5	20%
Strategic Prevention Framework: Evaluation / Sustainability	39	4	19%
Core Competencies for Prevention Professionals	37	5	18%
Strategic Prevention Framework: Coalition Capacity Building / Coalition Development	40	2	18%
Dialectical Behavior Techniques	29	7	16%

(N=231)

Nineteen respondents reported receiving "other" types of training that prepared them to support prevention efforts, including the following:

- Academic and professional training (e.g., MSW)
- Mental health support
  - Youth Mental Health First Aid
  - Resilience and trauma-informed practices
  - AZ ACES - Youth Resilience
  - Botvin Life Skills Middle School Education training
- Conflict resolution and crisis management
  - Crisis prevention intervention
  - Collaborative problem solving (Think Kids)
  - Acts on Facts

Exhibit 39 shows where respondents reported obtaining substance use prevention-related trainings and certifications, and respondents could report receiving training from more than one source. More than half of all respondents (67%) reported receiving their training from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Exhibit 39. Training Source

Training/Certification	Workforce	School MHPs & Nurses	Total
Substance Abuse and Mental Health Services Administration	124	33	67%
My organization	89	20	47%

Community Anti-Drug Coalitions of America	65	4	29%
Suicide Prevention Resource Center	31	13	19%
Prevention Technology Transfer Center	39	0	17%
Tribal/Regional Behavioral Health Authority	21	4	11%
Office of Juvenile Justice and Delinquency Prevention	14	1	6%

(N=234)

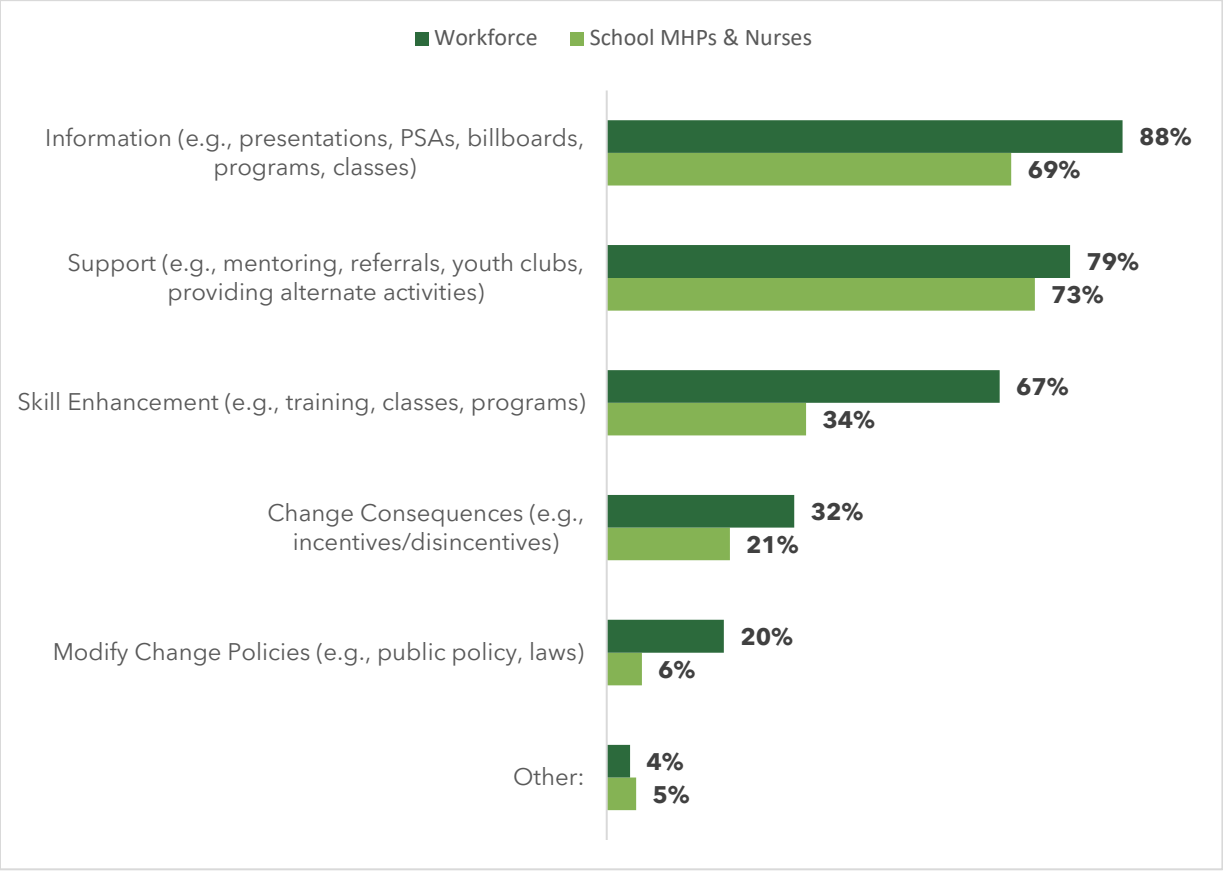
Forty respondents reported obtaining training from another source different from those provided; responses fell into the following themes:

- Federal and national organizations (e.g., DEA, CDC, FBI, National Guard, NAMI)
- Professional associations (e.g., PESI, NASW)
- Local and regional coalitions and organizations
    - Southwest Arizona Coalition for Leadership and Advocacy
    - Fountain Hills Drug Coalition
    - Graham County Substance Abuse Coalition
    - Pima County Health Department
    - Pima County Health
    - RiseUp! Glendale
    - Barbell Saves
- Community and school-based initiatives
    - QPR Institute
    - Stanford Harmony
    - Yes to Life
    - YMHFA (Youth Mental Health First Aid)
- Online
    - Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery (HECAOD)
    - Internet
    - Emails

Respondents were also asked to report on the types of substance use prevention activities that their organizations provide. Exhibit 40 illustrates the most common types of activities that respondents shared, which included information, support, and skill enhancement. It also shows workforce respondents reported their organizations were more than three times likely to be

involved in changing policy activities (20% v. 6%) and almost twice as likely to be involved in skill enhancement activities (67% v. 34%) than school mental health professionals and nurses.

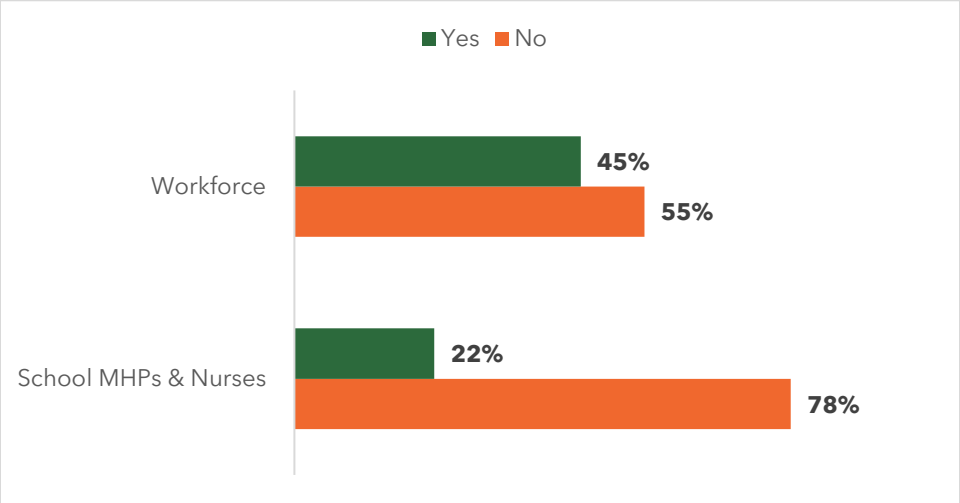
Exhibit 40. Types of Substance Use Prevention Activities



(N=265)

They were also asked, "Does your organization currently provide safe use and/or safe supply?" The majority of respondents answered "no" to this question. Exhibit 41 shows that less than a quarter (n=13, 22%) of school mental health professionals and nurses reported that their organizations provide safe use and/or safe supply (i.e., harm reduction) services.

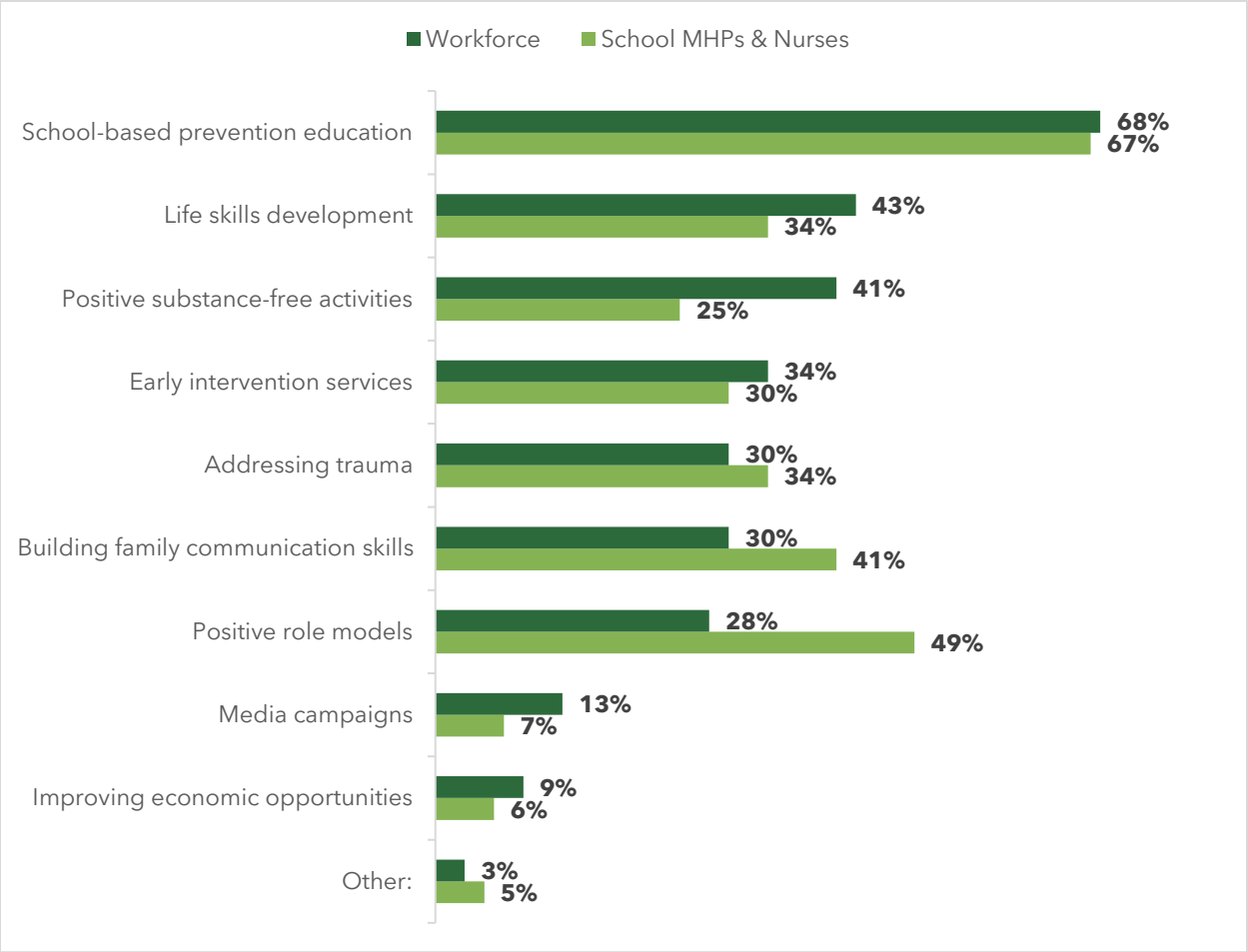
Exhibit 41. Safe Use Supply



(N=223)

Another question in the survey was, "What are the top three substance use prevention efforts that have been most successful for the population(s) you work with?" The activity selected as most successful by both groups was school-based prevention education. Exhibit 42 shows workforce respondents chose school-based prevention education (68%), life skills development (43%), and positive substance-free (41%) activities as their top three most successful strategies while school mental health professionals and nurses chose school-based prevention education (67%), positive role models (49%), and building family communication skills (41%).

Exhibit 42. Successful Intervention Activities

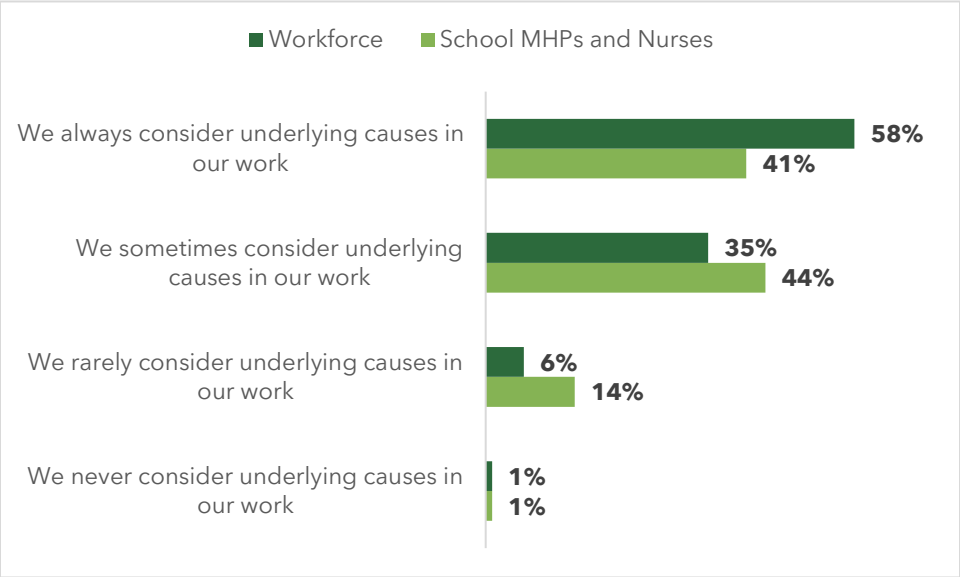


(N=276)

Addressing Underlying Causes of Addiction

Respondents were asked to rate how well they think their organization addresses the underlying causes of addiction, such as poverty, trauma, and systemic oppression. More than half of the respondents rated their organization as always considering underlying causes in their work. Exhibit 43 shows that 58% of school mental health professionals and nurse respondents rated their organizations as "sometimes" or "rarely" considering the underlying causes of addiction.

Exhibit 43. Underlying Causes of Addiction Rating



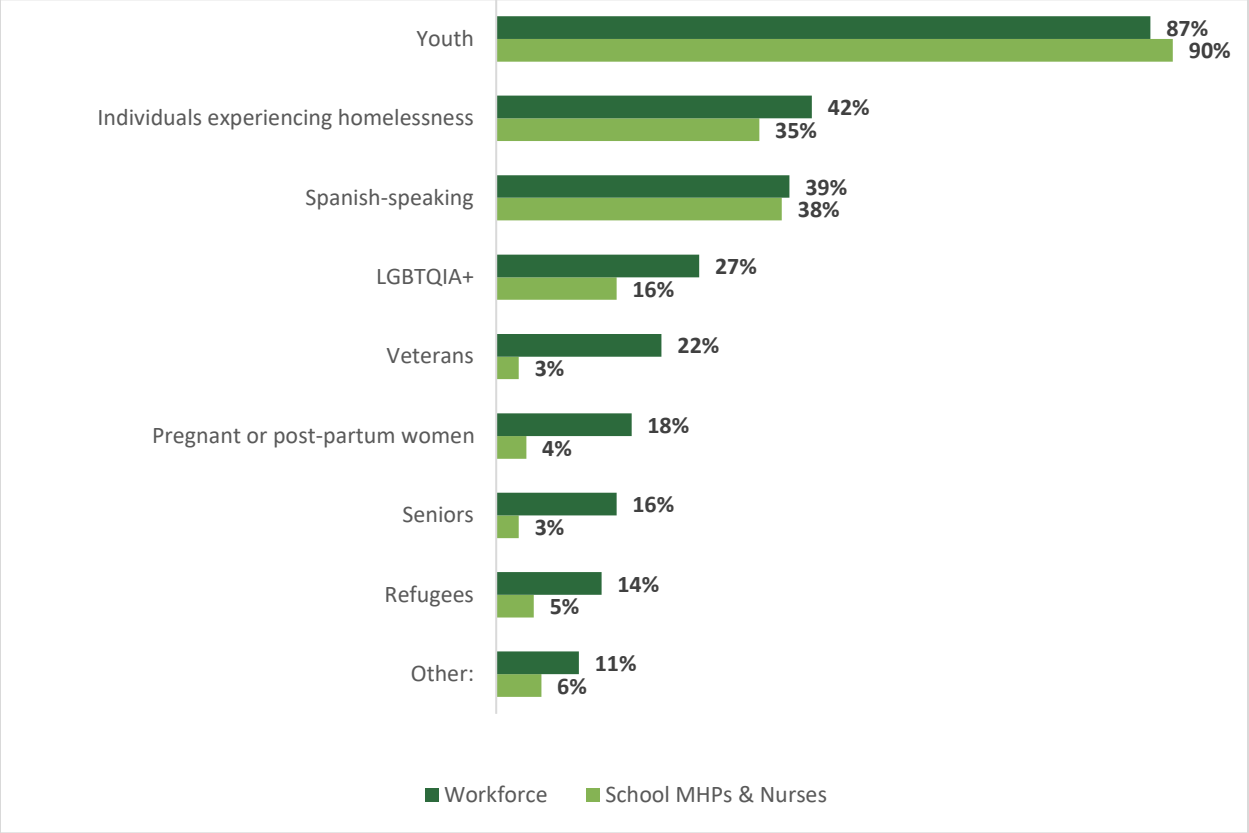
(N=276)

Survey respondents were also asked, "Does your organization have programs or services that are geared towards specific population needs?" Respondents were able to select more than one response. The top three specific populations served by both workforce and MHPs/nurse respondents were youth, individuals experiencing homelessness, and Spanish-speaking populations. However, the refugee, senior, and pregnant/post-partum women populations have overall lower service percentages. In "other," respondents wrote their organizations also had specific programs with the following themes:

- Age groups (preschool, elementary school, and young adults)
- Specialized populations (High-risk youth, neurodivergent youth, HIV/Aids community, justice-involved, SMI, and addiction)
- Indigenous communities (Native American, tribal communities, and federally recognized tribes)

Exhibit 44 shows that workforce respondents generally reported higher percentages across specific populations, reflecting the group's broad service range compared to school-based respondents.

Exhibit 44. Special Populations Served by Prevention Organizations



(N=252)

RISK & PROTECTIVE FACTORS

Substance use behaviors are influenced by a dynamic interplay of risk and protective factors that operate across individual, relational, community, and societal levels. **Risk factors increase the probability of early initiation, frequency, or severity of substance use, while protective factors mitigate those risks by enhancing resilience, promoting healthy coping strategies, and reinforcing positive social norms.** These factors are context-dependent and often vary by age, developmental stage, socio-cultural background, and geographic setting. Effective prevention strategies rely on a comprehensive understanding of these determinants to target the underlying conditions that contribute to vulnerability or resilience within specific populations.

Arizona faces unique challenges in substance use prevention due to its diverse population and regional disparities. Some of the Arizona-specific **risk factors** are highlighted below.

Rural and Tribal Community Isolation

Limited access to behavioral health services in rural and tribal areas contributes to increased substance use, particularly among Native American youth and adults (Arizona Department of Health Services [ADHS], 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2021).

High Rates of Adverse Childhood Experiences (ACEs)

Arizona consistently reports higher-than-average ACE scores, such as household substance use, incarceration, and domestic violence, all of which are predictive of early substance use (Children's Action Alliance, 2022).

Economic Insecurity and Unstable Housing

Poverty and housing instability, especially in areas such as South Tucson, Yuma County, and certain tribal nations, are associated with higher rates of opioid and methamphetamine use (Arizona Criminal Justice Commission [ACJC], 2022).

Border Proximity and Drug Trafficking Corridors

Arizona's proximity to the U.S.-Mexico border increases exposure to drug trafficking, particularly of fentanyl and methamphetamine (Drug Enforcement Administration [DEA], 2023).

Low Perception of Harm Among Youth

According to the Arizona Youth Survey, many adolescents underestimate the risks of marijuana and prescription drug misuse, particularly in counties with higher medical marijuana dispensary density (ACJC, 2022).

Limited School-Based Prevention Programs

Underfunded and rural districts often lack access to evidence-based prevention curricula, limiting early intervention efforts (Governor's Office of Youth, Faith and Family [GOYFF], 2023).

In contrast, some Arizona-specific **protective factors** include:

Strong Family and Cultural Connections

Cultural identity and intergenerational support serve as significant protective factors among Latino and Indigenous youth (SAMHSA, 2021; Inter Tribal Council of Arizona [ITCA], 2020).

Community-Based Coalitions and Prevention Networks

Coalitions like MATFORCE and regional efforts funded through GOYFF build community capacity for youth education, prevention, and early intervention (GOYFF, 2023).

Expanded Access to Peer Support and Recovery Services

Arizona has increased peer-based recovery programs and mobile units, especially in counties with high overdose rates (ADHS, 2023).

Screening and Early Intervention: Substance, Brief Intervention, and Referrals to Treatment (SBIRT)

The adoption of SBIRT across schools and community health centers offers early identification of substance misuse risks (Arizona Health Care Cost Containment System [AHCCCS], 2022).

Policy Support for Naloxone and MAT

Arizona's Naloxone Standing Order and expanded MAT coverage under Medicaid have improved access to overdose prevention and recovery support (ADHS, 2023).

Additionally, there are risk and protective factors for specific populations, which are discussed in the sections below.

Youth

Adolescents face multiple risk factors, including peer pressure, exposure to family substance use, and community-level influences. A lack of parental supervision and perceived low risk of substance use can also contribute to higher initiation rates. Conversely, youth prevention programs such as Students Against Destructive Decisions (SADD) and Project Alert in Arizona aim to educate and empower youth against substance use (SAMHSA, 2023).

LBBTQIA+ Populations

LGBTQIA+ individuals, particularly bisexual females and sexual minority males, report significantly higher substance use rates than their heterosexual peers. Bisexual females are three

times more likely to misuse opioids than straight females, and sexual minority males are 2-3 times more likely to use illicit drugs other than marijuana (SAMHSA, 2021-2022). Social stigma, discrimination, and mental health struggles contribute to these disparities. Protective factors include LGBTQIA+ affirming support networks, access to mental health services, and inclusive community policies.

Low Socioeconomic Status (SES) Groups

Individuals from low SES backgrounds face heightened risk due to economic instability, neighborhood violence, and limited healthcare access. Racial and ethnic minorities in lower-income areas may also experience additional stressors that contribute to substance use. Research highlights that empowerment-based interventions, such as mentoring and community engagement programs, can serve as protective factors for youth of color (Current Addiction Reports, 2020).

These risk and protective factors align closely with the themes that emerged during listening sessions throughout the state (Exhibits 45 & 46). The following section explores how participants described barriers and risks as well as sources of resilience, connection, and community support.

Statewide Factors

Exhibit 45. Risk Factors for Substance Use Identified by Listening Session Participants

Risk Factors	Description
Easy Access to Substances	Youth described widespread access to vapes, marijuana, alcohol, and fentanyl.
Parental Substance Use or Approval	Youth reported obtaining substances from parents or encountering permissive attitudes at home.
Lack of Supervision / After-School Gaps	Limited structured activities and supervision in the afternoon/evening.
Normalization of Substance Use	Legalization and cultural attitudes have reduced the perceived risks of use.
Mental Health & Trauma	Anxiety, depression, grief, and trauma were cited as drivers of use.
Peer Pressure & Social Media Influence	Substance use was influenced by peers and drug-related content on platforms like Snapchat.
Proximity to Drug Trafficking Routes	Border towns face increased access due to trafficking exposure.
Unstable Housing or Homelessness	Youth and adults in unstable living situations are at higher risk of use.

Exhibit 46. Protective Factors for Substance Use Identified by Listening Session Participants

Protective Factors	Description
Strong Family Communication	Parents who spoke openly about substance use created a protective buffer.
Participation in Structured Activities	Involvement in sports, clubs, and hobbies was seen as a strong protective influence.
Culturally Relevant Youth Programs	Programs that connected with identity and tradition were described as highly effective.
Supportive School Staff and Policies	Early intervention, counseling, and social-emotional learning in schools helped mitigate risk.
Coalition Involvement and Visibility	Coalitions provided education, outreach, and community-based solutions.
Youth Leadership Opportunities	Leadership roles empowered youth to make healthy choices.
Safe and Monitored Environments	The presence of trusted adults and structured settings provided emotional and physical safety.
Strong Family Communication	Parents who spoke openly about substance use created a protective buffer.

Factors Affecting Specific Regions and Populations

Listening sessions spanned the state, and while every session noted similarities in risk and protective factors, some differences were also observed.

In **border communities** (i.e., Nogales & Yuma), participants focused on risk factors such as exposure to drug trafficking, youth witnessing smuggling, and reduced consequences for being caught with substances. Protective factors discussed the support of culturally relevant education programs such as Circles of Peace in Nogales and the Yuma County Anti-Drug Coalition. **Tribal members** from Pascua Yaqui discussed risk factors such as intergenerational trauma and family history of alcohol abuse but focused on protections in the form of community cohesion and programs that align with traditions. **Rural areas of the state** (Kingman & Superior) focused on risk factors, including limited resources for youth, such as a lack of

> "The younger generation is leaning into those irresponsible ways because there is this wave of less hope, more anxiety and depression."
>
> – Listening session participant

after-school programming and organized activities, visible public use of substances in the community, and stigma surrounding issues such as mental health and addiction. Protective factors discussed in rural areas include tight-knit networks and grassroots coalition engagement.

Across **college campuses** (NAU, Yavapai College, and Arizona Western College), students addressed the risks of normalization of substance use and the influence of their peers (pressure to try substances and dorm living environment). Protective factors for this population included on-campus counseling, supportive resident assistants for students living on campus, and an increased focus on mental health.

> "They don't have that support group, that social group, that fitting in somewhere, and so the only thing left is to go do drugs and alcohol."
>
> – Interviewee

In discussions about **factors contributing to substance use risk among youth and college students, interviewees highlighted stress, social pressures, lack of social involvement**, **and family norms**. Stress, the most commonly cited risk factor, was discussed by one interviewee as it relates to adverse childhood experiences, noting that many youth have experienced or are currently experiencing trauma, which serves as a stressor. Another interviewee discussed how social media adds additional social pressure that contributes to stress. Interviewees suggested that young people turn to substances to cope with stress because they lack the skills to manage it in healthy ways.

Stakeholders and subject-matter experts participating in interviews identified **a lack of social involvement as a risk factor,** discussing the negative effects of not having a social group or activity. Focusing on school-age youth, one interviewee explained that not being a part of a social group, such as a sports team or band, made it more likely for them to use substances. Related to this, an interviewee from a rural region of the state emphasized boredom's role in driving substance use among youth.

Another risk factor that interviewees identified was **family norms surrounding substance use**, suggesting usage and acceptability of both alcohol and vaping in the home increased youth's accessibility to those substances. Interviewees also indicated that a tolerance for underage alcohol consumption at home contributes to young people using alcohol.

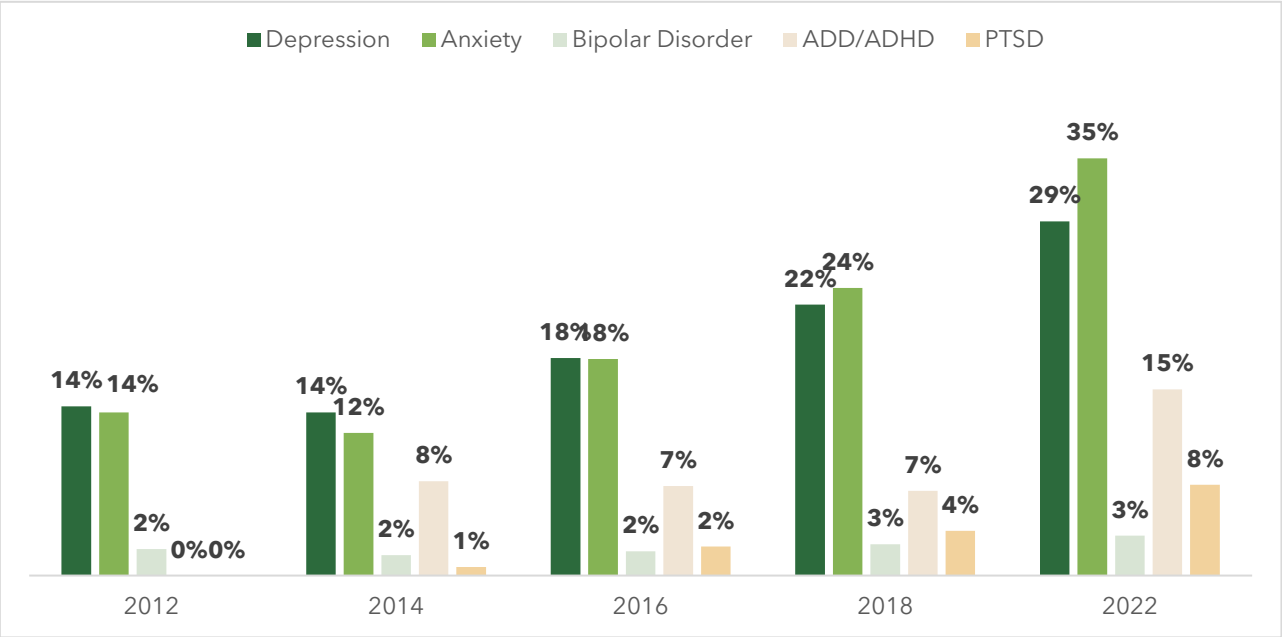
When asked about protective factors, interviewees commonly discussed **the role of pro-social groups and events, including athletics and clubs, in helping youth and young adults form supportive networks**. These activities often included social and prevention-focused events. Interviewees emphasized the value of having a community where youth and young adults can be themselves and connect without relying on substances.

Although mentioned less frequently, other **protective factors included parental and community influences**. Regarding parental influence, interviewees noted that it can positively or negatively affect substance use depending on the approach, emphasizing the importance of parents talking with young people about substance use. One interviewee noted that parental influence is among the "strongest" factors in the college-age population. Focusing more on the broader community, a few interviewees discussed the importance of community leadership and support in creating a culture that is welcoming and supports young people.

> "Believe it or not, parental influence is still probably one of the strongest in the college-age population. So that's a huge factor...they still listen to what their parents' influence is."
>
> – Interviewee

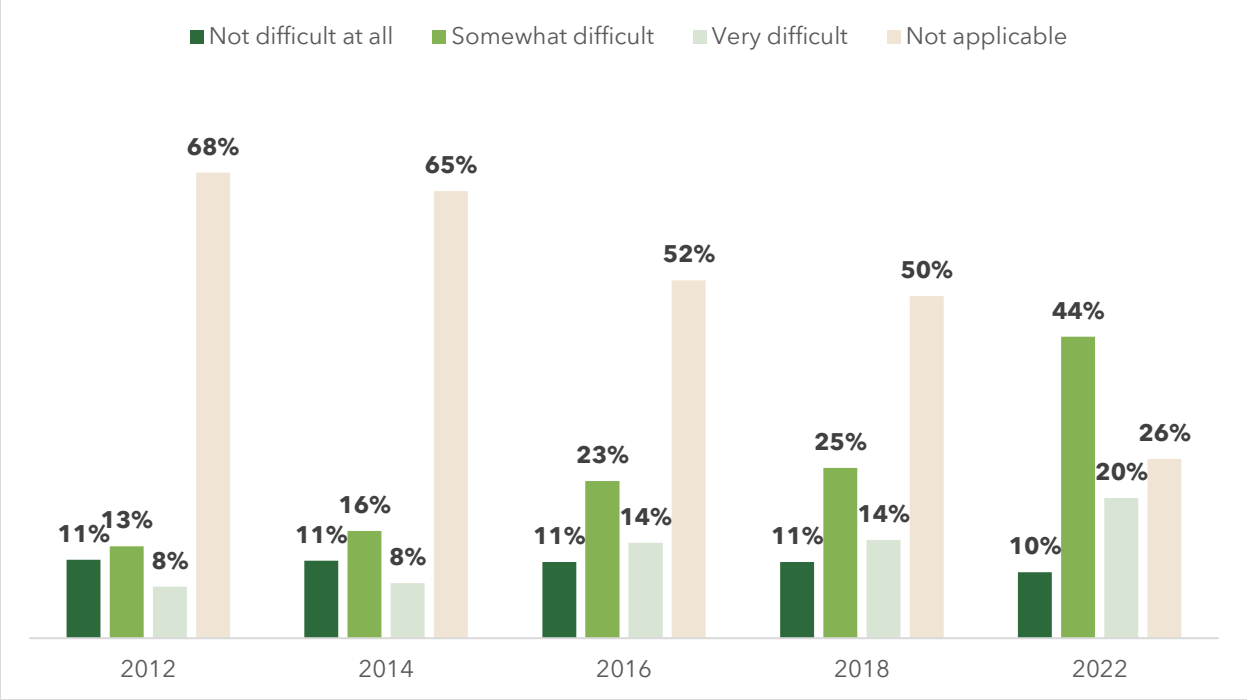
Mental health status and diagnosis are critical risk factors for substance use because individuals experiencing conditions such as depression, anxiety, PTSD, or other behavioral health challenges often turn to substances as a way to cope with emotional pain, stress, or feelings of hopelessness. Mental health disorders can increase vulnerability to initial substance use and escalate the likelihood of developing substance use disorders over time. Moreover, external stressors—such as trauma, economic hardship, or social isolation—can compound mental health struggles, creating additional pathways to substance misuse. Considering mental health is essential when discussing substance use risk because prevention, early intervention, and treatment efforts that integrate mental and behavioral health support are more effective at addressing root causes and reducing long-term harm. Addressing mental health needs alongside substance use prevention provides a more comprehensive approach to building resilience and promoting overall well-being. Exhibits 47 & 48 show college students' self-reported mental health status from the most recent AZIHE survey.

Exhibit 47. AZIHE Student Self-Reported Mental Health Diagnoses from 2012-2022



Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 48. AZIHE: How difficult has anxiety or depression made it for you to do your work, study, go to class, or get along with other people? (2012-2022)



Source: Arizona Institutions of Higher Education Network, 2022

PREVENTION NEEDS

Strengths and Gaps in Prevention

Arizona has made notable progress in establishing coalitions, education partnerships, and community awareness campaigns, particularly in larger metropolitan counties. Maricopa and Pima counties, for example, benefit from a relatively dense network of school-based programs, college prevention initiatives, and behavioral health partnerships. In these areas, listening session attendees described coordination among schools, healthcare providers, and prevention specialists as a foundational strength.

"Colleges are trying to inform more people, especially when it comes to ways to prevent [fentanyl use]," noted one student from Yuma, highlighting efforts underway in higher education settings. Coalition members also described active community engagement, with one sharing: "We're working with local partners to get ahead of these issues, not just react."

Policies supporting prevention efforts in schools and increased attention to fentanyl risks at the state level have also contributed to growing public awareness. In many areas, school staff and coalition leaders are integrating prevention messaging into broader health and wellness curricula.

Gaps and Disparities in Prevention Access

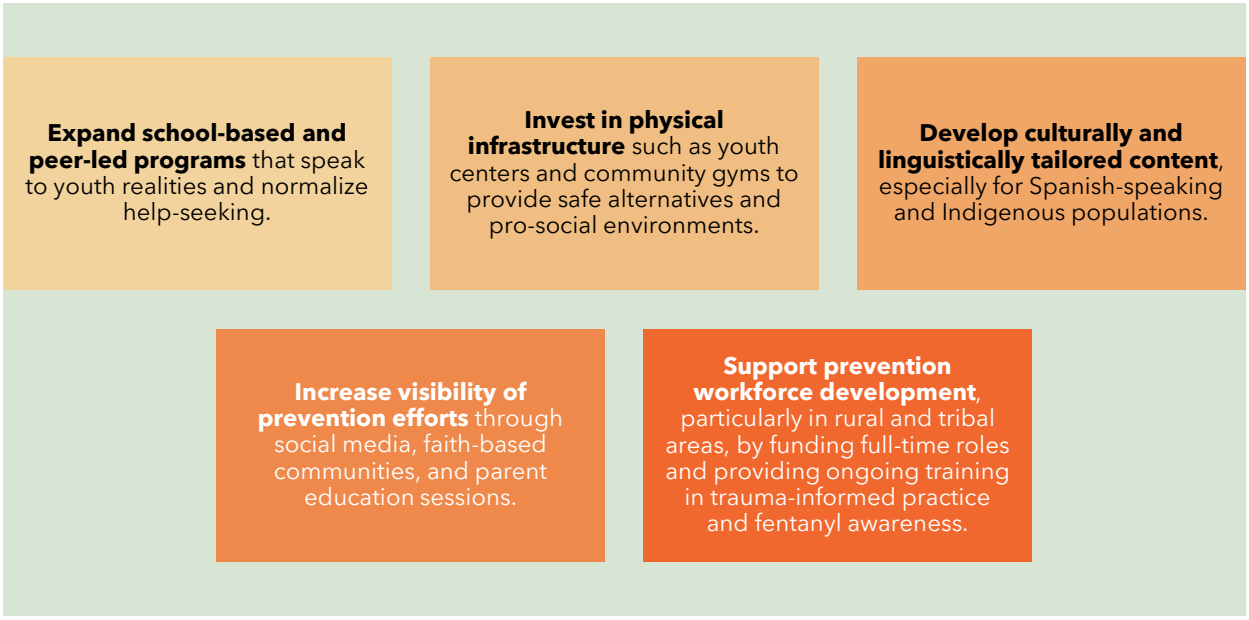
Despite these strengths, major gaps persist, especially outside of urban cores. In Mohave, Santa Cruz, and La Paz counties, listening session attendees reported thinly spread resources, limited staff capacity, and inconsistent access to programming. Youth and parents in these regions described few safe spaces or structured activities for adolescents, with some noting that prevention is largely absent from school systems or not delivered in culturally relevant ways.

"There is no support for sports… there are no spaces," a parent from Nogales shared, underscoring how a lack of infrastructure limits protective factors. A coalition representative noted, "We're trying to keep kids out of trouble, but there's nowhere for them to go after school." In tribal communities, access was described as particularly fragmented, with few prevention-specific roles and limited culturally responsive content.

Subpopulations are at greatest risk, such as LGBTQIA+ youth, young adults who are no longer in school, and Spanish-speaking families. These groups are frequently underserved due to language barriers, stigma, or lack of targeted outreach. The workforce serving these areas often lacks consistent training or community-based support, making it difficult to deliver sustained, trusted prevention messaging.

Participant-Identified Strategies for Addressing Gaps and Training Needs

Participants offered several recommendations to strengthen prevention efforts statewide:



CONCLUSION

Summary of Key Findings

The findings of this needs assessment indicate that while Arizona has an active and dedicated network of substance use prevention efforts, the current system faces significant limitations in terms of reach, consistency, cultural responsiveness, and workforce capacity. Substance use among youth and young adults continues to evolve, with marijuana and vaping increasingly normalized, alcohol use deeply embedded in social environments, and fentanyl continuing to pose a severe and growing threat across regions. Although there are ongoing efforts to address these issues, access to and effectiveness of prevention programming vary widely based on geography, population, and local resources.

Several themes emerged clearly across both quantitative and qualitative data sources. Youth and young adults are most likely to be introduced to substances through social networks, including peers and even family members. SMEs, stakeholders, and community members alike voiced concerns that the normalization of use within homes, especially for vaping, marijuana, and alcohol, undermines prevention messaging and contributes to low perceived risk among adolescents. In addition, the rise of high-potency marijuana products, THC vapes, and counterfeit pills laced with fentanyl has created new prevention challenges that require swift and targeted public health responses.

Geographic and demographic disparities were also evident. Rural, tribal, and border communities report limited access to prevention services, fewer prevention professionals, and minimal infrastructure to sustain programming. These areas also experience some of the highest rates of substance-related harm, including opioid overdoses and alcohol-induced mortality. Meanwhile, LGBTQIA+ youth, youth of color, and disconnected youth are consistently underserved, despite evidence indicating elevated risk and need for culturally affirming approaches.

Despite these gaps, the assessment found a strong foundation on which AHCCCS can build. Many schools, colleges, and coalitions are implementing evidence-based programs, often in partnership with community stakeholders. There is growing adoption of upstream prevention strategies that address mental health, trauma, and social isolation as underlying drivers of substance use. Arizona's prevention workforce demonstrates a strong commitment to improving outcomes among high-risk populations across the state, and many professionals are eager for further training and collaboration. Participants emphasized the importance of early intervention, community connection, culturally specific programming, and improved statewide coordination.

To ensure an equitable, data-informed, and sustainable prevention system, AHCCCS will need to support a dual approach: bolstering foundational infrastructure while innovating new models tailored to local context. **A shift toward upstream, community-driven, and system-coordinated prevention will better align with the evolving substance use landscape and the lived experiences of Arizona residents.**

Key Priorities & Recommendations

1. Expand and Diversify the Prevention Workforce

- Recruit and retain prevention professionals in underserved areas by offering competitive salaries, rural/tribal service stipends, and flexible career pathways.
- Provide targeted professional development focusing on prevention science, cultural humility, trauma-informed practices, motivational interviewing, and substance use trends.
- Support peer-led and community health worker models, especially in tribal and Spanish-speaking communities.
- Establish or expand regional training collaboratives to reduce duplication, support networking, and build shared standards across the state.

2. Strengthen Equity and Reach in Programming

- Prioritize funding for prevention efforts that explicitly serve high-need and underrepresented groups, including Indigenous youth, LGBTQIA+ teens, youth in foster care, and rural populations.
- Develop flexible program models that meet youth where they are—such as after-school centers, digital platforms, juvenile justice systems, or housing programs.
- Expand the availability of culturally specific programming, including integrating traditional practices in tribal communities and bilingual resources for Spanish-speaking families.
- Implement youth participatory approaches that involve adolescents in the design, delivery, and evaluation of prevention activities.

3. Improve Prevention Messaging and Education

- Launch a statewide media campaign (similar to that of current fentanyl awareness campaigns) to educate families on the risks of vaping, marijuana, and alcohol use among teens.
- Develop toolkits for parents and caregivers to address normalization of substance use in households and provide strategies for early conversations.
- Support social media micro-campaigns developed by youth or college students to increase relevance and engagement.
- Offer training for school staff to address vaping and marijuana use more effectively, including understanding device types, THC concentrations, and detection tools.

4. Promote Systemic Coordination and Cross-Sector Collaboration

- Convene interagency planning groups (e.g., education, health, juvenile justice) to coordinate funding, training, and messaging.
- Embed substance use prevention into mental health, behavioral health, and education initiatives, especially for K–12 settings and institutions of higher education.
- Establish state-supported partnerships with tribal nations, colleges, and community organizations to pilot innovative, co-designed prevention models.

5. Invest in Data Capacity and Evaluation

- Expand local-level data collection capabilities through technical assistance, mini-grants, and partnerships with universities and community-based organizations.
- Support community-based participatory research models to elevate local voices and generate community-owned data.

- Promote continuous quality improvement by encouraging grantees to use real-time data for adaptive implementation and to disaggregate data by key subpopulations.
- Publicly disseminate evaluation findings through infographics, interactive dashboards, and plain-language briefs tailored for different stakeholder audiences.

6. Advance Early Intervention and Mental Health Integration

- Integrate prevention messaging into school-based behavioral health screenings and restorative discipline practices.
- Fund early childhood and parenting programs that promote protective factors and educate families about substance use risks starting at a young age.
- Pilot multi-tiered systems of support (MTSS) models that incorporate substance use prevention as a key area of student wellbeing.

APPENDIX A: ACTIVE COALITIONS

Coalition (website linked)	County
Ajo SAPE (Substance Abuse Prevention and Education) Coalition	Pima
Amado Community Alliance	Pima
Apache County Youth Council	Apache
Arizona Border Alliance	Cochise
Arizona SADD	Statewide
Arizona Youth Partnership	Statewide
Be Awesome Coalition	Maricopa
Be Med Smart Coalition	Pima
CAREaz	Apache
Casa Grande Alliance	Pinal
Coolidge Youth Coalition	Pinal
Copper Basin Coalition	Gila
Copper Corridor Substance Abuse Coalition	Pinal
Fountain Hills Substance Abuse Prevention Coalition	Maricopa
Graham County Substance Abuse Coalition	Graham
Greenlee County Substance Abuse Coalition	Greenlee
Guadalupe Community Partnership	Maricopa
HEAAL/Help Enrich African American Lives	Maricopa
Healthy People Coalition	Pima
HOPE Coconino	Coconino
Laveen Coalition	Maricopa
LPKNC	Pima
Marana Prevention Alliance	Pima
MATFORCE	Yavapai
Mayahuel Prevention Consortium (MPC)	Pima
Mesa Prevention Alliance	Maricopa
Metro Phoenix Partners in Prevention	Maricopa
Mohave Substance Treatment Education Prevention Partnership (MSTEPP)	Mohave
Nexus Coalition	Navajo
Parker Area Alliance for Community Empowerment (PAACE)	La Paz
Peoria Primary Prevention Coalition (3PC)	Maricopa
Pima County Community Prevention Coalition	Pima
Pinal Hispanic Council – Eloy Governor's Alliance Against Drugs	Pinal
REACH North Phoenix Coalition	Maricopa
Rise Up! Glendale	Maricopa
RISP-Net (Refugee and Immigrant Service Provider Network)	Pima
Southeast Valley Community Alliance	Maricopa / Pinal
StandUP AJ	Maricopa / Pinal
STOPit Coalition (South Tucson Operation Prevention, Intervention & Treatment)	Pima
Tempe Coalition	Maricopa
The Santa Cruz County Drug Free Community Coalition	Santa Cruz
United Prevention	Maricopa

Urban Indian Coalition of Arizona	Maricopa
Way Out West Coalition (WOW Coalition)	Maricopa
West Phoenix Amanecer Coalition, CPLC Community Center	Maricopa
Young Adult Development Association of Havasu	Mohave
Youth Empowerment and LGBTQ Leadership (YELL) Coalition	Pima
Yuma County Anti-Drug Coalition	Yuma

Note: All data in this table is from the website www.saclaz.org. As of January 2025, all listed coalitions were active.

APPENDIX B: LISTENING SESSION GUIDES

Listening Session Guide: Coalitions

1) What are the major substance use issues in your community? What have you observed or experienced that makes you feel this way?
2) Currently, what substance(s) are causing the most harm in your community?
3) What are some of the current challenges you face in your prevention work? Consider challenges at different levels, such as micro (people), meso (organizations), and macro (policies, economics).
4) What is working well in the prevention work you are doing?
5) What are some of the more long-term consequences of substance use in your community?
6) What do you think are some of the main reasons why individuals in your community use substances? [PROBE: mental health issues, financial challenges, physical health issues, etc.]
7) When it comes to underage use of substances, what do you think are the main ways that youth in your community access substances? What makes you think that?
8) The results of the 2024 Arizona Youth Survey (AYS) of students in the 8th, 10th and 12th grades indicate that the top 4 reasons youth begin using substances are: 1) to have fun, 2) to get high or feel good, 3) to deal with stress from school, and 4) to deal with stress from parents and/or family. Taking these reasons into consideration, do you have any ideas on what sorts of prevention-focused activities may be beneficial to youth in your community?
9) What efforts are you aware of that the community and/or educational institutions has/have used to try and prevent substance use among community members?
    a. Currently, how effective do you think these efforts are?
    b. What ways do you think these efforts could be improved?
    c. Do you believe these changes/interventions could effectively reduce or eliminate substance use in your community?
10) How do you feel like the legalization/normalization of marijuana in recent years has influenced youths' use of other substances, if at all?
11) What sorts of collaboration is happening in your community among different groups (faith-based, behavioral health, medical, law enforcement, education, etc.) related to prevention work? [PROBE: What area(s) do you feel you could benefit from increased collaboration?]
12) How does your agency/coalition/organization address underlying causes of addiction? An underlying cause would be any event or situation that could initiate substance use or make it difficult to stop (poverty, historical trauma, systematic oppression, untreated mental illness, etc).
13) AHCCCS is conducting this NA to determine what the best way is to allocate funding for future years. Where do you think funding would be best directed? [PROBE: Do you have any recommended actions or strategies that would help to make these suggestions a reality?]

Listening Session Guide: Parents & Educators

1) What are the major substance use issues in your community? What have you observed or experienced that makes you feel this way?
2) Currently, what substance(s) are causing the most harm in your community?
3) What are some of the more long-term consequences of substance use in your community?
4) What do you think are some of the main reasons why individuals in your community use substances? [PROBE: mental health issues, financial challenges, physical health issues, etc.]
5) When it comes to underage use of substances, what do you think are the main ways that youth in your community access substances? What makes you think that?
6) The results of the 2024 Arizona Youth Survey (AYS) of students in the 8th, 10th and 12th grades indicate that the top 4 reasons youth begin using substances are: 1) to have fun, 2) to get high or feel good, 3) to deal with stress from school, and 4) to deal with stress from parents and/or family. Taking these reasons into consideration, do you have any ideas on what sorts of prevention-focused activities may be beneficial to youth in your community?
7) Are you aware of any current prevention-focused education activities that are occurring in middle/high schools? If so, which ones? Do you support this kind of education for youth? Why or why not?
8) What efforts are you aware of that the community and/or educational institutions has/have used to try and prevent substance use among community members?
    a. Currently, how effective do you think these efforts are?
    b. What ways do you think these efforts could be improved?
    c. Do you believe these changes/interventions could effectively reduce or eliminate substance use in your community?
9) How do you feel like the legalization/normalization of marijuana in recent years has influenced youths' use of other substances, if at all?
10) AHCCCS is conducting this NA to determine what the best way is to allocate funding for future years. Where do you think funding would be best directed? [PROBE: Do you have any recommended actions or strategies that would help to make these suggestions a reality?]

Listening Session Guide: College Students

1) What are the major substance use issues in your community? What have you observed or experienced that makes you feel this way?
2) Currently, what substance(s) are causing the most harm in your community?
3) What are some of the more long-term consequences of substance use in your community?
4) How do you think college students obtain substances?
5) How do you feel like the legalization/normalization of marijuana in recent years has influenced youths' use of other substances, if at all?
6) What do *you* think are the main factors that lead to youth consuming substances?
    a. Do you have any ideas on what sorts of prevention efforts would be beneficial to you and your peers?
7) What efforts are you aware of that the community and/or NAU has/have used to try and prevent substance use among community members?
    a. Currently, how effective do you think these efforts are?
    b. What ways do you think these efforts could be improved?
    c. What kinds of changes/interventions could effectively reduce or eliminate substance use in your community?
8) AHCCCS is conducting this NA to determine what the best way is to allocate funding for future years. Where do you think funding would be best directed? PROBE: Do you have any recommended actions or strategies that would help to make these suggestions a reality?
9) Is there anything else you would like to share with us today about prevention efforts in your community or in general?

APPENDIX C: INTERVIEW GUIDE

AHCCCS Prevention Needs Assessment: Interview Protocol

Introduction:

Hello, and thank you for agreeing to take part in this interview. I'm [blank] from LeCroy & Milligan Associates, and we are working with AHCCCS to conduct a Substance Use Prevention Needs Assessment for the state of Arizona. AHCCCS conducts this assessment once every five years to get a better idea of what sorts of prevention efforts are occurring across the state, what is working well, and what gaps in services may remain. As part of this effort, we are interviewing people with experience and/or expertise in substance use prevention activities. Just so you are aware, AHCCCS is defining primary prevention for the purpose of this assessment as "*the programs, interventions, and strategies that are directed at individuals who have not been determined to require treatment for substance use and delivered prior to the onset of a Substance Use Disorder (SUD). Substance use primary prevention strategies generally include education, information dissemination, problem identification and referral, environmental strategies, alternative activities, and community-based processes.*"

I'd like to ask you some questions about your experience prevention work in [*with specific community, organization, or special population* (as relevant)]. **This interview will take between 30 minutes to an hour to complete depending on how much information you have to share.**

We'd like to record this interview so we can refer back to what you have shared with us. Please know that nothing you say will be identified as coming from you or your organization. As an example, we may say something like, "*a director of a prevention program in Maricopa County*" or "*a volunteer in prevention work in Santa Cruz County*".

I'd like to make sure you know that:

- There are no right or wrong answers;
- your participation is completely voluntary; and
- you can choose to not answer any question or end the interview at any time.

Do you have any questions before we get started?

Questions for all interviewees:

1. What do you think are major substance use issues in [region/community/special populations] you serve?

2. What substances are causing the most harm in the [region/community/special populations] you serve? [PROBE: How have you learned about that?]
    a. What kinds of harm are they causing?
    b. Are you aware of any substances that are causing more harm for any specific groups compared to the community as a whole?

3. What causes people in [region/community/special populations] to use these substances? Do you feel that the cause(s) or contributors to substance use differ by subpopulations (for example by gender, age, LGBTQIA+, race/ethnicity, economic status, etc.)? [PROBE: Can you provide specific examples or stories that illustrate these causes?]

4. Are there any particular issues or risks people in [region/community/special populations] have that are contributing to using these substances? [PROBE: mental health issues, financial challenges, lack of employment, physical health problems, lack of recreational opportunities, etc.]

5. What would you say are the protective factors and/or strengths people in [region/community/special populations] have that help prevent substance use? [PROBE: social supports, belief/value systems, substance-free activities, etc.]

6. What kind of prevention efforts does your [region/community/special population] need more of?

Additional questions for prevention providers:

7. With whom does your organization/agency collaborate in its primary prevention activities? [PROBE: School districts, local government agencies, faith-based organizations, law enforcement]
    a. In what ways do you collaborate? How effective is that collaboration?
    b. Are there any barriers to collaboration that you have encountered?
    c. What primary prevention programming, activities, etc. are most lacking in your organization/region/community?

8. Besides additional funding, what else would help with primary prevention efforts in the area(s) you serve? [PROBE: Do you have access to substance use data for your area? How do you utilize that data? Are you in need of staff with specific skills? What specific type(s) of community or government support would be most beneficial?]

Additional questions for healthcare providers / experts:

9. Can you describe any specific programs or initiatives that integrate primary prevention into healthcare?

10. Are there any training or educational needs that would enable healthcare providers to better support prevention efforts?

11. In what ways might your organization increase support of primary prevention activities in your community?

12. Are there any practices that the medical field could change to enhance prevention efforts?

APPENDIX D: WORKFORCE SURVEY

AHCCCS Prevention Needs Assessment: Workforce Survey

LeCroy & Milligan Associates is working with AHCCCS to conduct a Substance Use Prevention Needs Assessment for the state of Arizona. As part of this effort, we are collecting information from people who work as paid staff, volunteers, or interns in the field of substance use prevention. Someone in the substance use prevention community identified you as a person who should be invited to participate.

Thank you for taking the time to complete this short, 20-question survey – it takes approximately 10 minutes to complete. The information you provide will assist us in determining what the state is currently doing well and where gaps in services may remain. **Upon completion of the survey, you will be redirected to a page where you can enter your name and email address so we can send you a digital gift card in the amount of $15 as a thank you for your time.**

Please keep in mind the following definition of **primary prevention** as you complete this survey: *The programs, interventions, and strategies that are directed at individuals who have not been determined to require treatment for substance use and delivered prior to the onset of a Substance Use Disorder (SUD). Substance use primary prevention strategies generally include education, information dissemination, problem identification and referral, environmental strategies, alternative activities, and community-based processes.*

1) Do you currently work or volunteer in the field of substance use prevention?
    - Yes
    - No
2) Which of the following best describes your role within your organization?
    - Executive leadership (e.g., director, assistant director, administrator)
    - Mid-level management (e.g., manager, supervisor)
    - Health Educator
    - Program Coordinator
    - Prevention Education Specialist
    - Intern
    - Volunteer / Community Advocate
    - Other:
3) In what county or counties do you engage in substance use prevention activities? (select all that apply)
    - Apache
    - Cochise
    - Coconino
    - Gila
    - Graham
    - Greenlee
    - La Paz
    - Maricopa
    - Mohave
    - Navajo
    - Pima
    - Pinal
    - Santa Cruz
    - Yavapai
    - Yuma
4) My organization currently has staff available that provide services in the following language(s) (select all that apply):
    - English
    - Spanish
    - Other language(s) (please specify):
    - We use an external interpretation service
5) What type of communities does your organization serve? (select all that apply)
    - Rural (fewer than 500,000 people)
    - Urban (500,000 or more people)
6) What type(s) of substance use prevention activities does your organization provide?
    - Information (e.g., presentations, PSAs, billboards, programs, classes)
    - Skill Enhancement (e.g., training, classes, programs)

- Support (e.g., mentoring, referrals, youth clubs, providing alternate activities)
- Change consequences (e.g., incentives/disincentives including citations, fines, rewards)
- Modify change policies (e.g., public policy, laws)
- Other:
- I don't know

7) Does your organization currently provide safe use and/or safe supply (i.e. harm reduction) services?
   - Yes
   - No
   - I don't know
8) What types of primary prevention efforts are **not** currently available in your community that you think are needed?
   - Prevention-focused classes and/or programs offered to **elementary students**
   - Prevention-focused classes and/or programs offered to **middle school students**
   - Prevention-focused classes and/or programs offered to **high school students**
   - Prevention-focused classes and/or programs offered to **college-age students**
   - Prevention-focused classes and/or programs offered to **adults**
   - Prevention-focused materials available in an individual's preferred language
   - Culturally competent staff and/or volunteers
   - Local support hotline and/or crisis line (including text-based support)
   - Other
   - I don't know
9) What are the **top three substance use prevention efforts** that have been the most successful for the population(s) you work with?
   - School-based prevention education
   - Positive substance-free activities
   - Life skills development
   - Positive role models
   - Building family communication skills
   - Addressing trauma
   - Media campaigns
   - Improving economic opportunities
   - Early intervention services
   - Other:
10) Please rate how well you think your organization addresses underlying causes of addiction, such as poverty, trauma, and systemic oppression.
   - We consider underlying causes in all our work
   - We consider underlying causes in some of our work
   - We rarely consider underlying causes
   - We don't really think underlying causes affect our work

11) Does your organization have specific programs or services that are geared towards populations with specific needs? (select all that apply)
    - Veterans
    - LGBTQIA+
    - Youth
    - Seniors
    - Spanish-speaking
    - Refugees
    - Individuals experiencing homelessness
    - Pregnant or postpartum women
    - Other:
12) Where do you get substance use prevention-related trainings and/or certifications? (select all that apply)
    - PTTC (Prevention Technology Transfer Center)
    - T/RBHA (Tribal/Regional Behavioral Health Authority)
    - CADCA (Community Anti-Drug Coalitions of America)
    - SAMHSA (Substance Abuse and Mental Health Services Administration)
    - OJJDP (Office of Juvenile Justice and Delinquency Prevention)
    - SPRC (Suicide Prevention Resource Center)
    - My organization
    - Other:
    - Not applicable
13) What training(s) **have you received** to help you be more prepared to support substance abuse prevention efforts? (select all that apply)
    - SAPST (Substance Abuse Prevention Specialist Skills Training)
    - Core Competencies for Prevention Professionals
    - Prevention Ethics
    - ASIST (Applied Suicide Prevention Intervention Skills Training)
    - safeTALK (Suicide Alertness for Everyone)
    - Cultural Competency 101
    - QPR (Question, Persuade, Refer)
    - Strategic Prevention Framework- Introduction to the Strategic Prevention Framework
    - Strategic Prevention Framework- Conducting a Community Needs Assessment
    - Strategic Prevention Framework- Coalition Capacity Building/Coalition Development
    - Strategic Prevention Framework- Strategic Planning/Logic Models
    - Strategic Prevention Framework- Evaluation/Sustainability
    - Motivational Interviewing/Techniques
    - Cognitive Behavioral Techniques
    - Dialectical Behavior Techniques

- Substance Use Screening Tools
- Other:
- Not applicable
- None of the above

14) What additional training(s) **have you not had, but would like to have**? (select all that apply)
    - SAPST (Substance Abuse Prevention Specialist Skills Training)
    - Core Competencies for Prevention Professionals
    - Prevention Ethics
    - ASIST (Applied Suicide Prevention Intervention Skills Training)
    - safeTALK (Suicide Alertness for Everyone)
    - Cultural Competency 101
    - QPR (Question, Persuade, Refer)
    - Strategic Prevention Framework- Introduction to the Strategic Prevention Framework
    - Strategic Prevention Framework- Conducting a Community Needs Assessment
    - Strategic Prevention Framework- Coalition Capacity Building/Coalition Development
    - Strategic Prevention Framework- Strategic Planning/Logic Models
    - Strategic Prevention Framework- Evaluation/Sustainability
    - Motivational Interviewing/Techniques
    - Cognitive Behavioral Techniques
    - Dialectical Behavior Techniques
    - Substance Use Screening Tools
    - Other:
    - Not applicable
    - None of the above
15) Which substance(s) do you believe are affecting your community the most? (select all that apply)
    - Prescription Drugs (illicit use only)
    - Methamphetamines
    - Opiates
    - Marijuana/Cannabis
    - Underage use of Marijuana/Cannabis
    - Alcohol - Binge drinking
    - Alcohol - Driving under the influence
    - Underage alcohol consumption
    - Underage use of tobacco products (including cigarettes, vapes, and chewing tobacco)
    - Other:

16) What do you see as the **top 3 barriers** to substance use primary prevention efforts in the communities where you work?
    - Policies or laws
    - Stigma around substance use
    - Normalization of substance use
    - Insufficient community engagement
    - Inadequate training for prevention providers
    - Limited access to prevention programs
    - Limited coordination between prevention providers
    - Limited coordination between prevention providers and other types of providers (i.e., mental health, positive youth activities, etc.)
    - Cultural barriers
    - Insufficient number of prevention workers or volunteers
    - Limited funding
17) Other than funding, what resources would help your community to be more effective in substance use prevention efforts? (select all that apply)
    - Prevention experts
    - Facilities/building/space
    - Help running meetings effectively
    - Help with strategic planning
    - Data from the state about substance use in your community
    - More training for staff and/or volunteers
    - Help evaluating the impact of prevention programming
    - Help engaging the community
    - More coordination between organizations working in the substance use field
    - More diversity in the prevention workforce
    - Other:
    - I don't know
18) What is your highest level of education?
    - Less than high school graduate
    - High school graduate (including GED)
    - Technical school or certificate program
    - Some college
    - College graduate (2 or 4-year degree)
    - Post-graduate (masters, doctorate)
19) How many years have you worked in the field of substance use prevention?
    - 1 year or less
    - 2 – 4 years
    - 5 – 7 years
    - 8 – 10 years
    - More than 10 years

20) What is your current employment status in substance use prevention?
    - Employed full-time (35 hours or more per week)
    - Employed part-time (less than 35 hours per week)
    - Intern
    - Volunteer

APPENDIX E: ADDITIONAL EXHIBITS

Exhibit 49. AZIHE Sample Sizes

	2012	2014	2016	2018	2022
Under 21	934	1,888	2,244	1,815	1,515
21-25	690	1,424	1,691	1,348	1,094
All*	1,624	3,312	3,935	3,163	2,609

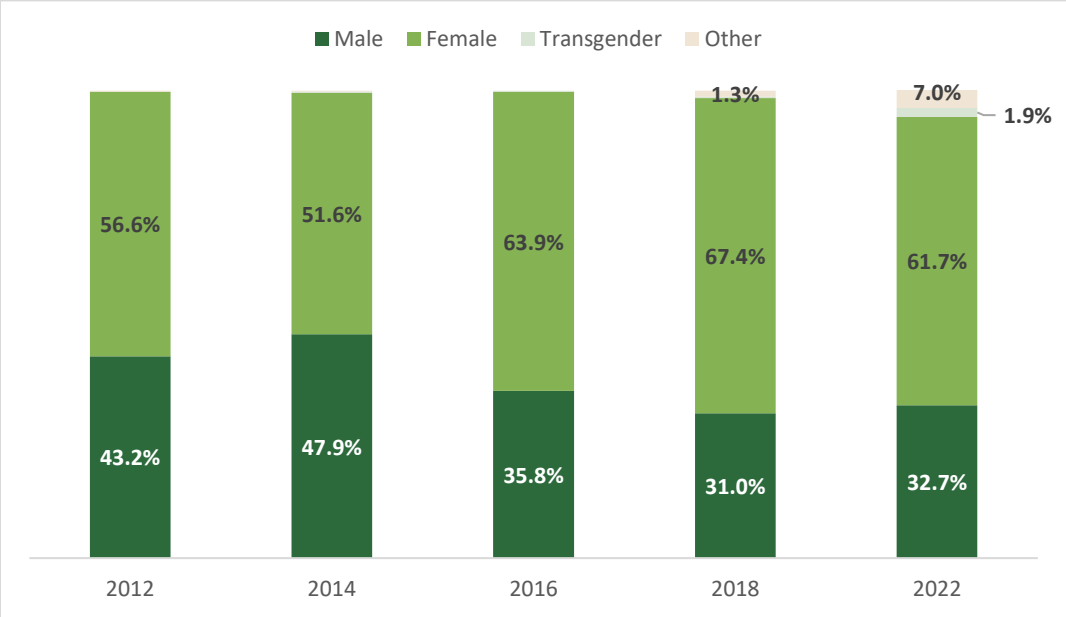
*Data displayed below in exhibits 45-48 reflects the combined responses from students in both age categories

Exhibit 50. AZIHE Race/Ethnicity of Students from 2012-2022

	2012	2014	2016	2018	2022
African American	3.3%	3.0%	2.7%	3.4%	4.1%
Asian/Pacific Islander	6.7%	8.6%	6.8%	8.2%	12.5%
Caucasian	67.9%	61.3%	54.5%	58.3%	7.0%
Hispanic/Latino	15.1%	20.4%	27.9%	21.7%	23.6%
Native American/Alaska Native	2.5%	2.1%	2.9%	2.0%	3.4%
Interracial	4.1%	4.6%	4.9%	5.5%	N/A
Other	0.3%	N/A	0.2%	0.9%	2.9%

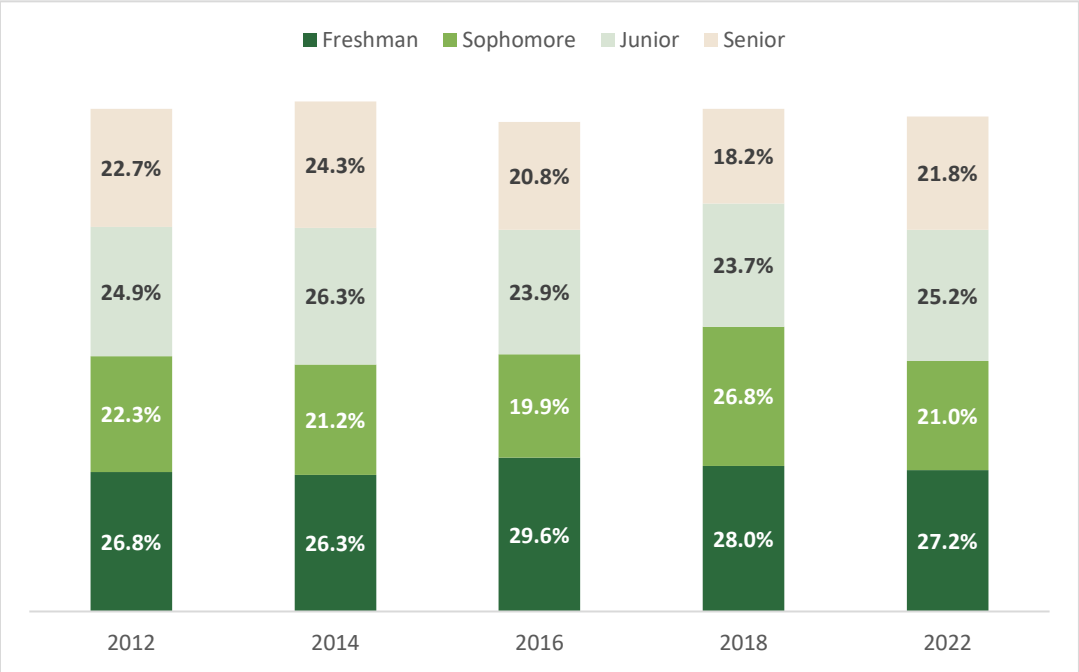
Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 51. AZIHE Gender of Students from 2012-2022



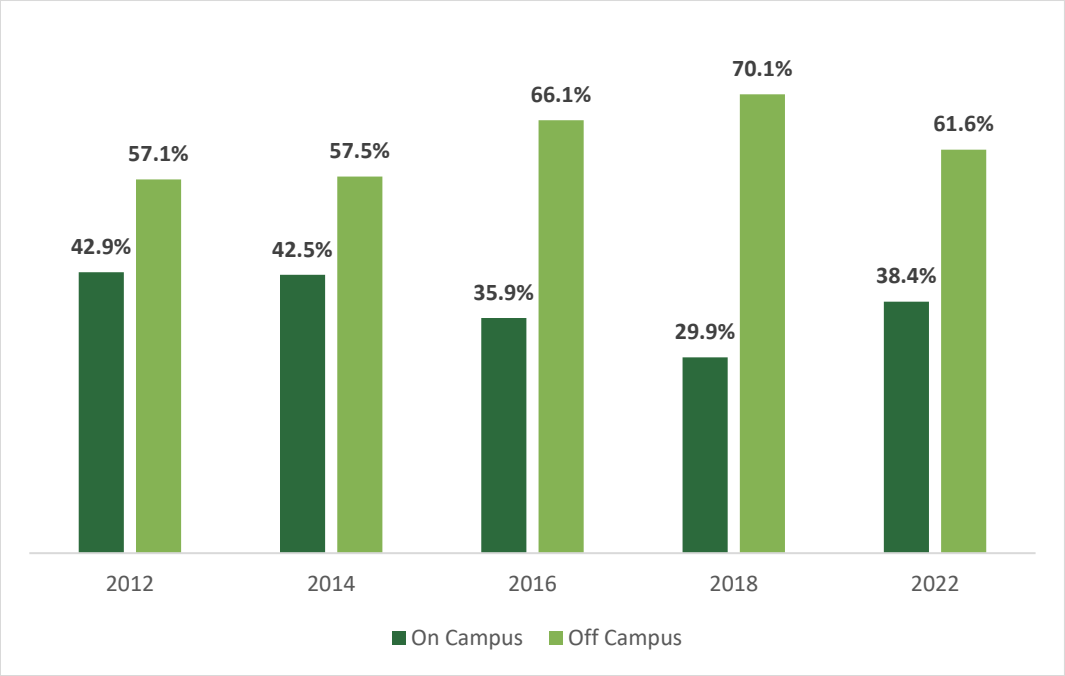
Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 52. AZIHE Student Classification from 2012-2022



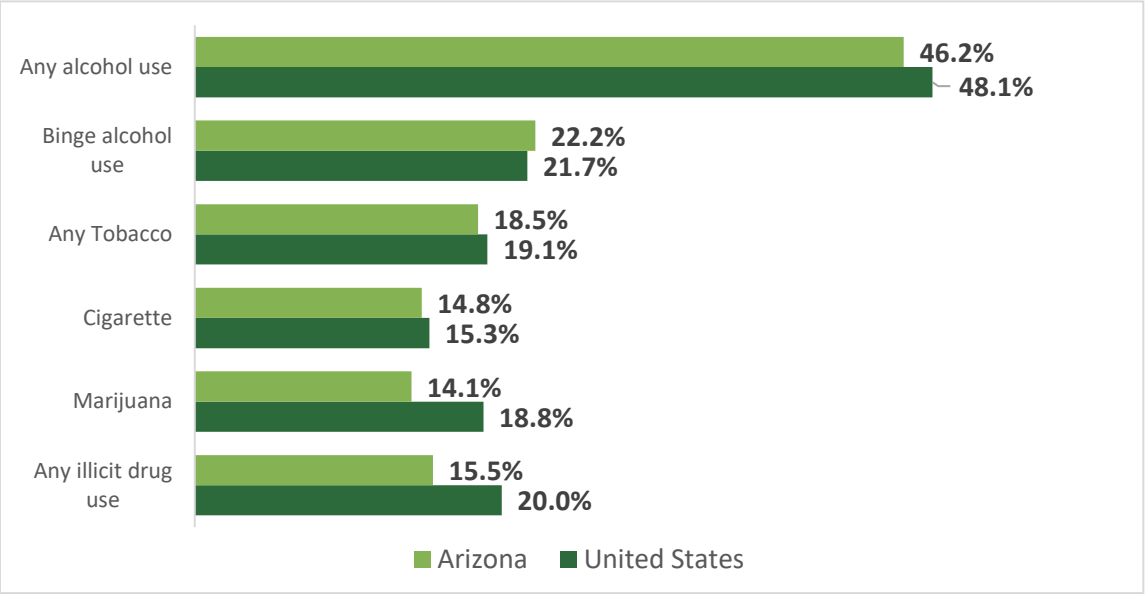
Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 53. AZIHE Student Living Arrangements 2012-2022



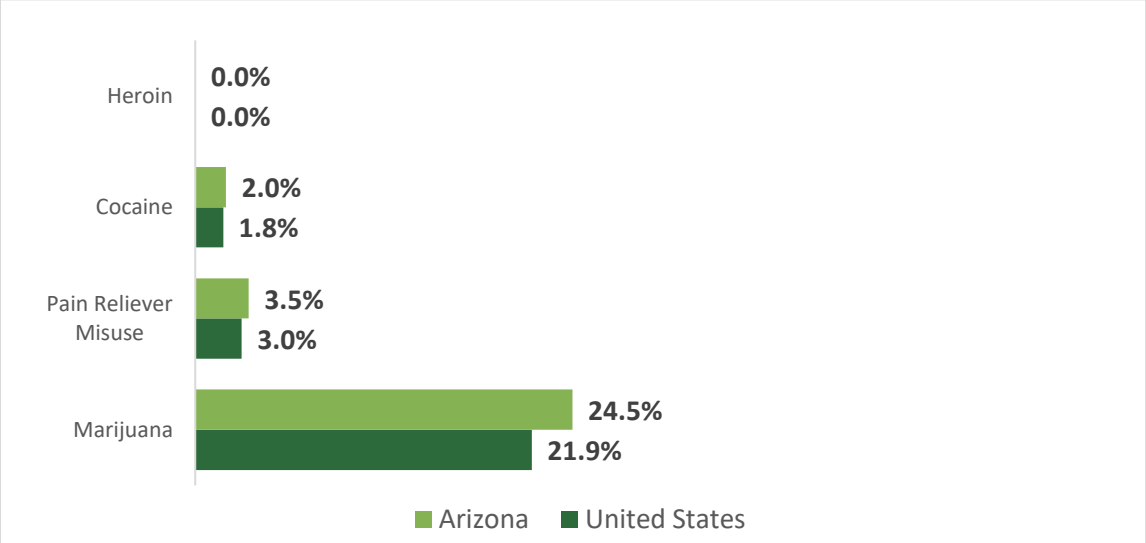
Source: Arizona Institutions of Higher Education Network, 2022

Exhibit 54. Prevalence of Past Month Substance Use Among those 12 and Older in the U.S. and Arizona, 2021-2022



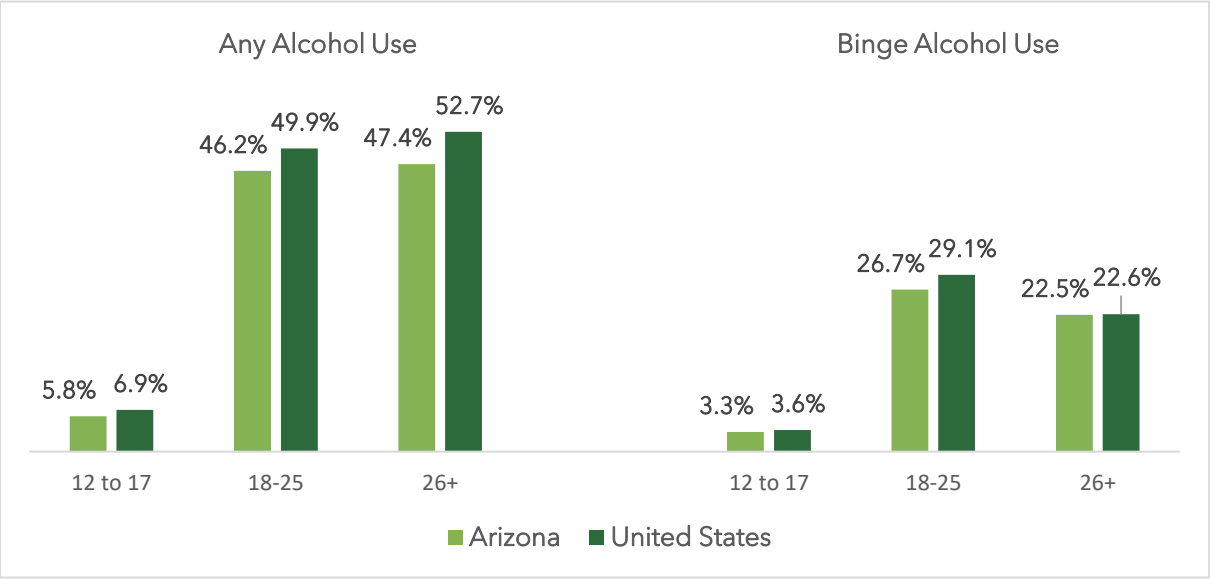
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021-2022

Exhibit 55. Prevalence of Past Year Drug Use Among those 12 and Older in the U.S. and Arizona, 2022-2023



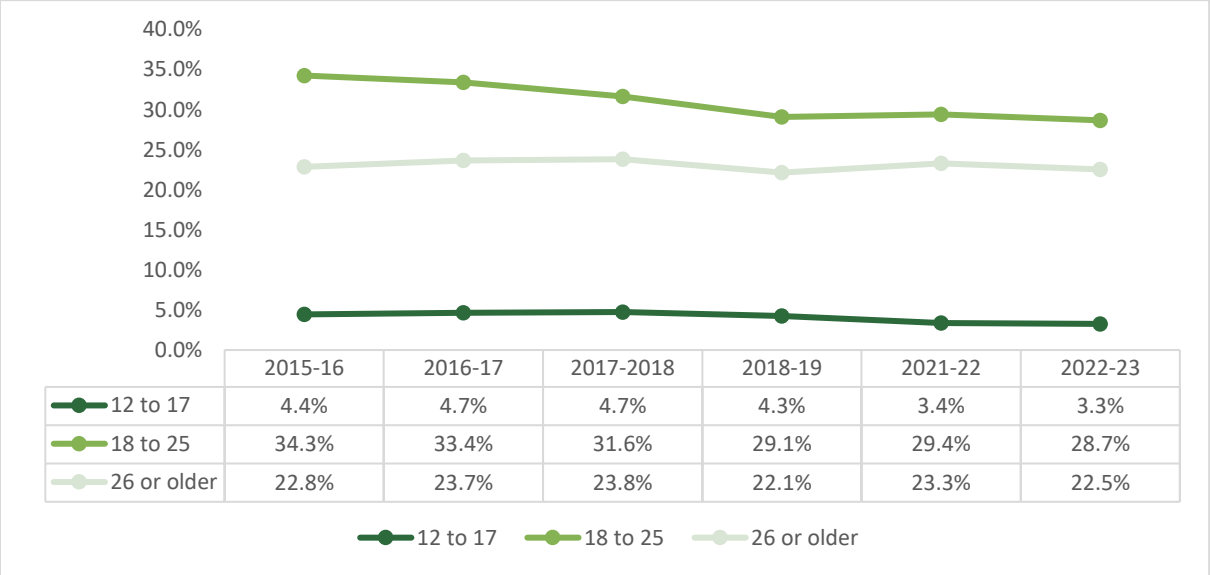
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023. Note: Estimates for youths aged 12 to 17 are not available for past year heroin use because this outcome was extremely rare among youths aged 12 to 17 in the 2022 and 2023 National Surveys on Drug Use and Health. As a result, estimates for people aged 12 or older are also not produced.

Exhibit 56. Prevalence of Past Month Alcohol Use and Binge Alcohol Use by Age Group in the U.S. and Arizona, 2022-2023



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

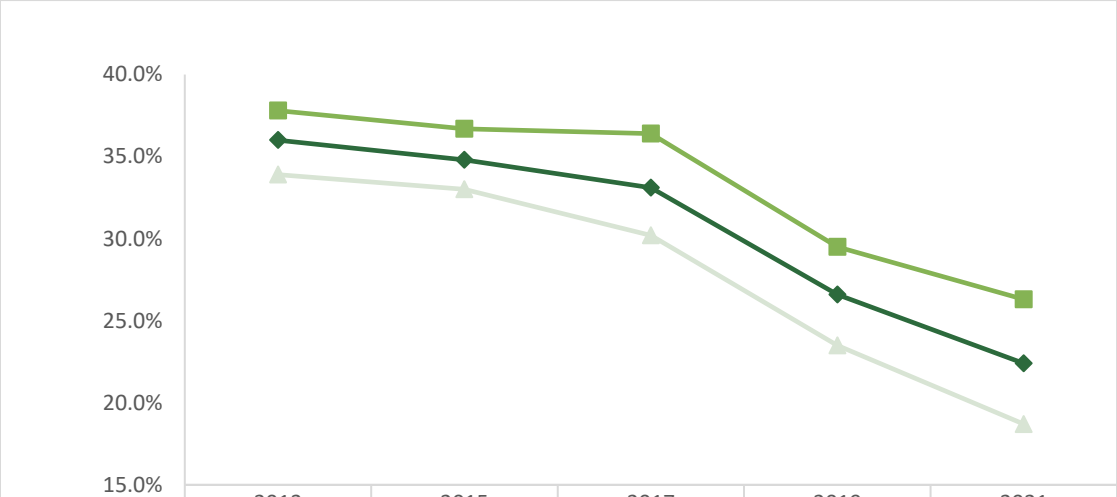
Exhibit 57. Trends in Prevalence of Past Month Binge Drinking in Arizona by Age Group, 2015-2023



	2015-16	2016-17	2017-2018	2018-19	2021-22	2022-23
12 to 17	4.4%	4.7%	4.7%	4.3%	3.4%	3.3%
18 to 25	34.3%	33.4%	31.6%	29.1%	29.4%	28.7%
26 or older	22.8%	23.7%	23.8%	22.1%	23.3%	22.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014-2023; data unavailable for 2019-2020

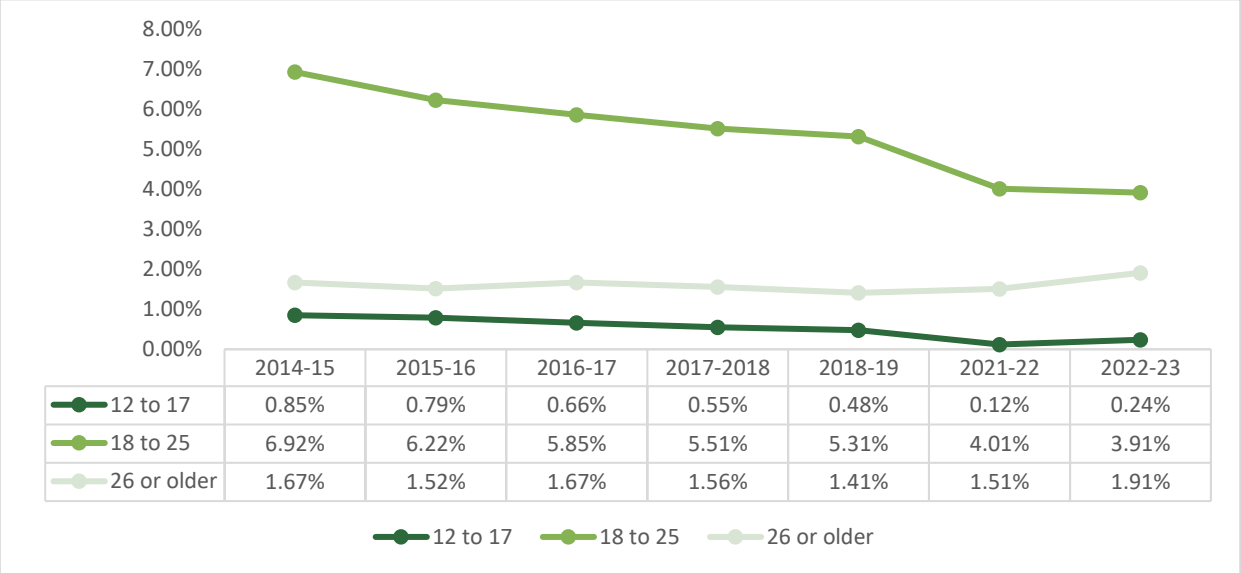
Exhibit 58. Trends in Prevalence of Past Month Alcohol Use Among Arizona High School Students by Gender, 2013-2021



	2013	2015	2017	2019	2021
Total	36.0%	34.8%	33.1%	26.6%	22.4%
Female	37.8%	36.7%	36.4%	29.5%	26.3%
Male	33.9%	33.0%	30.2%	23.5%	18.7%

Source: CDC, High School Youth Risk Behavior Survey (YRBS), 2021; Arizona did not have representative data reported for 2023; 2021 is the most recent available data.

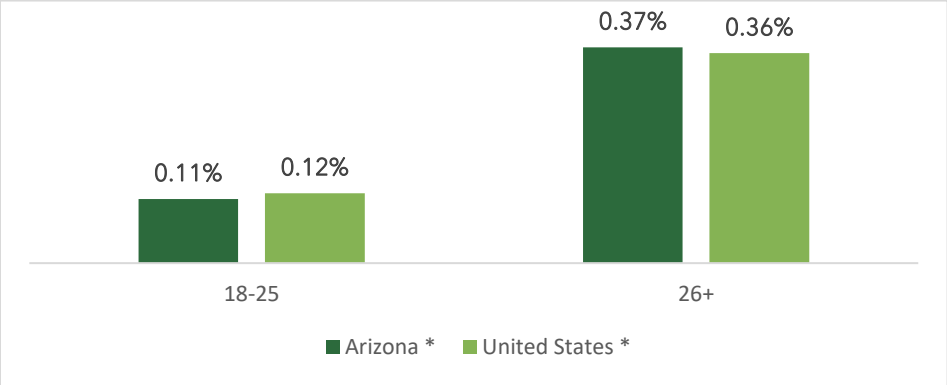
Exhibit 59. Prevalence of Past Year Cocaine Use by Age Group for the U.S. and Arizona, 2014-2023



	2014-15	2015-16	2016-17	2017-2018	2018-19	2021-22	2022-23
12 to 17	0.85%	0.79%	0.66%	0.55%	0.48%	0.12%	0.24%
18 to 25	6.92%	6.22%	5.85%	5.51%	5.31%	4.01%	3.91%
26 or older	1.67%	1.52%	1.67%	1.56%	1.41%	1.51%	1.91%

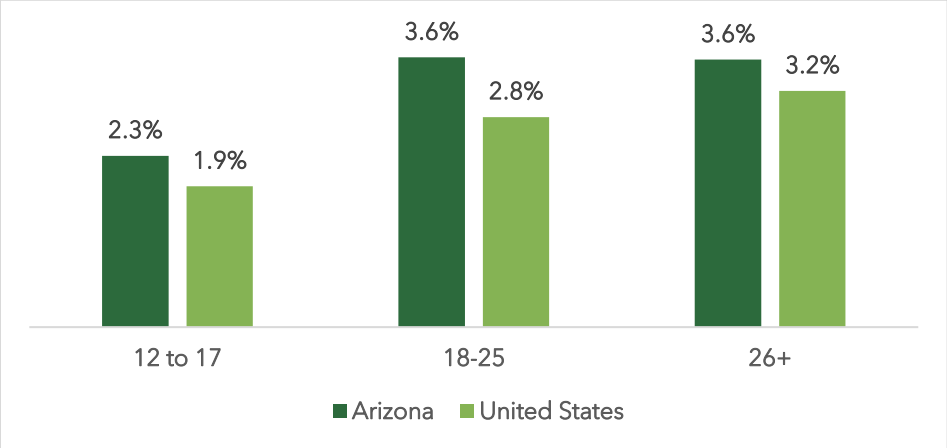
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014-2023

Exhibit 60. Prevalence of Past Year Heroin Use by Age Group in the U.S. and Arizona, 2022-2023



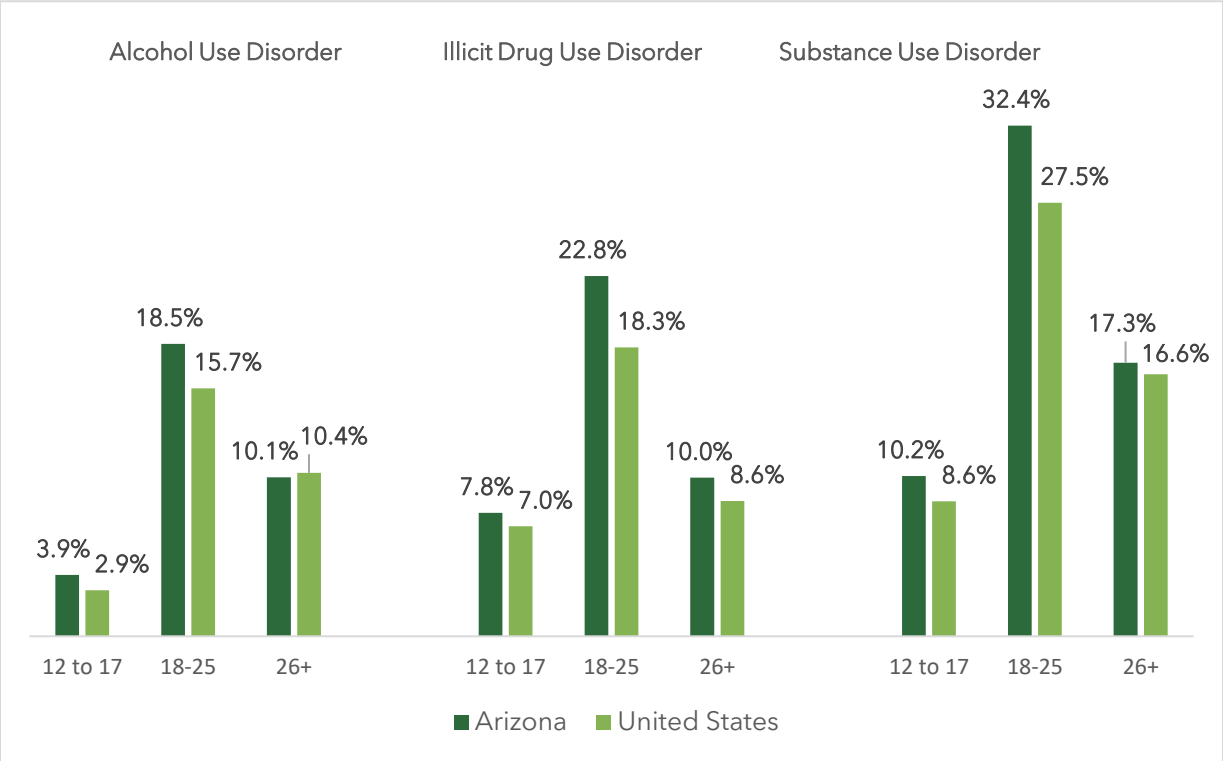
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023. NOTE: Estimates for youths aged 12 to 17 are not available for past-year heroin use because this outcome was extremely rare among youths aged 12 to 17 in the 2022 and 2023 National Surveys on Drug Use and Health. As a result, estimates for people aged 12 or older are also not produced.

Exhibit 61. Prevalence of Past Year Pain Reliever Misuse by Age Group for the U.S. and Arizona, 2022-2023



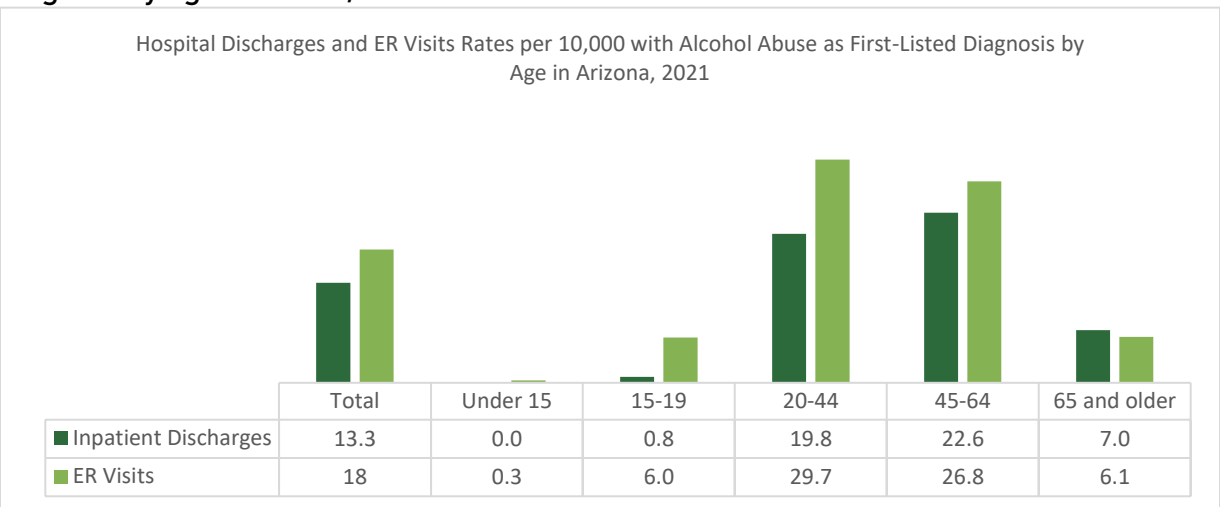
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

Exhibit 62. Prevalence of Past Year Alcohol, Illicit Drug Use and Substance Use Disorder by Age Group for the U.S. and Arizona, 2022-2023



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022-2023

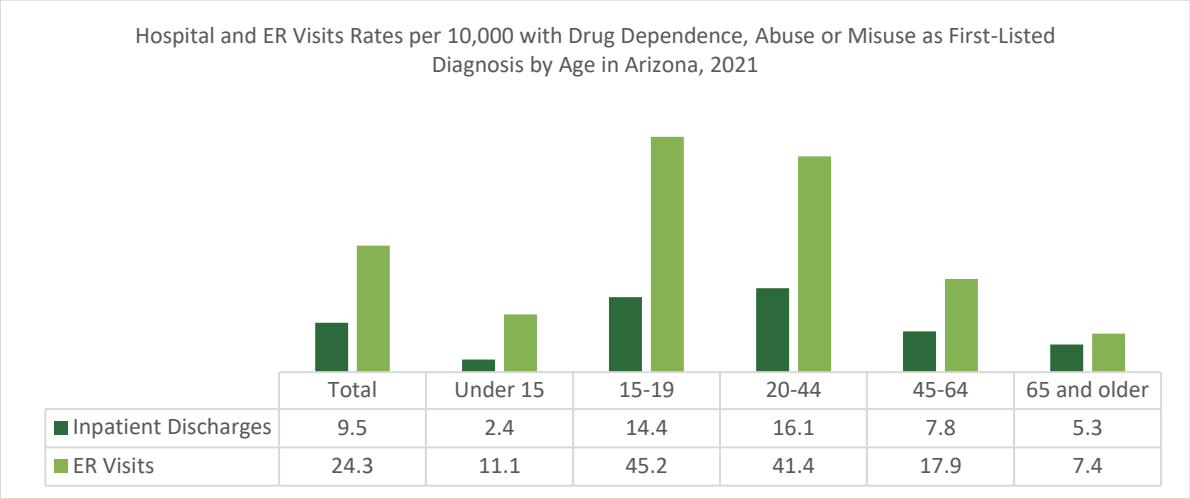
Exhibit 63. Inpatient Discharges and Emergency Room Visits with Alcohol Abuse as First-Listed Diagnosis by Age in Arizona, 2021



	Total	Under 15	15-19	20-44	45-64	65 and older
Inpatient Discharges	13.3	0.0	0.8	19.8	22.6	7.0
ER Visits	18	0.3	6.0	29.7	26.8	6.1

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

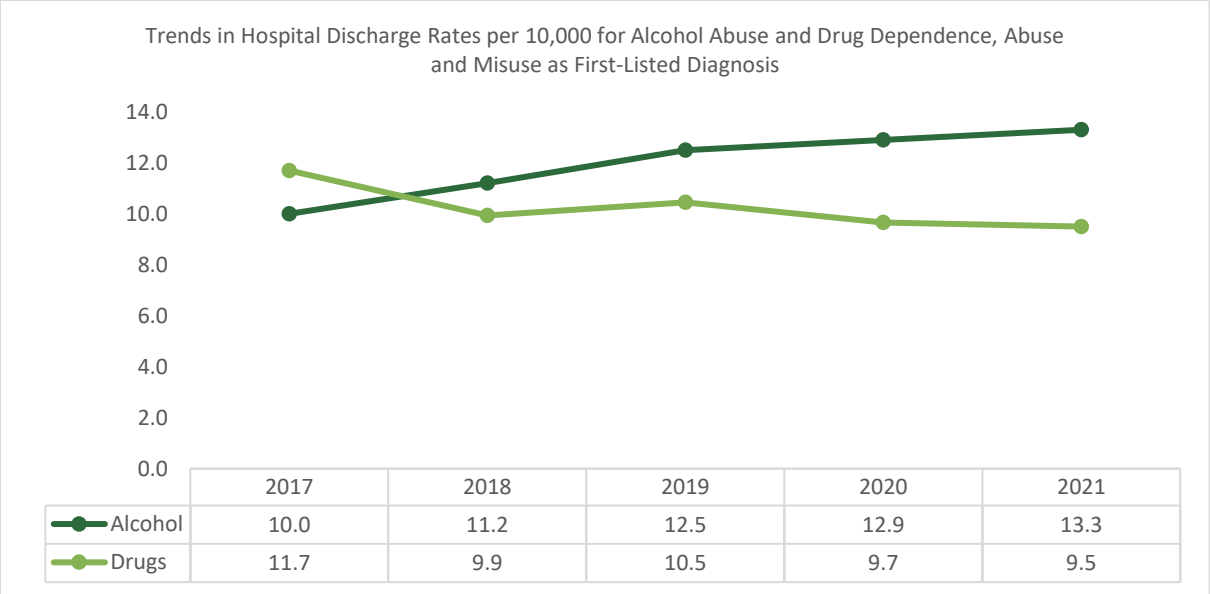
Exhibit 64. Hospital Discharge and Emergency Room Visit Rates per 10,000 with Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Age in Arizona, 2021



	Total	Under 15	15-19	20-44	45-64	65 and older
Inpatient Discharges	9.5	2.4	14.4	16.1	7.8	5.3
ER Visits	24.3	11.1	45.2	41.4	17.9	7.4

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

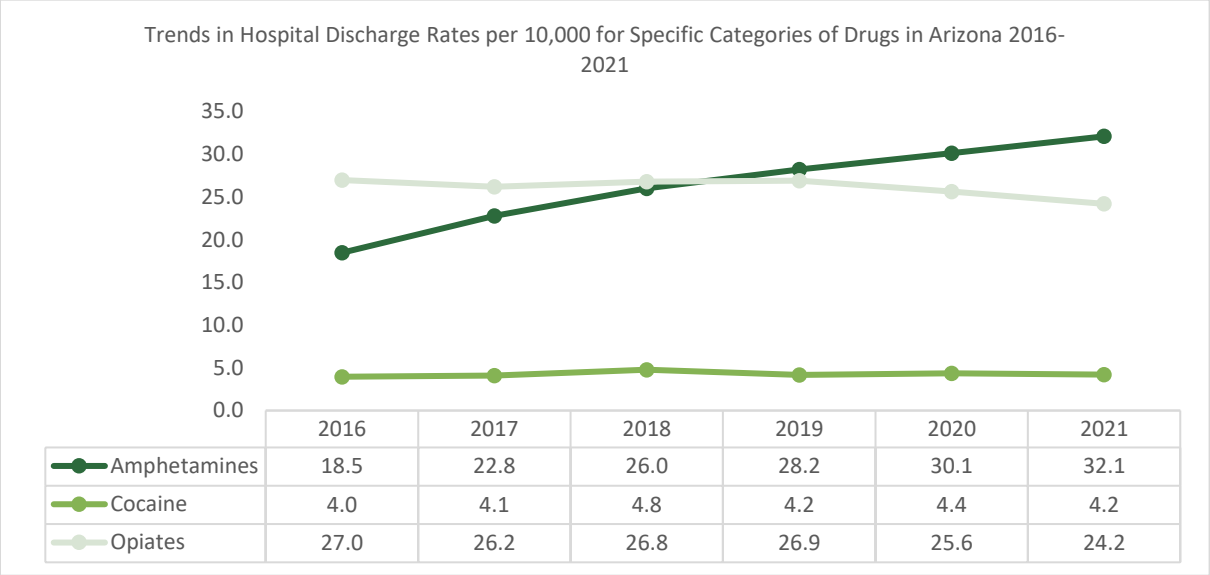
Exhibit 65. Trends in Hospital Discharge Rates per 10,000 for Alcohol Abuse and Drug Dependence, Abuse and Misuse as First-Listed Diagnosis in Arizona, 2017-2021.



	2017	2018	2019	2020	2021
Alcohol	10.0	11.2	12.5	12.9	13.3
Drugs	11.7	9.9	10.5	9.7	9.5

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 66. Trends in Hospital Discharge Rates per 10,000 for Specific Categories of Drugs in Arizona, 2016-2021.

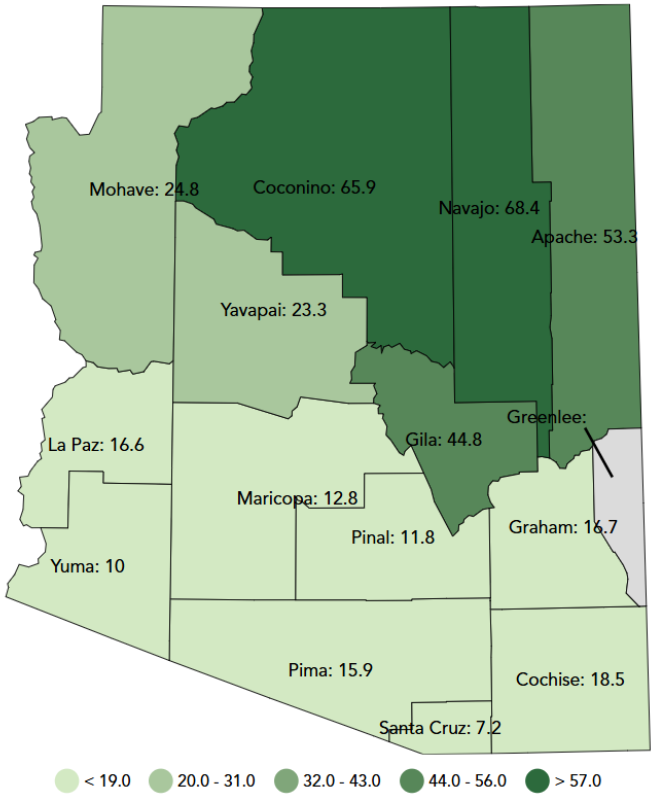


	2016	2017	2018	2019	2020	2021
Amphetamines	18.5	22.8	26.0	28.2	30.1	32.1
Cocaine	4.0	4.1	4.8	4.2	4.4	4.2
Opiates	27.0	26.2	26.8	26.9	25.6	24.2

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) Hospital inpatient discharges and emergency room visits statistics.

Exhibit 67. Emergency Department Visit Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Arizona County, 2021

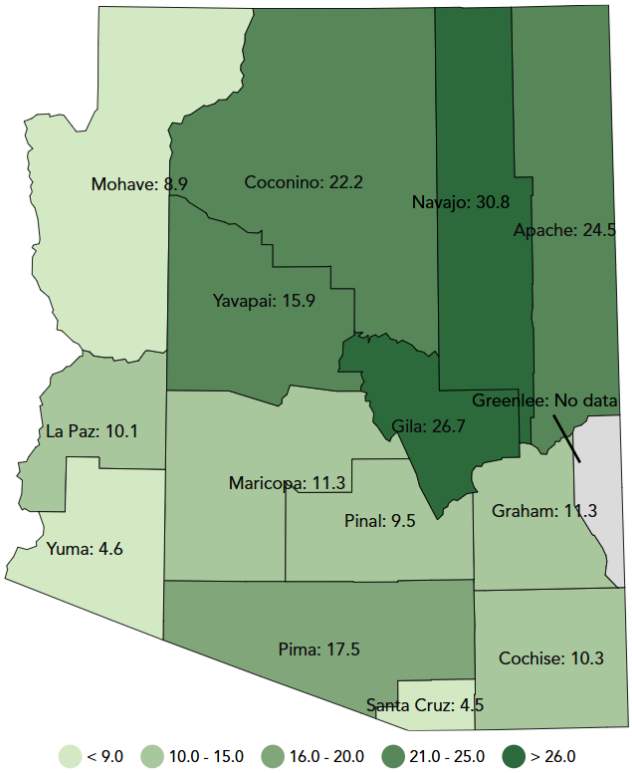
Rank	County	Rate
1	Navajo	68.4
2	Coconino	65.9
3	Apache	53.3
4	Gila	44.8
5	Mohave	24.8
6	Yavapai	23.3
7	Cochise	18.5
8	Graham	16.7
9	La Paz	16.6
10	Pima	15.9
11	Maricopa	12.8
12	Pinal	11.8
13	Yuma	10.0
14	Santa Cruz	7.2
--	Greenlee	N/A



Source: Arizona Department of Health Services, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 68. Hospital Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Arizona County, 2021

Rank	County	Rate
1	Navajo	30.8
2	Gila	26.7
3	Apache	24.5
4	Coconino	22.2
5	Pima	17.5
6	Yavapai	15.9
7	Graham	11.3
8	Maricopa	11.3
9	Cochise	10.3
10	La Paz	10.1
11	Pinal	9.5
12	Mohave	8.9
13	Yuma	4.6
14	Santa Cruz	4.5
--	Greenlee	N/A



Source: Arizona Department of Health Services, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 69. Hospital Discharge Counts and Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2021

Race/Ethnicity	Count	Rate per 10,000
White non-Hispanic	6,529	16.3
Hispanic or Latino	1,206	5.2
Black or African American	389	10.3
American Indian or Alaska Native	1,368	47.1
Asian or Pacific Islander	94	3.2
Refused/Unknown	68	NA

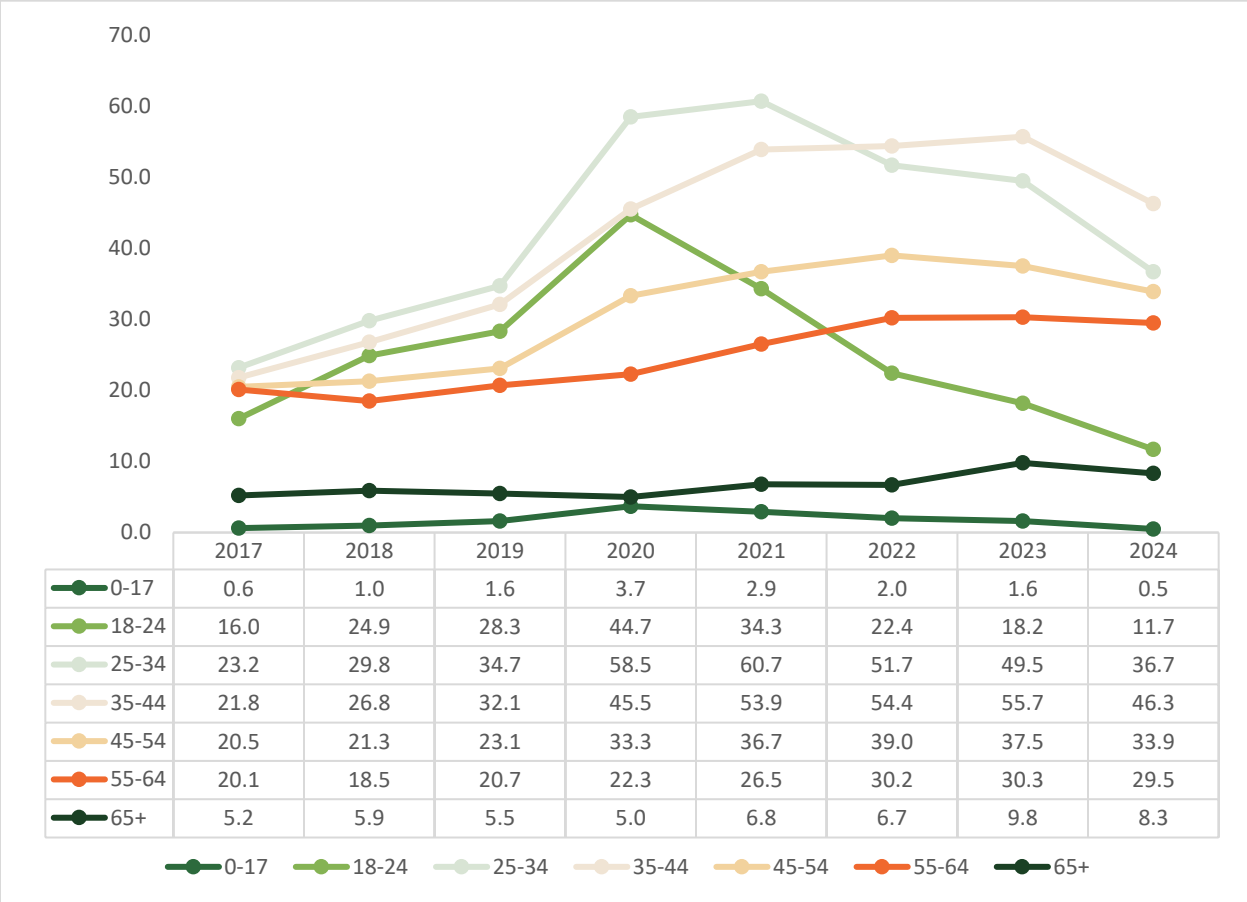
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 70. Inpatient Discharge and ED Visit Counts and Rates per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2021

	Inpatient Discharge		ED Discharge	
Race/Ethnicity	Count	Rate per 10,000	Count	Rate per 10,000
White non-Hispanic	4,310	10.8	10,468	26.1
Hispanic or Latino	1,629	7.0	4,410	19.0
Black / African American	512	13.6	1,536	40.8
American Indian / Alaska Native	342	11.8	807	27.8
Asian or Pacific Islander	86	2.9	219	7.5
Refused / Unknown	70	N/A	242	N/A

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2021) *Hospital inpatient discharges and emergency room visits statistics*.

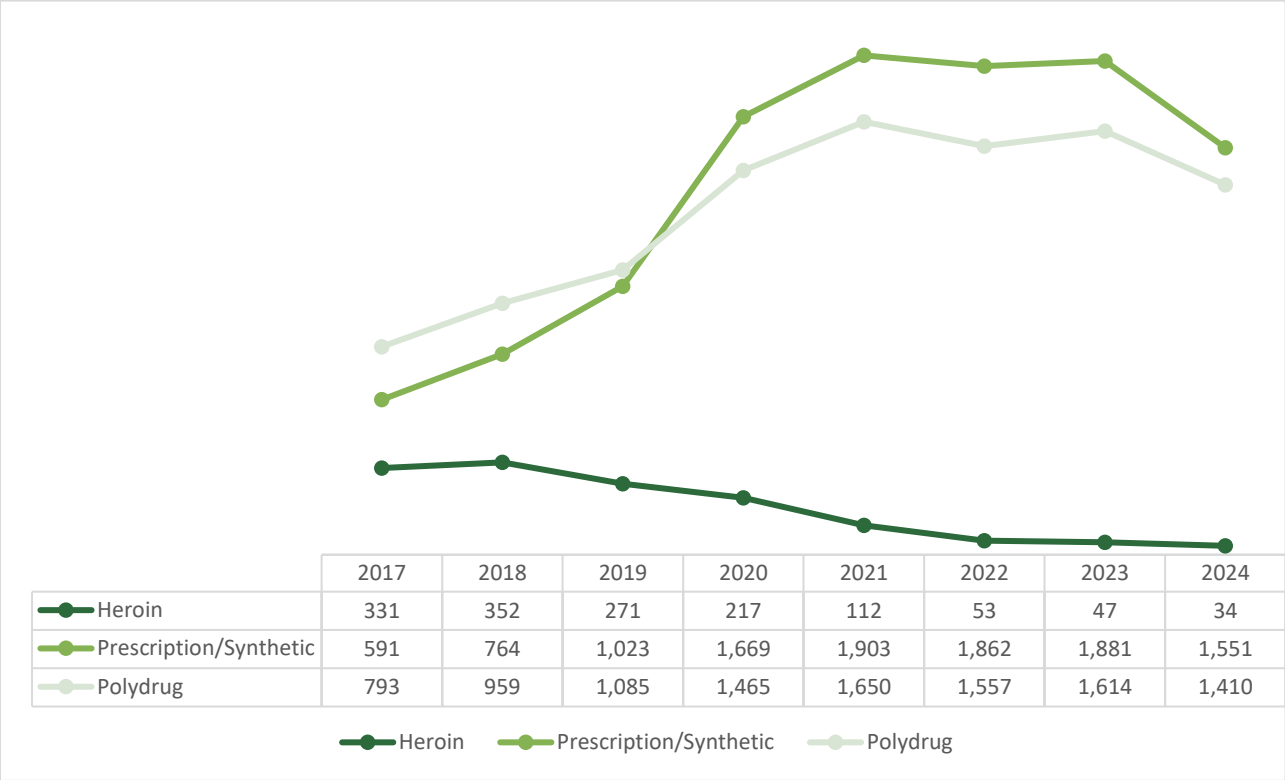
Exhibit 71. Opioid 8-Year Death Rate per 100,000 Population in Arizona by Age Group, 2017-2024



	2017	2018	2019	2020	2021	2022	2023	2024
0-17	0.6	1.0	1.6	3.7	2.9	2.0	1.6	0.5
18-24	16.0	24.9	28.3	44.7	34.3	22.4	18.2	11.7
25-34	23.2	29.8	34.7	58.5	60.7	51.7	49.5	36.7
35-44	21.8	26.8	32.1	45.5	53.9	54.4	55.7	46.3
45-54	20.5	21.3	23.1	33.3	36.7	39.0	37.5	33.9
55-64	20.1	18.5	20.7	22.3	26.5	30.2	30.3	29.5
65+	5.2	5.9	5.5	5.0	6.8	6.7	9.8	8.3

Source: Arizona Department of Health Services, Opioid Prevention Dashboard. Note: From 2017-2024, the average opioid fatality rate per 100,000 was 21.7, across all age groups. The total number of opioid deaths in that time across all age groups was 12,662.

Exhibit 72. Trends in Number of Opioid Deaths by Heroin, Prescription/Synthetic Opioids, and Polydrug in Arizona, 2017-2024

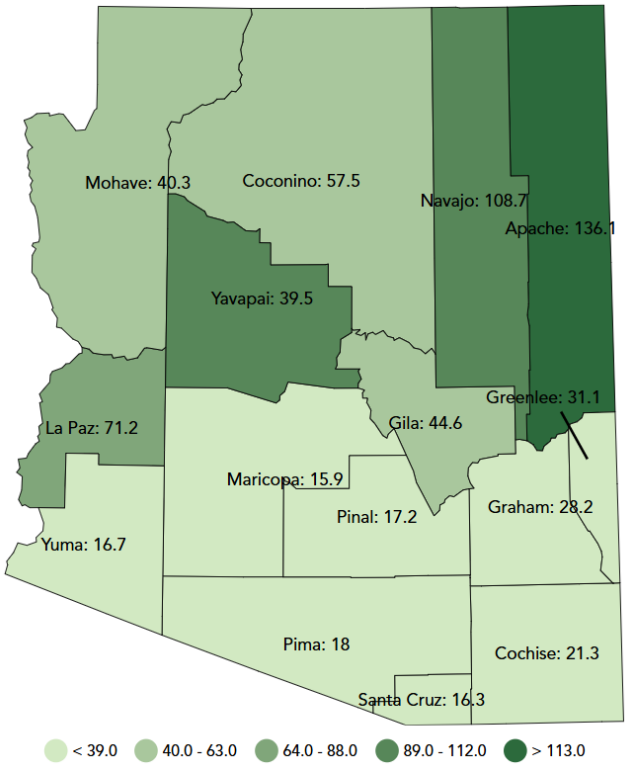


	2017	2018	2019	2020	2021	2022	2023	2024
Heroin	331	352	271	217	112	53	47	34
Prescription/Synthetic	591	764	1,023	1,669	1,903	1,862	1,881	1,551
Polydrug	793	959	1,085	1,465	1,650	1,557	1,614	1,410

Source: Arizona Department of Health Services, Opioid Prevention Dashboard
Note: The prescription/synthetic category includes all "other opioids" except heroin. This includes fentanyl, as well as prescription medications (e.g., oxycodone, hydrocodone), whether obtained legally or illicitly. The polydrug includes opioids in combination with non-opioid substances. All polydrug deaths are also counted in either of the other two categories.

Exhibit 73. Alcohol-Induced Death Rates per 100,000 by Arizona County, 2022

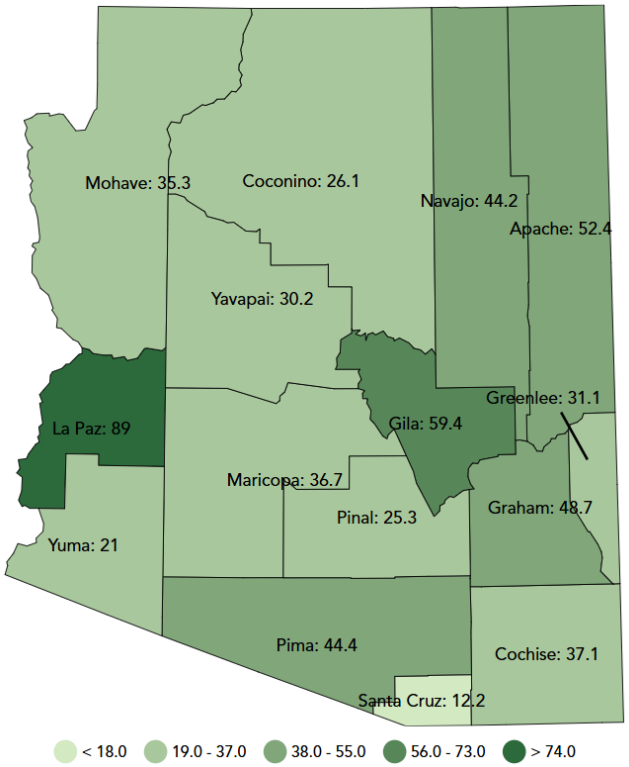
Rank	County	Rate
1	Apache	136.1
2	Navajo	108.7
3	La Paz	71.2
4	Coconino	57.5
5	Gila	44.6
6	Mohave	40.3
7	Yavapai	39.5
8	Greenlee	31.1
9	Graham	28.2
10	Cochise	21.3
11	Pima	18
12	Pinal	17.2
13	Yuma	16.7
14	Santa Cruz	16.3
15	Maricopa	15.9



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

Exhibit 74. Drug-Induced Death Rates per 100,000 by Arizona County, 2022

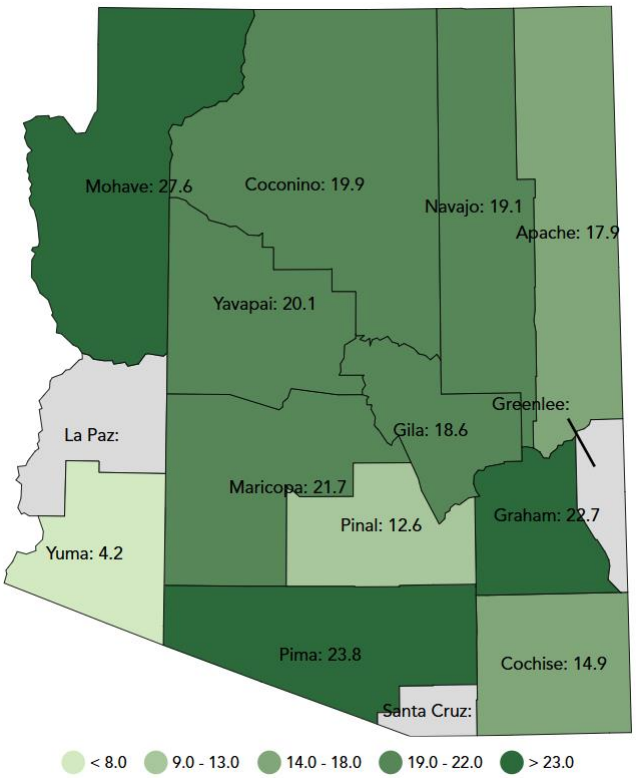
Rank	County	Rate
1	La Paz	89
2	Gila	59.4
3	Apache	52.4
4	Graham	48.7
5	Pima	44.4
6	Navajo	44.2
7	Cochise	37.1
8	Maricopa	36.7
9	Mohave	35.3
10	Greenlee	31.1
11	Yavapai	30.2
12	Coconino	26.1
13	Pinal	25.3
14	Yuma	21
15	Santa Cruz	12.2



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

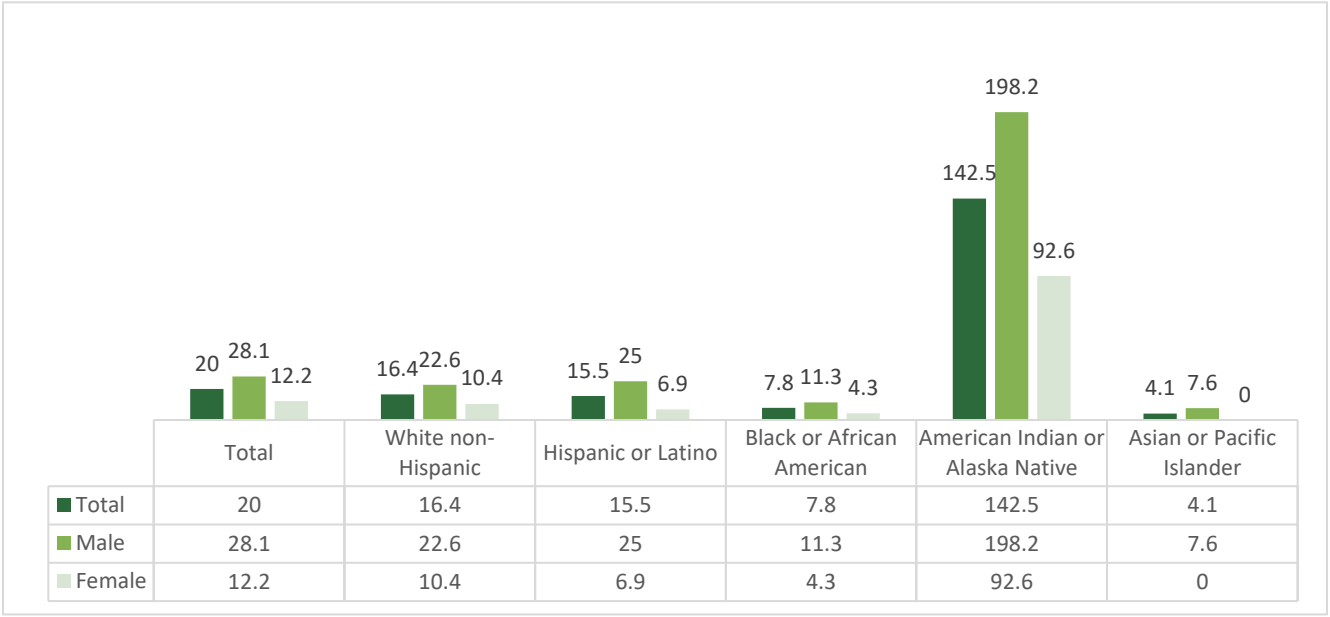
Exhibit 75. Opioid-Induced Death Rates per 100,000 by Arizona County, 2024

Rank	County	Rate
1	Mohave	27.6
2	Pima	23.8
3	Graham	22.7
4	Maricopa	21.7
5	Yavapai	20.1
6	Coconino	19.9
7	Navajo	19.1
8	Gila	18.6
9	Apache	17.9
10	Cochise	14.9
11	Pinal	12.6
12	Yuma	4.2
--	Greenlee	N/A
--	La Paz	N/A
--	Santa Cruz	N/A



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

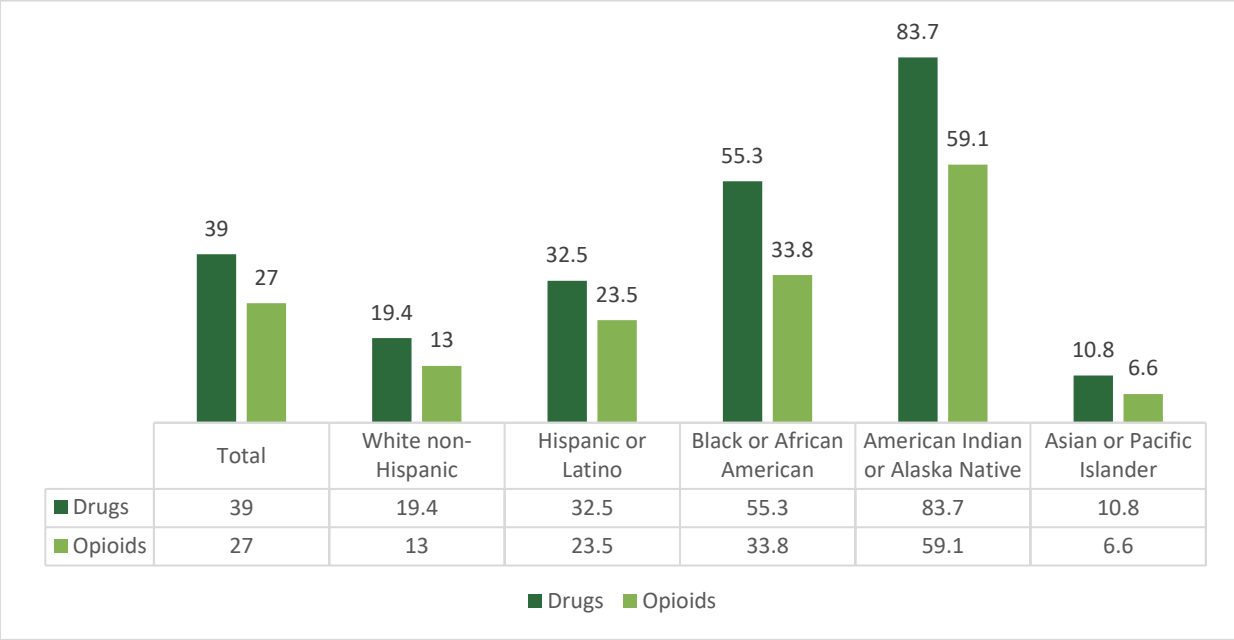
Exhibit 76. Alcohol-Induced Death Rates per 100,000 by Gender and Race/Ethnicity in Arizona, 2022



	Total	White non-Hispanic	Hispanic or Latino	Black or African American	American Indian or Alaska Native	Asian or Pacific Islander
Total	20	16.4	15.5	7.8	142.5	4.1
Male	28.1	22.6	25	11.3	198.2	7.6
Female	12.2	10.4	6.9	4.3	92.6	0

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

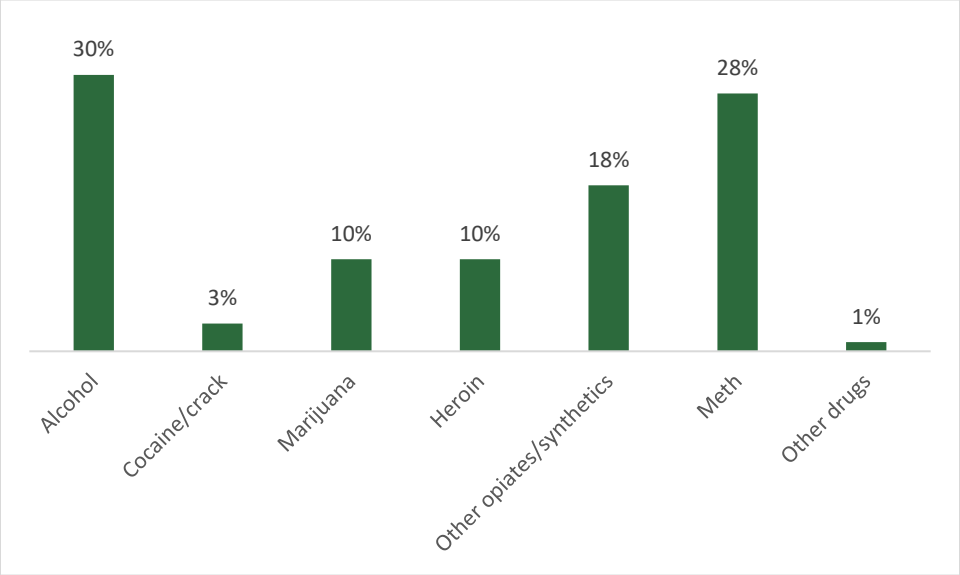
Exhibit 77. Opioid and Drug-Induced Death Rates per 100,000 by Race/Ethnicity in Arizona, 2022



	Total	White non-Hispanic	Hispanic or Latino	Black or African American	American Indian or Alaska Native	Asian or Pacific Islander
Drugs	39	19.4	32.5	55.3	83.7	10.8
Opioids	27	13	23.5	33.8	59.1	6.6

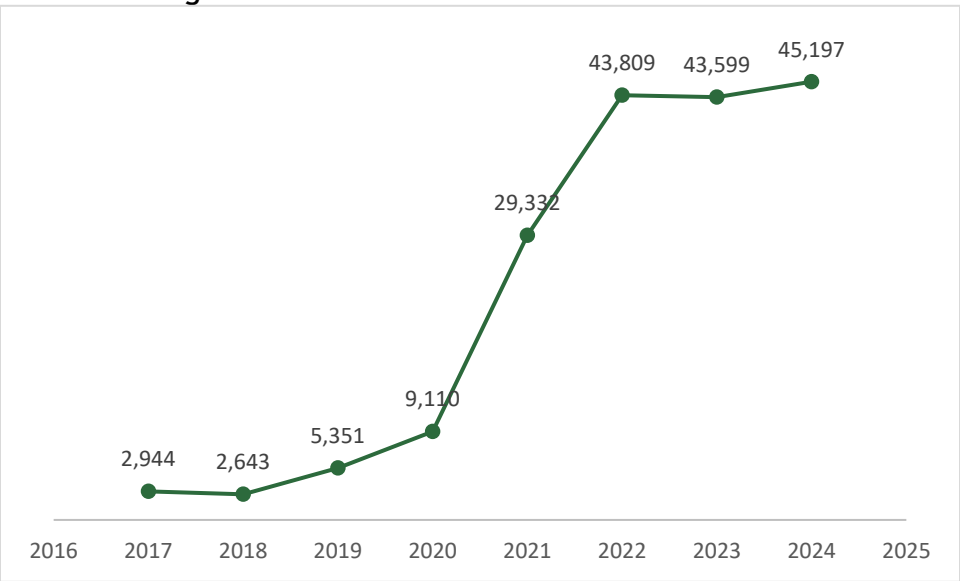
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Exhibit 78. Percentage of Substance Use Admissions by Primary Substance of Misuse among Arizonans Aged 12 and Older, 2022



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

Exhibit 79. Drug-Related Arrests in Arizona in 2017-2024



Source: Arizona Department of Public Safety, Arizona Crime Statistics Theme-Oriented Public Site.
Note: This includes the total number of drug/narcotic violations and drug equipment violations.

Exhibit 80. Percentage of Students Who Used Substances on One or More Occasions During Their Lifetime

Substance	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	SantaCruz	Yavapai	Yuma	State Avg
Cigarettes	9.6	7.3	5.9	10.8	6.6	0	6.3	5	7.5	5.2	5	5	7.3	10.5	4.4	5.4
E-Cigarettes	21.1	25.1	17.6	26.9	17.6	7.5	20.4	13.9	19.5	12.4	15.7	15.9	21.1	25.5	13.4	15.3
Alcohol	24.8	37.4	26.3	24.7	21.8	11.9	29.2	26.4	31.7	20.3	25.6	25.7	34.4	38.2	19.2	27.1
Marijuana	17.3	19	18.3	24.7	16	6	25	14.3	18.9	9.2	17.6	16.1	12.5	24.6	7.5	15.2
Marijuana concentrates	13.7	13.9	13.3	16.1	10.3	6	18.1	10.6	13	3.6	11.7	12.6	9.8	18.2	7.3	11.2
Marijuana edibles	14.4	12.6	13.3	18.3	10.8	4.5	20.6	11.4	14.8	8	11.8	12.9	6.4	19.8	7.1	11.8
Cocaine	0.4	1.2	0.5	1.1	1.3	0	0.7	0.9	1	0.4	0.6	1.4	0.7	1.3	0.9	0.9
Hallucinogens	4.3	4	3.6	3.2	3.6	3	4	2.8	3.4	3.6	3.8	2.4	1.3	6.8	2.5	3.1
Inhalants	4.3	3.8	3.8	5.4	3	3	3.3	3.5	4.7	6.8	3.8	3.6	2.6	4.5	3.9	3.6
Methamphetamines	0.7	0.1	0.5	1.1	0.6	0	1.5	0.5	0.8	0.4	0.3	0.6	0.6	0.5	0.8	0.5
Heroin	0.4	0.3	0.1	2.2	0.5	0	0	0.4	0.6	0	0.3	0.7	0.6	0.3	0.3	0.4
Ecstacy	0.4	0.5	0.9	2.2	1.6	1.5	2.2	0.8	1.2	0.4	0.7	0.8	0.7	1.6	0.6	0.8
Steroids	0.7	1.5	0.4	3.2	1	1.5	0.7	0.8	0.9	1.2	0.8	1.5	0.8	1.3	0.8	0.9
Prescription pain relievers	2.5	3	2.5	7.5	4	1.5	2.6	3.1	3.9	3.6	2.8	2.6	3.8	4.8	3.7	3.2
Prescription stimulants	0.7	2.1	0.9	6.5	2.5	1.5	1.8	1.9	1.5	3.2	1.8	1.7	2	2.6	1.6	1.9
Prescription sedatives	0.7	1.6	0.7	3.2	1.9	0	0.7	1.2	0.7	1.2	1.4	1.2	0.9	1.6	1.2	1.2
Synthetic drug users	0.4	0.2	0.6	1.1	0.6	0	0.7	0.6	0.9	0.4	0.4	1.4	0.2	0.8	0.5	0.6
Over the counter drugs	2.9	3.1	2.5	6.5	4	3	2.9	2.8	4.7	2.4	2.8	2.6	2	4.8	2.5	2.9
Poly drug use	6.8	5.8	5.3	5.4	6.2	1.5	8.1	5.7	7	5.2	5.1	6.2	3.9	11	2.6	5.8
Alcohol & pain relievers	1.8	1	1.2	3.2	2.2	0	2.2	1.4	1.8	2	1.1	1.3	1.4	2.5	2.2	1.5

Source: Arizona Youth Survey, 2024

Exhibit 81. Percentage of Students Who Used Substances on One or More Occasions During the Past 30 Days

Substance	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	SantaCruz	Yavapai	Yuma	StateAvg
Cigarettes	3.2	2.4	1.1	1.1	2.2	0	2.6	1.4	2.2	1.2	1.1	1.9	2.4	3.3	0.8	1.5
E-Cigarettes	11.8	13.3	9	17.2	9	4.5	9.9	6.3	10.1	5.2	6.3	7.6	10.8	13.4	5.5	7.1
Alcohol	9	20	11.3	10.8	10.8	4.5	16.1	11.8	14.2	4	11	11.1	20.8	17.4	8.8	12.3
Marijuana	8.6	9.4	8.6	19.4	7.3	3	13.9	6.9	8	2.8	8.7	8.5	5.1	13.8	3.7	7.4
Marijuana concentrates	6.1	6.3	5.8	10.8	4.6	3	8.8	4.8	5.5	0	5.3	6	3.7	10.2	3.1	5.1
Marijuana edibles	1.4	3.5	3.2	11.8	2.5	3	5.8	3.3	3.8	0.8	2.7	3.9	1.3	6.5	3.3	3.3
Cocaine	0.4	0.3	0.1	0	0.3	0	0	0.3	0.4	2.8	0.2	0.3	0.3	0.8	0.3	0.3
Hallucinogens	1.1	0.9	0.6	0	0.5	1.5	1.1	0.7	0.7	0	0.7	1.3	0.4	1.9	0.5	0.7
Inhalants	1.4	1.3	1.1	1.1	0.3	0	0.4	1	1.1	0.8	1.2	0.4	1.1	0.8	1.2	1
Methamphetamines	0.4	0	0.2	0	0.2	0	1.5	0.2	0.2	2.8	0.1	0.3	0.2	0.3	0.2	0.2
Heroin	0	0	0.1	0	0.2	0	0	0.2	0.2	0	0.1	0.3	0.3	0.1	0.2	0.2
Ecstacy	0.4	0	0.4	1.1	0.5	0	0.4	0.2	0.1	0	0.2	0.4	0.2	0.2	0.3	0.2
Steroids	0.7	0.3	0	0	0	1.5	0.4	0.3	0.3	0.4	0.2	0.8	0.4	0.5	0.3	0.3
Prescription pain relievers	0.4	1.1	0.7	4.3	1.1	1.5	0.7	0.9	1.1	1.6	0.9	1	1.4	0.8	1.2	0.9
Prescription stimulants	0	0.5	0.2	3.2	0.8	1.5	0.7	0.5	0.3	1.2	0.5	0.6	0.4	0.4	0	0.5
Prescription sedatives	0	0.6	0.1	1.1	0.3	0	0	0.3	0.3	0.4	0.3	0.3	0.3	0.2	0.2	0.3
Synthetic drug users	0	0	0.4	0	0	0	0	0.2	0.7	0.4	0.1	0.4	0.1	0.2	0.2	0.2
Over the counter drugs	0.7	1	0.6	2.2	0.8	3	0.4	0.8	1.1	0.4	0.6	0.7	0.7	1.4	0.8	0.8
Poly drug use	2.5	2.6	1.7	2.2	2.2	1.5	3.7	2	2	2.4	1.7	3.1	1.1	4.5	0.8	2.1
Alcohol & pain relievers	0.4	0.4	0.4	1.1	0.8	0	0.7	0.3	0.4	0	0.5	0.4	0.3	0.7	0.6	0.4
Binge drinking	5.7	8.7	3.2	3.2	4.9	3	6.9	4.2	5.2	2.8	3.8	4.9	10.3	7.6	3.8	4.5

Source: Arizona Youth Survey, 2024

Exhibit 82. Percentage of Students at Risk - Community, Family, School, and Peer and Individual Risk Factors

	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	SantaCruz	Yavapai	Yuma	Statewide
Community																
Low neighborhood attachment	51.1	51.2	50.1	59.3	50.8	42.6	66	43.3	56.4	43.9	53.2	46.5	49.4	55.1	56.5	45.8
Laws & norms favorable to drug use	24.7	28.2	36.9	54.7	32.3	25	43.7	31.2	40.3	34.3	41.6	34	33.4	36.8	40.5	32.8
Perceived availability of drugs	17.3	23.3	24.3	20	18.9	16.9	28.1	21.4	24.8	19.3	22.3	20.7	17.5	26.6	18.5	21.7
Perceived availability of handguns	33.2	18.8	25.7	24.4	33.2	32.3	24.7	23.3	32.9	41.8	24.6	23.9	15.5	27.9	26.9	24
Family																
Poor family management	21.8	29.2	38.4	51.1	33.3	29.7	45	30.1	33.7	29.9	39.1	33.2	29.4	37.9	47.5	31.7
Family conflict	35.8	38.5	41.2	52.8	37	42.2	49.2	42.1	45.5	42.6	42	39	34.9	41.8	48.9	41.9
Family history of antisocial behavior	20.5	20.4	24	41.4	22.9	25.4	38.3	20.8	29.1	24.9	26.1	19.1	17	28.1	21.1	21.8
Parental attitudes favorable to drug use	18.9	16.5	20.8	15.9	13.2	12.5	27.2	16.5	21.9	12.9	19.5	17.3	12.1	24.6	11.8	17.1
Parental attitudes favorable to antisocial behavior	48	41.4	44.1	46	35.9	35.9	46.7	44.3	46.2	49.4	44.8	41.4	34.7	47.1	42.3	44
School																
Academic failure	44.1	53	51.3	54.7	44	66.7	53.8	43.4	45.9	34.5	56.4	53	53.3	50	50.4	45.7
Low commitment to school	61.8	56.8	66.2	67.7	62.3	68.1	69.9	64.2	65.1	64.8	65.7	70.9	51.4	68.2	53.7	64
Peer and Individual																
Rebelliousness	20.8	18.5	19.7	23.4	21	13.4	30.2	21.9	22.7	21.9	23.4	23.2	19.9	23.7	26.2	22
Early initiation of drug use	9.4	10.9	10.6	22.6	8.4	3	15.1	7.9	12.1	8.8	9.4	6.9	7.6	13.9	9.4	8.6
Attitudes favorable to antisocial behavior	35.7	32.9	43.3	31.1	31.7	36.9	43.4	40.7	38.8	38.8	38.4	43.2	30.3	41.9	31.2	39.8
Attitudes favorable to drug use	22.3	21.3	28	27.5	20.2	23.1	29.6	25.1	27.1	16.3	27.4	26.3	18.9	29.7	20.3	25.1
Perceived risk of drug use	53.6	54.1	59.7	77.2	46.3	64.6	74.4	59.1	60.3	55.7	68.6	64.3	48.9	64.6	58.7	59.8
Interaction with antisocial peers	37.1	35.8	33.8	52.1	40	42	47.5	34.5	44.5	41.7	42.9	41.9	38.6	42.8	45.1	36.4
Friends' use of drugs	8.4	14.3	15.2	31.3	14.8	5.8	23.7	14.2	16.2	13.1	17.6	13	13	20.7	16.5	14.8
Rewards for antisocial behavior	34.4	37.4	41.5	42.9	31.3	29.2	40.8	39.2	39.7	34.3	39.5	35.3	34.7	39.8	32.1	38.8
Gang involvement	1.4	5.7	6.6	22.3	7.9	0	7.3	5.2	7.3	3.9	9	6.5	5.6	8.5	14.6	6
Total																
Students with High Risk*	27.6	22.1	29	47.9	24	23.6	38.7	25.4	30.5	29.1	29.7	24.6	16.6	32.3	27.4	26

Source: Arizona Youth Survey, 2024. *Percentage of students who have more than a specified number of risk factors operating in their lives (8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors).

Exhibit 83. Percentage of Students Reporting Protection - Community, Family, School, and Peer and Individual Risk Factors

	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	SantaCruz	Yavapai	Yuma	Statewide
Community																
Rewards for Prosocial Involvement	39.6	25.6	20.8	25.6	33.7	24.6	25.3	24.7	25.4	32.6	20.6	26.6	22.1	23.6	15.7	24.5
Family																
Family Attachment	63	54	57.1	49.4	59.8	67.2	40.7	59.9	49.4	59.3	51.7	56.6	56.4	54.1	56	58.3
Opportunities for Prosocial Involvement	67.5	59.1	62.3	53.9	66.8	64.1	50.2	64.6	57.4	69.3	59.6	58.7	63.9	60.5	59.9	63.5
Rewards for Prosocial Involvement	64.6	53.1	55.3	58.6	61.3	73.4	44.7	61.2	51.1	59.8	56.5	54.2	60.5	55.1	58.5	59.8
School																
Opportunities for Prosocial Involvement	70.9	65.3	72.6	51	72.3	61.1	58.6	70.2	69.2	73.5	71.5	71.2	66.5	62	69.9	69.8
Rewards for Prosocial Involvement	55.5	50	48.7	45.8	55.7	62	53.6	53.6	49.7	50.2	59	49.1	57.1	50.9	60	53.8
Peer and Individual																
Belief in the Moral Order	63.7	58.6	57.2	54.3	60.6	77.6	56.4	57.7	57.6	60.2	57.3	55.5	64.5	56.4	53.7	57.8
Interaction with Prosocial Peers	52.8	47.3	46.4	26	50.7	59.4	32.4	52.1	49.7	58.3	39.7	43.6	49.2	39.8	41.8	49.9
Prosocial Involvement	38.4	29.6	37.7	28.1	37.9	35.2	34.9	37.8	38.4	40.4	28.1	26.7	32.3	30.2	36.9	36.2
Rewards for Prosocial Involvement	56.4	49.3	46.6	39.6	46	44.6	43.6	48.1	50.9	59.6	42.2	36.9	48.3	43.8	44	47.4
Total																
Students with High Protection*	75.5	62.8	64.4	56.3	70.5	69.4	57.4	67.4	63	76.2	59.9	59.4	66.6	59.1	57.3	66

Source: Arizona Youth Survey, 2024. *Percentage of students who have 4 or more protective factors operating in their lives.

APPENDIX F: REFERENCES

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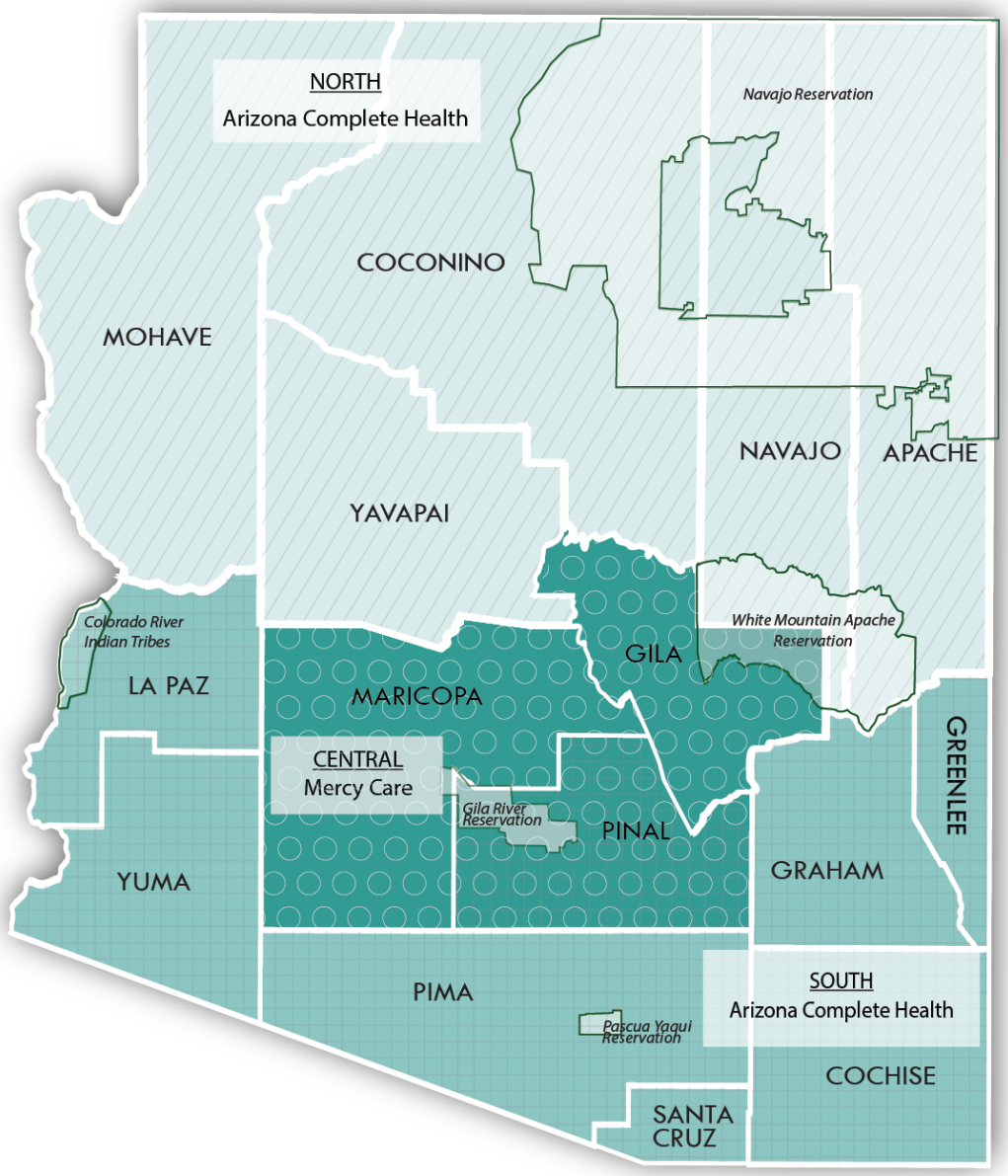
APPENDIX G: REPORT ACRONYMS

ACEs	Adverse Childhood Experiences
ACJC	Arizona Criminal Justice Commission
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System (Medicaid)
AYS	Arizona Youth Survey
CDC	Centers for Disease Control and Prevention
DCS	Department of Child Safety
DEA	Drug Enforcement Agency
DPS	Arizona Department of Public Safety
GOYFF	Governor's Office of Youth, Faith, and Family
LMA	LeCroy & Milligan Associates, Inc.
MAT	Medication Assisted Treatment
MHPs	Mental Health Professionals
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Use and Health
PTTC	Prevention Technology Transfer Center
QPR	Question, Persuade, Refer
SAMHSA	Substance Abuse and Mental Health Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SES	Socioeconomic Status
SPF	Strategic Prevention Framework
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
SUD	Substance Use Disorder
TEDS	Treatment Episode Data Set
WFS	The Workforce Survey
YRBS	High School Youth Risk Behavior Survey

APPENDIX H: AHCCCS SERVICE MAP

ACC-RBHA/TRBHA Map
Effective October 1, 2024



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.