Alabama

UNIFORM APPLICATION
FY2010

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 470 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

Form 1

DUNS Number: 929956324-

Uniform Application for FY 2010 Substance Abuse Prevention and Treatment Block Grant

1. State Agency to be the Grantee for the Block Grant:

Agency Name:	Alabama Department of Mental Health and Mental Retardation	
Organizational Unit:	Substance Abuse Services Division	
Mailing Address:	100 North Union Street	
City:	Montgomery	Zip Code: 36130-1410

2. Contact Person for the Grantee of the Block Grant:

Name:	John Houston	
Agency Name:	Alabama Department of Mental Health and Mental Retardation	
Mailing Address:	100 North Union Street	
City:	Montgomery	Code: 36130-1410
Telephone:	(334) 242-3107	FAX: (334) 242-0684
Email Address:	john.houston@mh.alabama.gov	

3. State Expenditure Period:

From: 10/1/2006 To: 9/30/2007

4. Date Submitted:

Date: 10/1/2009 8:51:50 PM Original: ◉ Revision: ○

5. Contact Person Responsible for Application Submission:

Name:	Brandon Folks	Telephone:	(334) 353-7175
Email Address:	brandon.folks@mh.alabama.gov	FAX:	(334) 242-0759

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FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act

Title XIX of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications

As required by Title XIX of the PHS Act (continued)

IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929

X. Maintenance of Effort Regarding State Expenditures, Section 1930

With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."

XI. Restrictions on Expenditure of Grant, Section 1931

XII. Application for Grant; Approval of State Plan, Section 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."

XIV. Requirement of Reports and Audits by States, Section 1942

XV. Additional Requirements, Section 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Services Provided By Nongovernmental Organizations, Section 1955

I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Alabama

Name of Chief Executive Officer or Designee: Bob Riley

Signature of CEO or Designee:

Title: Governor

Date Signed:

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that

his or her knowledge, and that he or she is aware

By signing the certification, the undersigned certifies

that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application. **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Commissioner
APPLICANT ORGANIZATION AL Dept. of MH/MR	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____
date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:
$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Commissioner
APPLICANT ORGANIZATION AL Dept. of MH/MR	DATE SUBMITTED

FY 2007 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2007 is reflected on line 8 of the Notice of Block Grant Award.

$23,767,166

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

Goal #1: Continuum of Substance Abuse Treatment Services

FY 2007 (COMPLIANCE)

This goal was met during the SAPT BG 2007 expenditure period. The Substance Abuse Services Division (SASD), within the Alabama Department of Mental Health expended Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funds to maintain and enhance the continuum of substance abuse treatment services throughout Alabama. The Division strived to increase client access to substance use disorder prevention and treatment services and referral to appropriate levels of care. The SASD maintained a continuum of substance use disorder care which included; prevention, information and referral, assessment, outpatient, intensive outpatient, detoxification, short-term residential, long-term residential, case management, specialized women's services, HIV early intervention services and methadone treatment.

The SASD contracted with forty-four community organizations for the provision of prevention and treatment services (refer to Form 6). The SASD utilized a fee-for-service contract mechanism that included a Billing Manual which defined services, established reimbursement rates, identified service billing codes, defined the client population, etc. contractors submitted monthly billing documentation including the NIDA Minimum Data Set, client identification, service provided and length of service. The data system in operation in 2007 required collection of the described data elements for all services reimbursed by the SASD, including those paid with SAPT BG funds. The SASD did not collect information regarding the expenditure of local funding but all contracted programs received some local funding for the support of prevention and treatment services. Expenditures from the 2007 SAPT BG were tracked to the individual client level through the Stand-Alone Uniform Data Reporting System (SUDS). Reports regarding expenditures and service information for the SAPT BG Application are generated from the SUDS data system.

How the SAPT BG funds were used to meet the goals, objectives and activities of the FY 2007 Application:

During the SAPT BG expenditure period the SASD purchased services that were included in Alabama's continuum of care (as defined in the SASD Contract Billing Manual, Goal #1-Attachment #1) from the following certified community providers.

I. Adult Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4

Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
The Bridge, Inc	DeKalb	1
Cahaba MHC	Dallas/Perry/Wilcox	3
Calhoun Cleburne MHC	Calhoun	2
Cheaha MHC	Talladega/Clay	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Shelby	2
Dauphin Way Lodge	Mobile	4
East Alabama MHC	Lee/Russell	3
East Central MHC	Pike	3
CED MHC	Cherokee/Etowah/DeKalb	1
Hope House	Blount	2
Human Resource Development	Clarke/Elmore	4/1
Huntsville Madison MHC	Madison	1
JCCEO	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Mental Healthcare of Cullman	Cullman	1
MHC of North Central	Morgan/Limestone	1
Mobile MHC	Mobile	4
Mountain Lakes	Jackson/Marshall	1
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Recovery Services	DeKalb	1
South Central MHC	Coffee/Covington/Conecuh	4
Southwest MHC	Escambia/Monroe	4
UAB	Jefferson	2
West Alabama MHC	Marengo	3
Wiregrass MHC	Houston	4

II. Adolescent Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	**County**	**Region**
Baldwin County MHC	Baldwin	4
The Bridge, Inc.	Cullman/Etowah/Mobile/St. Clair/ Tuscaloosa	1/2/4
Cahaba MHC	Dallas	3
Calhoun Cleburne MHC	Calhoun	2
East Central MHC	Pike	3
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Chilton/Shelby	2
Huntsville Madison MHC	Madison	1

Lighthouse Counseling Center	Montgomery	3
Riverbend MHC	Colbert/Lauderdale	1
UAB	Jefferson	2

III. Adult Detoxification: As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Cheaha MHC	Talladega	2

* Location of the program, however, admissions are accepted from any county.

IV. Adult Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Dauphin Way Lodge	Mobile	4
Mountain Lakes MHC	Marshall	1
Riverbend MHC	Franklin	1
South Central MHC	Conecuh	4
Wiregrass MHC	Houston	4
New Centurions	Etowah	1

* Location of the program, however, admissions are accepted from any county.

V. Adolescent Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
The Bridge, Inc.	Etowah/Mobile	1 / 4
Northwest MHC	Walker	1

* Location of the program, however, admissions are accepted from any county.

VI. Adult Residential Rehabilitation (Long-Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Anniston Fellowship House	Calhoun	2
Birmingham Fellowship House	Jefferson	2
CED Fellowship House	Etowah	1
Dauphin Way Lodge	Mobile	4

Lighthouse of Tallapoosa County	Tallapoosa	3
The Pathfinder	Madison	1
St. Anne's Home	Jefferson	2
Phoenix House	Tuscaloosa	2
SA Council of N.W. AL	Lauderdale	1
Lighthouse of Cullman	Cullman	1
The Shoulder	Baldwin	4
Second Choice	Mobile	4
Rapha Ministries	Etowah	1
Emma's Harvest Home	Mobile	4

* Location of the program, however, admissions are accepted from any county.

VII. Special Women's Services: As defined in the SASD Contract Billing Manual.

Intensive Outpatient:

Program	**County**	**Region**
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
East Alabama MHC	Lee	3
Lighthouse Counseling Center	Montgomery	3
Mobile MHC	Mobile	4
North Central MHC	Morgan	1
SA Council of N.W. AL	Franklin	1
Southwest Alabama MHC	Escambia	4
UAB	Jefferson	2

In-home Intervention:

Program	**County**	**Region**
North Central MHC	Morgan	1

Residential:

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
SA Council of N.W. AL	Franklin	1

* Location of the program, however, admissions are accepted from any county.

VIII. Methadone Treatment: As defined in the SASD Contract Billing Manual.

Program	**County**	**Region**
Mobile MHC	Mobile	4

UAB	Jefferson	2

IX. HIV Early Intervention: As defined in the SASD Contract Billing Manual, including:

- HIV Group Counseling;
- HIV Family Counseling;
- HIV Individual Counseling;
- HIV Case Management;
- Orasure HIV Test/Pre-Test Counseling; and
- HIV Medical Assessment.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Cahaba MHC	Dallas	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
East Central MHC	Pike	3
Huntsville Madison MHC	Madison	1
Lighthouse Counseling Center	Montgomery	3
Mobile MHC	Mobile	4
UAB	Jefferson	2

X. Prevention: As defined in the SASD Contract Billing Manual.

Program	County	Region
Agency for Substance Abuse Prevention	Calhoun	1
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
CED MHC	Cherokee/Etowah/DeKalb	1
Cheaha MHC	Talladega	2
Cherokee County SA Council	Cherokee	1
Chilton Shelby MHC	Shelby	2
Council on SA	Montgomery	3
Cullman MHC	Cullman	1
Drug Education Council	Mobile	4
East Alabama MHC	Lee	3
East Central MHC	Pike	3
Franklin Memorial	Mobile	4
Gateway	Jefferson	2
Huntsville Madison MHC	Madison	1
JCCEO	Jefferson	2
Family and Child Services	Jefferson	2
Lighthouse Counseling Center	Montgomery	3

Mountain Lakes MHC	Marshall	1
North Central MHC	Morgan	1
North Central SA Council	Cullman	1
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Sayno	Montgomery	3
South Central MHC	Coffee	4
Southwest MHC	Monroe/Escambia	4
UAB	Jefferson	2
West Alabama MHC	Marengo	4
Wiregrass MHC	Houston	4

Who will be/is currently being served by Alabama's continuum of care?

The SAPT BG funds are used to purchase prevention and treatment services for individuals qualifying in accordance with clinical and financial specifications published in the contract exhibits (Goal #1-Attachment #2) and the SASD contract Billing Manual (Goal #1-Attachment #1). Priority populations are identified in both documents. Local contract providers determine individuals served based on published specifications and face-to-face clinical and financial assessments. During the 2007 SAPT BG expenditure period, the following clients received services through contracting community substance abuse providers.

- A total of 20,965 individuals were reported as admitted for substance abuse treatment.

- Sex:
  - Male 14,570 (69%)
  - Female 6,395 (31%)

- Race:
  - White 12,216 (59%)
  - Black or African American 8,501 (40%)
  - Native Hawaiian/Pacific Is. 6 (1%>)
  - Asian 34 (1%>)
  - American Indian 74 (1%>)
  - More than one race 65 (1%>)
  - Unknown 69 (1%>)

  - Not Hispanic of Latino 20,744 (99%)
  - Hispanic of Latino 221 (1%)

- Age:
  - 17 and under 1,512 (7%)
  - 18 – 24 4,074 (19%)
  - 25 – 44 11,313 (55%)
  - 45 – 64 3,978 (19%)
  - 65 and over 88 (1%>)

- Pregnant (of total females):
  - Yes 216 (3%)

  - White 144 (67%)
  - Black 66 (31%)

How does Alabama deliver the continuum of services?

All SAPT BG funds are used to purchase prevention and treatment services, that are clearly defined in the SASD Contract Billing Manual (Goal #1-Attachment #1) and the SASD contract exhibits (Goal #1-Attachment #2), through contracts with certified community providers. During the 2007 SAPT BG expenditure period the SASD implemented contracts with forty-four certified community provider organizations. Each provider organization hired staff that meet certification standards and are capable of providing prevention and treatment services in accordance with documented, professional requirements. Persons in need of treatment approach the local programs from a variety of referral sources including: court/criminal justice; individual; family; school systems; other community healthcare providers; other alcohol and drug treatment providers; employers; schools, etc.

All individuals referred receive a psycho-social assessment to determine the need for treatment; observation for TB symptoms and referral for screening and testing, if necessary; an offer of HIV EIS services; and a referral to a level of care that is indicated as most appropriate.

FY 2009 (PROGRESS)

The SASD implemented the Alabama Substance Abuse Information System (ASAIS) on July 1, 2008. ASAIS includes service and funding coding (Goal #1-Attachment #3) to allow the SASD to track all SAPT BG expenditures to accommodate reporting requirements.

The SASD executed contracts with community providers for the provision of services that are defined in the SASD Contract Billing Manual (Goal #1-Attachment #1) and the substance abuse specific exhibits that are part of each contract (Goal #1-Attachment #2). The contract exhibits include criteria for determining clinical and financial qualification for clients served. Contracts were executed with the following providers to assure provision of the substance abuse continuum of care in Alabama for FY 2009.

I. Adult Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
The Bridge, Inc	DeKalb	1
Cahaba MHC	Dallas/Perry/Wilcox	3

Calhoun Cleburne MHC	Calhoun	2
Cheaha MHC	Talladega/Clay	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Shelby	2
Dauphin Way Lodge	Mobile	4
East Alabama MHC	Lee/Russell	3
East Central MHC	Pike	3
CED MHC	Cherokee/Etowah/DeKalb	1
Family Life Center	Jackson/Morgan	1
Hope House	Blount	2
Human Resource Development	Clarke/Elmore	4/1
Huntsville Madison MHC	Madison	1
Insight Center	Clarke	4
JCCEO	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Marwin Counseling	Marion	1
Mental Healthcare of Cullman	Cullman	1
MHC of North Central	Morgan/Limestone	1
Mobile MHC	Mobile	4
Mountain Lakes	Jackson/Marshall	1
New Pathways	St. Clair	2
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Recovery Services	DeKalb	1
South Central MHC	Coffee/Covington/Conecuh	4
Southwest MHC	Escambia/Monroe	4
UAB	Jefferson	2
West Alabama MHC	Marengo	3
Wiregrass MHC	Houston	4

II. Adolescent Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	**County**	**Region**
Baldwin County MHC	Baldwin	4
The Bridge, Inc.	Cullman/Etowah/Mobile/St. Clair/ Tuscaloosa	1/2/4
Cahaba MHC	Dallas	3
Calhoun Cleburne MHC	Calhoun	2
East Central MHC	Pike	3
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Chilton/Shelby	2

Huntsville Madison MHC	Madison	1
Riverbend MHC	Colbert/Lauderdale	1
UAB	Jefferson	2
East Alabama MHC	Lee	3
Wiregrass MHC	Houston	4
MHC of North Central	Morgan	1

III. Adult Detoxification: As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Cheaha MHC	Talladega	2

* Location of the program, however, admissions are accepted from any county.

IV. Adult Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Dauphin Way Lodge	Mobile	4
Mountain Lakes MHC	Marshall	1
Riverbend MHC	Franklin	1
South Central MHC	Conecuh	4
Wiregrass MHC	Houston	4

* Location of the program, however, admissions are accepted from any county.

V. Adolescent Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
The Bridge, Inc.	Etowah/Mobile	1 / 4
Northwest MHC	Walker	1

* Location of the program, however, admissions are accepted from any county.

VI. Adult Residential Rehabilitation (Long-Term Residential): As defined in the SASD Contract Billing Manual.

Program	**County***	**Region**
Anniston Fellowship House	Calhoun	2
Birmingham Fellowship House	Jefferson	2

CED Fellowship House	Etowah	1
Dauphin Way Lodge	Mobile	4
Lighthouse of Tallapoosa County	Tallapoosa	3
The Pathfinder	Madison	1
St. Anne's Home	Jefferson	2
Phoenix House	Tuscaloosa	2
SA Council of N.W. AL	Lauderdale	1
Lighthouse of Cullman	Cullman	1
The Shoulder	Baldwin	4
Second Choice	Mobile	4
Rapha Ministries	Etowah	1
New Centurions	Etowah	1
Emma's Harvest Home	Mobile	4

* Location of the program, however, admissions are accepted from any county.

VII. Special Women's Services: As defined in the SASD Contract Billing Manual.

Intensive Outpatient:

Program	**County**	**Region**
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
East Alabama MHC	Lee	3
Mobile MHC	Mobile	4
North Central MHC	Morgan	1
SA Council of N.W. AL	Franklin	1
Southwest Alabama MHC	Escambia	4
UAB	Jefferson	2

In-home Intervention:

Program	**County**	**Region**
North Central MHC	Morgan	1

Residential:

Program	**County***	**Region**
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
SA Council of N.W. AL	Franklin	1

* Location of the program, however, admissions are accepted from any county.

VIII. Methadone Treatment: As defined in the SASD Contract Billing Manual.

Program	County	Region
Mobile MHC	Mobile	4
Northwest Treatment Center	Jefferson	2
Shelby County Treatment Center	Shelby	2
Walker Recovery Center	Walker	1
Colonial Management Group	Jefferson	2

IX. HIV Early Intervention: As defined in the SASD Contract Billing Manual, including:

- HIV Group Counseling;
- HIV Family Counseling;
- HIV Individual Counseling;
- HIV Case Management;
- Orasure HIV Test/Pre-Test Counseling; and
- HIV Medical Assessment.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Cahaba MHC	Dallas	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
East Central MHC	Pike	3
Huntsville Madison MHC	Madison	1
Lighthouse Counseling Center	Montgomery	3
Mobile MHC	Mobile	4
UAB	Jefferson	2

X. Prevention: As defined in the SASD Contract Billing Manual.

Program	County	Region
Agency for Substance Abuse Prevention	Calhoun	1
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
CED MHC	Cherokee/Etowah/DeKalb	1
Cheaha MHC	Talladega	2
Cherokee County SA Council	Cherokee	1
Chilton Shelby MHC	Shelby	2
Council on SA	Montgomery	3
Cullman MHC	Cullman	1
Drug Education Council	Mobile	4
East Alabama MHC	Lee	3
East Central MHC	Pike	3
Franklin Memorial	Mobile	4

Huntsville Madison MHC	Madison	1
JCCEO	Jefferson	2
Family and Child Services	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Mountain Lakes MHC	Marshall	1
North Central MHC	Morgan	1
North Central SA Council	Cullman	1
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Sayno	Montgomery	3
South Central MHC	Coffee	4
Southwest MHC	Monroe/Escambia	4
UAB	Jefferson	2
West Alabama MHC	Marengo	4
Wiregrass MHC	Houston	4
City of Selma	Dallas	3
Marshall County Commission	Marshall	1
Regional Alliance 4 Children		
Sylacauga Alliance	Talladega	2
Tuscaloosa County BOE	Tuscaloosa	2
Tuskegee University	Macon	3
Wilcox County Commission	Wilcox	3

FY 2010 (INTENDED USE)

The SASD will continue efforts to increase efficiency, improve access, and enhance the quality and outcomes of substance use disorder services. Emphasis will be on completing the "System Improvement Initiative" which includes the implementation of standardized screening and assessment instruments, adopting ASAM level of care determination, expanded ASAM levels of care (Table #1), client enrollment with a unique client identifier, and increased use of evidence-based prevention and treatment practices.

TABLE #1

LEVELS OF CARE		
Service Level	**Pop Code**	
LEVEL .5 EARLY INTERVENTION SERVICES		
Level .5	w	Early Intervention Services for Adults
Level .5	x	Early Intervention Services for Adolescents
LEVEL I OUTPATIENT TREATMENT		
Level I	w	Outpatient Treatment for Adults
Level I	x	Outpatient Treatment for Adolescents
Level I	y	Outpatient Treatment for Pregnant Women and Women with Dependent Children
Level I	z	Outpatient Treatment for Persons with Co-occurring Substance use and Mental Illness Disorders
Level I-D		Ambulatory Detoxification Without Extended On-Site Monitoring
Level I-O		Opioid Maintenance Therapy
LEVEL II INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION		
Level II.1	w	Intensive Outpatient Treatment for Adults
Level II.1	x	Intensive Outpatient Treatment for Adolescents
Level II.1	y	Intensive Outpatient Treatment for Pregnant Women and Women with Dependent Children
Level II.1	z	Intensive Outpatient Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level II.5	w	Partial Hospitalization Treatment for Adults
Level II.5	x	Partial Hospitalization Treatment for Adolescents
Level II.5	y	Partial Hospitalization Treatment for Pregnant Women and Women with Dependent Children
Level II.5	z	Partial Hospitalization Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level II-D		Ambulatory Detoxification With Extended On-Site Monitoring
LEVEL III RESIDENTIAL TREATMENT		
Level III.01	w	Transitional Residential Treatment for Adults
Level III.01	x	Transitional Residential Treatment for Adolescents
Level III.01	y	Transitional Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.01	z	Transitional Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.1	w	Clinically Managed Low Intensity Residential Treatment for Adults
Level III.1	x	Clinically Managed Low Intensity Residential Treatment for Adolescents
Level III.1	y	Clinically Managed Low Intensity Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.1	z	Clinically Managed Low Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.3	w	Clinically Managed Medium Intensity Residential Treatment for Adults
Level III.3	y	Clinically Managed Medium Intensity Residential Treatment for Pregnant Women and Women with Dependent Children

Level III.3	z	Clinically Managed Medium Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.5	x	Clinically Managed Medium Intensity Residential Treatment for Adolescents
Level III.5	xy	Clinically Managed Medium Intensity Residential Treatment for Pregnant Adolescent Girls or Adolescent Girls with Dependent Children
Level III.5	xz	Clinically Managed Medium Intensity Residential Treatment for Adolescents with Co-occurring Substance Related and Mental Illness Disorders
Level III.5	w	Clinically Managed High Intensity Residential Treatment for Adults
Level III.5	y	Clinically Managed High Intensity Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.5	z	Clinically Managed High Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.7	w	Medically Monitored Intensive Residential Treatment for Adults
Level III.7	y	Medically Monitored Intensive Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.7	z	Medically Monitored Intensive Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.7	x	Medically Monitored High-Intensity Residential Treatment for Adolescents
Level III.7	xy	Medically Monitored High Intensity Residential Treatment for Pregnant Adolescent Girls or Adolescent Girls with Dependent Children
Level III.7	xz	Medically Monitored High Intensity Residential Treatment for Adolescents with Co-occurring Substance Related and Mental Illness Disorders
Level III.7-D		Medically Monitored Residential Detoxification

The new assessment, level of care determination and expanded ASAM levels of care will be implemented prior to the end of SFY 2010.

The SASD will continue to seek additional State funding to support expansion of adult outpatient treatment, adolescent outpatient treatment and prevention activities to unserved counties in Alabama. However, economic realities indicate State and federal funding, at best, will be level. If level funding occurs, the SASD will continue the provision of the previously described prevention and treatment continuum, with the same certified providers and serving approximately the same numbers of individuals. In addition, SAPT BG funds will continue to be contracted with community providers using billing and reporting requirements included in the SASD Contract Billing Manual and contract.

If opportunities to expand services should occur, the SASD will pursue the goals described in the Planning Narrative: increase residential detoxification services; increase residential beds for females; increase the number of counties offering adult outpatient treatment; increase the number of counties offering publicly supported evidence-based prevention services; develop adolescent residential treatment programs; and increase the number of co-occurring outpatient services for children and adolescents.

FY 2009 (PROGRESS)

The SASD implemented the Alabama Substance Abuse Information System (ASAIS) on July 1, 2008. ASAIS includes service and funding coding (Goal #1-Attachment #3) to allow the SASD to track all SAPT BG expenditures to accommodate reporting requirements.

The SASD executed contracts with community providers for the provision of services that are defined in the SASD Contract Billing Manual (Goal #1-Attachment #1) and the substance abuse specific exhibits that are part of each contract (Goal #1-Attachment #2). The contract exhibits include criteria for determining clinical and financial qualification for clients served. Contracts were executed with the following providers to assure provision of the substance abuse continuum of care in Alabama for FY 2009.

I. Adult Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
The Bridge, Inc	DeKalb	1
Cahaba MHC	Dallas/Perry/Wilcox	3
Calhoun Cleburne MHC	Calhoun	2
Cheaha MHC	Talladega/Clay	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Shelby	2
Dauphin Way Lodge	Mobile	4
East Alabama MHC	Lee/Russell	3
East Central MHC	Pike	3
CED MHC	Cherokee/Etowah/DeKalb	1
Family Life Center	Jackson/Morgan	1
Hope House	Blount	2
Human Resource Development	Clarke/Elmore	4/1
Huntsville Madison MHC	Madison	1
Insight Center	Clarke	4
JCCEO	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Marwin Counseling	Marion	1
Mental Healthcare of Cullman	Cullman	1
MHC of North Central	Morgan/Limestone	1
Mobile MHC	Mobile	4
Mountain Lakes	Jackson/Marshall	1
New Pathways	St. Clair	2
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Recovery Services	DeKalb	1
South Central MHC	Coffee/Covington/Conecuh	4
Southwest MHC	Escambia/Monroe	4
UAB	Jefferson	2
West Alabama MHC	Marengo	3
Wiregrass MHC	Houston	4

II. Adolescent Intensive Outpatient: As defined in the SASD Contract Billing Manual to include: Psycho-Social Assessment; Diagnostic Screening; Case Management; Individual Counseling; Group Counseling; Family Counseling; and Didactic Group Education.

Program	County	Region
Baldwin County MHC	Baldwin	4
The Bridge, Inc.	Cullman/Etowah/Mobile/St. Clair/ Tuscaloosa	1/2/4
Cahaba MHC	Dallas	3
Calhoun Cleburne MHC	Calhoun	2
East Central MHC	Pike	3
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Chilton Shelby MHC	Chilton/Shelby	2
Huntsville Madison MHC	Madison	1
Riverbend MHC	Colbert/Lauderdale	1
UAB	Jefferson	2
East Alabama MHC	Lee	3
Wiregrass MHC	Houston	4
MHC of North Central	Morgan	1

III. Adult Detoxification: As defined in the SASD Contract Billing Manual.

Program	County*	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Cheaha MHC	Talladega	2

* Location of the program, however, admissions are accepted from any county.

IV. Adult Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	County*	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
Dauphin Way Lodge	Mobile	4
Mountain Lakes MHC	Marshall	1
Riverbend MHC	Franklin	1
South Central MHC	Conecuh	4
Wiregrass MHC	Houston	4

* Location of the program, however, admissions are accepted from any county.

V. Adolescent Crisis Residential (Short Term Residential): As defined in the SASD Contract Billing Manual.

Program	County*	Region
The Bridge, Inc.	Etowah/Mobile	1 / 4
Northwest MHC	Walker	1

* Location of the program, however, admissions are accepted from any county.

VI. Adult Residential Rehabilitation (Long-Term Residential): As defined in the SASD Contract Billing Manual.

Program	County*	Region
Anniston Fellowship House	Calhoun	2
Birmingham Fellowship House	Jefferson	2
CED Fellowship House	Etowah	1
Dauphin Way Lodge	Mobile	4
Lighthouse of Tallapoosa County	Tallapoosa	3
The Pathfinder	Madison	1
St. Anne's Home	Jefferson	2
Phoenix House	Tuscaloosa	2
SA Council of N.W. AL	Lauderdale	1
Lighthouse of Cullman	Cullman	1
The Shoulder	Baldwin	4
Second Choice	Mobile	4
Rapha Ministries	Etowah	1
New Centurions	Etowah	1
Emma's Harvest Home	Mobile	4

* Location of the program, however, admissions are accepted from any county.

VII. Special Women's Services: As defined in the SASD Contract Billing Manual.

Intensive Outpatient:

Program	County	Region
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
East Alabama MHC	Lee	3
Mobile MHC	Mobile	4
North Central MHC	Morgan	1
SA Council of N.W. AL	Franklin	1
Southwest Alabama MHC	Escambia	4
UAB	Jefferson	2

In-home Intervention:

Program	County	Region
North Central MHC	Morgan	1

Residential:

Program	County*	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
SA Council of N.W. AL	Franklin	1

* Location of the program, however, admissions are accepted from any county.

VIII. Methadone Treatment: As defined in the SASD Contract Billing Manual.

Program	County	Region
Mobile MHC	Mobile	4
Northwest Treatment Center	Jefferson	2
Shelby County Treatment Center	Shelby	2

Walker Recovery Center	Walker	1
Colonial Management Group	Jefferson	2

IX. HIV Early Intervention: As defined in the SASD Contract Billing Manual, including:

- HIV Group Counseling;
- HIV Family Counseling;
- HIV Individual Counseling;
- HIV Case Management;
- Orasure HIV Test/Pre-Test Counseling; and
- HIV Medical Assessment.

Program	County	Region
Alcohol and Drug Abuse Treatment	Jefferson	2
Cahaba MHC	Dallas	2
Cheaha MHC	Talladega	2
Chemical Addictions Program	Montgomery	3
East Central MHC	Pike	3
Huntsville Madison MHC	Madison	1
Lighthouse Counseling Center	Montgomery	3
Mobile MHC	Mobile	4
UAB	Jefferson	2

X. Prevention: As defined in the SASD Contract Billing Manual.

Program	County	Region
Agency for Substance Abuse Prevention	Calhoun	1
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
CED MHC	Cherokee/Etowah/DeKalb	1
Cheaha MHC	Talladega	2
Cherokee County SA Council	Cherokee	1
Chilton Shelby MHC	Shelby	2
Council on SA	Montgomery	3
Cullman MHC	Cullman	1
Drug Education Council	Mobile	4
East Alabama MHC	Lee	3
East Central MHC	Pike	3
Franklin Memorial	Mobile	4
Huntsville Madison MHC	Madison	1
JCCEO	Jefferson	2
Family and Child Services	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Mountain Lakes MHC	Marshall	1
North Central MHC	Morgan	1
North Central SA Council	Cullman	1
Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Sayno	Montgomery	3
South Central MHC	Coffee	4
Southwest MHC	Monroe/Escambia	4

UAB	Jefferson	2
West Alabama MHC	Marengo	4
Wiregrass MHC	Houston	4
City of Selma	Dallas	3
Marshall County Commission	Marshall	1
Regional Alliance 4 Children		
Sylacauga Alliance	Talladega	2
Tuscaloosa County BOE	Tuscaloosa	2
Tuskegee University	Macon	3
Wilcox County Commission	Wilcox	3

FY 2010 (INTENDED USE)

The SASD will continue efforts to increase efficiency, improve access, and enhance the quality and outcomes of substance use disorder services. Emphasis will be on completing the "System Improvement Initiative" which includes the implementation of standardized screening and assessment instruments, adopting ASAM level of care determination, expanded ASAM levels of care (Table #1), client enrollment with a unique client identifier, and increased use of evidence-based prevention and treatment practices.

TABLE #1

LEVELS OF CARE
Service Level Pop
Code
LEVEL .5 EARLY INTERVENTION SERVICES
Level .5 w Early Intervention Services for Adults
Level .5 x Early Intervention Services for Adolescents
LEVEL I OUTPATIENT TREATMENT
Level I w Outpatient Treatment for Adults
Level I x Outpatient Treatment for Adolescents
Level I y Outpatient Treatment for Pregnant Women and Women with Dependent Children
Level I z Outpatient Treatment for Persons with Co-occurring Substance use and Mental Illness Disorders
Level I-D Ambulatory Detoxification Without Extended On-Site Monitoring
Level I-O Opioid Maintenance Therapy
LEVEL II INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION
Level II.1 w Intensive Outpatient Treatment for Adults
Level II.1 x Intensive Outpatient Treatment for Adolescents
Level II.1 y Intensive Outpatient Treatment for Pregnant Women and Women with Dependent Children
Level II.1 z Intensive Outpatient Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level II.5 w Partial Hospitalization Treatment for Adults
Level II.5 x Partial Hospitalization Treatment for Adolescents
Level II.5 y Partial Hospitalization Treatment for Pregnant Women and Women with Dependent Children
Level II.5 z Partial Hospitalization Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level II-D Ambulatory Detoxification With Extended On-Site Monitoring
LEVEL III RESIDENTIAL TREATMENT
Level III.01 w Transitional Residential Treatment for Adults
Level III.01 x Transitional Residential Treatment for Adolescents
Level III.01 y Transitional Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.01 z Transitional Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.1 w Clinically Managed Low Intensity Residential Treatment for Adults
Level III.1 x Clinically Managed Low Intensity Residential Treatment for Adolescents
Level III.1 y Clinically Managed Low Intensity Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.1 z Clinically Managed Low Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.3 w Clinically Managed Medium Intensity Residential Treatment for Adults
Level III.3 y Clinically Managed Medium Intensity Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.3 z Clinically Managed Medium Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.5 x Clinically Managed Medium Intensity Residential Treatment for Adolescents

Level III.5 xy Clinically Managed Medium Intensity Residential Treatment for Pregnant Adolescent Girls or Adolescent Girls with Dependent Children
Level III.5 xz Clinically Managed Medium Intensity Residential Treatment for Adolescents with Co-occurring Substance Related and Mental Illness Disorders
Level III.5 w Clinically Managed High Intensity Residential Treatment for Adults
Level III.5 y Clinically Managed High Intensity Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.5 z Clinically Managed High Intensity Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.7 w Medically Monitored Intensive Residential Treatment for Adults
Level III.7 y Medically Monitored Intensive Residential Treatment for Pregnant Women and Women with Dependent Children
Level III.7 z Medically Monitored Intensive Residential Treatment for Persons with Co-occurring Substance Use and Mental Illness Disorders
Level III.7 x Medically Monitored High-Intensity Residential Treatment for Adolescents
Level III.7 xy Medically Monitored High Intensity Residential Treatment for Pregnant Adolescent Girls or Adolescent Girls with Dependent Children
Level III.7 xz Medically Monitored High Intensity Residential Treatment for Adolescents with Co-occurring Substance Related and Mental Illness Disorders
Level III.7-D Medically Monitored Residential Detoxification

The new assessment, level of care determination and expanded ASAM levels of care will be implemented prior to the end of SFY 2010.

The SASD will continue to seek additional State funding to support expansion of adult outpatient treatment, adolescent outpatient treatment and prevention activities to unserved counties in Alabama. However, economic realities indicate State and federal funding, at best, will be level. If level funding occurs, the SASD will continue the provision of the previously described prevention and treatment continuum, with the same certified providers and serving approximately the same numbers of individuals. In addition, SAPT BG funds will continue to be contracted with community providers using billing and reporting requirements included in the SASD Contract Billing Manual and contract.

If opportunities to expand services should occur, the SASD will pursue the goals described in the Planning Narrative: increase residential detoxification services; increase residential beds for females; increase the number of counties offering adult outpatient treatment; increase the number of counties offering publicly supported evidence-based prevention services; develop adolescent residential treatment programs; and increase the number of co-occurring outpatient services for children and adolescents.

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal, Selective and Indicated:

• ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

o ***Universal Direct. Row 1***—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

• ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

• ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FFY 2007 (Compliance)

In collaboration with Alabama Department of Public Health, Substance Abuse Services Division (SASD) continued to support primary prevention services to reduce the incidence of alcohol and other drug abuse and related problems through the North Regional and South Regional Information Clearing House, prevention providers, and prevention coalitions.

SASD continued to build the capacity of the Clearing Houses and Department of Public Health to provide planning and policy support, coordination, and public information to communities and coalitions throughout the state. Specialized organizations addressed specific substance abuse issues.

A. Information Dissemination

1.) Alabama funded the North Regional and South Regional Information Clearing House to provide effective health communication products to prevent substance abuse among youth. Pre-teenagers were a focus of this year's campaign. Because parents have a powerful influence over children in this age group, these guardians were the primary target population for the material.

Who:	Parents and guardians of pre-teen youth
What:	LifeSkills for Parents, Here, Now and Down the Road, Second Step
When:	Current
Where:	Health centers, SASD funded prevention programs, after school and other agencies, and middle schools
How:	Contract that was extended through FFY2007
Changes:	All of the above products were distributed as part of the Clearing Houses and educational facilities which represented an increase in service.

B. Education

1.) SASD Prevention Programs attended statewide/regional meetings.

Who:	SASD and Clearing Houses
What:	To provide opportunities for all substance abuse providers to meet and interact with other providers throughout the state. Representatives were asked to attend these meetings so they could learn more about what treatment programs do and at the same time, educate them about prevention. These meetings afforded the opportunity for providers to be updated about all issues, and changes/policy updates in the field of substance abuse.
When:	Quarterly
Where:	Throughout the state
How:	SASD organized these meetings through the Clearing Houses

2.) SASD continued to fund 34 prevention programs throughout the state to provide science-based substance abuse prevention programs. These programs utilize science/evidence-based programs/strategies to prevent alcohol (with particular emphasis on underage drinking), marijuana, and other drug abuse among children, pre – K to youth up to 18 years of age. Some of the programs implement environmental prevention approaches, that seek to change the overall context within which substance abuse occurs. Environmental prevention efforts focus on substance availability, norms, and regulations. Other programs selected other science-based program/strategies from CSAP's science/evidence-based models list. As SASD continues its efforts to increase the competency of Prevention Programs in using scientifically based models of prevention, technical assistance was provided by SASD and the Clearing Houses.

Who:	Pre – K to youth up to 18 years of age
What:	Science-based Substance Abuse Prevention Programs/Strategies
When:	FFY 2007
Where:	Schools, housing developments, community agencies, after-school programs and recreation centers
How:	Contracts awarded to SASD Prevention Programs

C. Alternatives

1.) Community health organizations, located throughout the stated, continued to collaborate with Alabama Department of Economic and Community Affairs (ADECA), local public health, police, school, community and others. Mini-grants offered communities opportunities to collaborate on substance abuse prevention and alternative activity services. Science/evidence-based CSAP model programs offered complementary opportunities for leadership-promoting activities.

Who:	Youth-serving professionals and parents of teenagers
What:	Leadership and community programs
When:	FFY 2007
Where:	Statewide
How:	ADECA collaboration and competitive grants to health and human service contractors

D. Problem Identification and Referral

No Problem Identification & Referral strategies are utilized in Alabama. Information & Referral services are rendered by the Clearinghouses. No Prevention dollars are being utilized for screening and or assessment of Treatment.

E. Community Based Processes

1.) SASD continued to support the North and South Regional Clearing Houses to provide the following services: community health planning, prevention program planning, evaluation, organizational development, and professional development. They

assisted community groups and organizations with a broad array of issues, including science/evidence based principals and programs, collaboration, cultural competence, coalition development social policy initiatives and media campaigns.

Who:	Community groups and coalitions, school systems, and faith communities
What:	Consultation and training
When:	FFY 2007
Where:	Coalitions and organizations, housing developments, faith communities, and other community settings
How:	Competitive contracts awarded to two Regional Clearing Houses to provide training and technical assistance

2.) The North and South Regional Clearing Houses continued working partnerships with organizations. The partnerships collaborate in examining and responding to community challenges regarding alcohol and other drug use. The Regional Clearing Houses assisted in assessing needs and resources, planning and implementing programs. They also guide organizations and groups in approaching strategic planning, cultural competence, science/evidence-based prevention, evaluation, and organizational development.

Who:	Community members, coalitions, school systems, faith communities, government and other civic organizations
What:	Technical assistance for developing and fostering coalitions, planning, implementing, and evaluating prevention programs
When:	FFY 2007
Where:	Community groups, youth organizations, coalitions, and school systems
How:	SASD staff and competitive two-year contracts awarded to regional human service agencies to provide training as well as support for networking and building linkages as part of the State Prevention System

F. Environmental

1.) The North Regional and South Regional Clearing House continued to provide consultation and training to community-based groups, coalitions, organizations and schools on how to maximize the effectiveness of environmental strategies that impact systemic change related to ATOD use. All of the SASD Prevention Providers implemented environmental strategies.

Who:	Community coalitions, community stakeholders, and school systems.
What:	Consultation and training to influence ATOD policies, rules/regulations, and community norms at local, regional, and state levels.
When:	FFY2007
Where:	Community educational and social services settings, and community partnerships.
How:	Contracts awarded to the two agencies to provide technical assistance and training.

In summary, the recipients of the Block Grant funds included primary prevention programs, such as prevention providers, Clearing Houses, and Department of Education. Funded treatment programs included methadone, outpatient counseling, residential rehabilitation, detoxification, transitional care services, case management and supportive housing. Additionally, Block Grant funds maintain statewide support services designed to enhance the State's service delivery system.

FFY 2009 (Progress)

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Chilton-Shelby (MHC)	Education	Individual	LifeSkills, Too Good For Drugs	Jemison, Chilton County High Montevallo School	40	DS, AS	5th & 10th graders
	Education/ Alternative	Peer/ Individual/ Family	LifeSkills, Second Step	Church	20	DS, AS	5th graders, siblings, parents
	Education/ Alternative	Peer/ Individual/ Family	LifeSkills, Second Step	Church	40	SB	5th graders, siblings, parents
	Environmental	Decrease the overall use of alcohol among 10th graders at Chilton County High School thru the following objectives: Objective 1: Enhance the involvement of the preexisting SADD Chapter within the Chilton County area, Objective 2: The SADD Chapter will conduct four different publicity campaigns at sporting and community events throughout the Clanton area, Objective 3: Reduce alcohol availability and access by conducting underage compliance check to measure the extent of underage sales problem, Objective 4: Facilitate four messages about the dangers of alcohol aimed towards the Faith-Based Community in Chilton County.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Riverbend	Alternative	Community	LifeSkills	Church, YMCA	550	DS, AS, W, S, SB	4th – 6th graders
	Education/ Information Dissemination	Peer/Individual Community	LifeSkills	Schools	839	DS, AS, W, S, SB	4th – 6th graders
	Environmental	Collaborate with school systems to monitor compliance with the policy on tobacco use as evidenced by the frequency of tobacco related suspensions in Wilson, Brooks, Waterloo, and Central Elementary Schools. Engage Peers for Life group to assist in educating and mentoring younger students in discouraging underage use of tobacco products. Collaborate with 27 local business owners to promote/insure adherence to laws concerning sales of tobacco products to underage youth as evidenced by statistics from the Alcohol Beverage Control Board and the Lauderdale County Sheriff's office.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Drug Education Council	Education/ Alternative	Individual/ Community	Staying Connected With Your Teen, and Too Good for Drugs & Violence	Church, School, Community Center	2400	AS, W, S	10 – 18 yr olds
	Environmental	Promote healthy beliefs and attitudes in youth and parents concerning underage alcohol use and other substance use. Changes in beliefs and attitudes over the course of plan implementation will be assessed by outside evaluators, working in collaboration with the Drug Education Council and community partners. Decrease youth access to alcohol by improving adults' understanding of laws surrounding the sale of alcohol in the community. Changes in understanding of laws will be assessed by outside evaluators and community partners, including area law enforcement agencies. To work with community-based coalitions such as the Underage Drinking Task Force, Marijuana Task Force, DUI Task Force, Communities That Care/Drug-Free Communities Coalition, and others to improve the organization and effectiveness of alcohol, tobacco and other drug use prevention services in the community.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
East Alabama MHC	Alternative	Individual	Peacemakers	Middle School	35	AS	12 – 15 yr olds
	Education	Individual	Second Steps, Project ALERT, Too Good for Drugs, Smart Moves	Boys and Girls, School	50	DS, AS	7 – 15 yr olds
	Environmental	Establish or strengthen a parent advocacy group within Lee and Tallapoosa County. Partner with law enforcement and the ABC Board to strengthen public policy encouraging retailers of alcohol and tobacco products to participate in the responsible vendors program.Hold school-based programs & media campaigns to educate youth regarding legal and health-related consequences of alcohol abuse. Hold Area Town Hall Meeting in Opelika and Auburn and conduct media campaigns to educate parents, schools, businesses, and policy makers, regarding underage drinking.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
West Alabama MHC	Education	Individual	Too Good for Drugs	Elementary and Middle School	198	DS	K – 9th graders
	Alternative	Individual/ Parent	Parenting Wisely	West Alabama MHC	56	AS	Parent/Child
	Environmental	Conduct workshops and community activities with in the Hale county community to relay educational information on alcohol and drug usage. These workshops and activities will give the county helpful information on how to identify and address issues with underage drinking among their children and family. Develop different publicity slogans on bill boards and radio to relay the message of staying alcohol, and drug free.Conduct the second Youth Camp in Marengo and Hale County for children from homes of parents with addictions (Drugs, Alcohol) in a positive setting to educate them against alcohol and drug use and give them information to take home to their parents or other adults about the effects of alcohol and drugs on the body.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Northwest MHC	Education	Individual	Too Good for Drugs	Fayette, Lamar, Marion, Walker & Winson Co. Schools	95	DS, AS, S	5 – 13 yr olds
	Alternative	Individual	Too Good for Drugs	Fayette, Lamar, Marion, Walker & Winson Co. Schools	111	DS, AS, S	5 – 13 yr olds
	Education	Individual	Too Good for Drugs & Violence	Fayette, Lamar, Marion, Walker & Winson Co.	83		19 and older
	Environmental	To conduct 3 educational outreach programs that include prevalence rates and correlates or concerns about substance abuse to community leaders and sponsorship groups. To conduct 3 educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles with community leaders, sponsorship groups, and area parents. To conduct 2 local media campaigns emphasizing the consequences of substance abuse and aimed at reducing demand for illicit substances through prevention programming. In Walker County we will conduct 3 educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented. Outcome measure will be gathered from participants in the form of post-tests to determine whether their						

		knowledge has increased. To conduct 3 educational outreach programs for community leaders, area parents and local sponsorship groups on prevention programs, goals staff requirements, and other startup aspects of programming, measuring increase in knowledge with post-tests. To conduct 2 local media campaigns describing the benefits of prevention programs for reducing the consequences of substance abuse. We will also participate in the Children's Policy Council plan to work on passing an indoor clean air policy and create new smoking ordinances. The Walker County CPC has received a Public Health Second-Hand Smoke grant. This grant creates a Youth Council and utilizes the Youth Employment Program. Activities to include: Attend CPC strategizing and planning meetings for the indoor clean air policy, Attend CPC strategizing and planning meetings for the creation of new smoking ordinances, Attend the Youth Council meetings and events and help with their facilitation, Attend city council, county commission meetings and other meetings and trainings for officials. Winston County has received an UPS Capacity-building Grant, which will provide some environmental strategies to the community. To best leverage resources, we will work with the prevention plan our coalition is proposing. The plan will involve public awareness and other activities with both adults and youth. Our activities will include: Attend Coalition strategizing and planning meetings for the UPS grant, Attend Coalition strategizing and planning meetings for the creation of new smoking ordinances and other policy changes, Attend the Coalition events and help with their facilitation, and Help with the Public Awareness campaign.

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Oakmont	Education	Individual	Positive Action	Oakmont	191	DS	6th & 8th graders
	Education	Individual/Community/ School	LifeSkills	Bush Middle School	384	DS	6th & 8th graders
	Education	Community	Strengthening Families	Oakmont	80	FB, SB	6th & 8th graders
	Alternative	Individual/ Family	Strengthening Families	Oakmont	248	W, S	6th, 8th, siblings
	Environmental	Promote clear, strong, and consistent messages among children and youth in the Ensley community surrounding "Saying No to Alcohol Use/Abuse". Assess the need for the revision of community practices and policies by thoroughly reviewing alcohol beverage sale patterns and zoning laws which impact the Ensley Community. We have been doing it through fairs conducted by Oakmont as well as showing different films on the dangers of drugs, having some youth form the alternative schools talk to the children and conducting fairs with the children, their parents and siblings. We have also distributed posters to each class that shows the physical dangers of alcohol abuse along with handing out pamphlets for the children to take home.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Southwest MHC	Alternative	Individual	Reconnecting Youth, Anger Management for Youth	School	84	AS, SB	At-risk teens
	Education	Family	Parenting Wisely, Signs of Suicide Help for Parents	Family Center	384	AS	Caregivers and parents of at-risk teens
	Environmental	Form a partnership with area businesses by the end of the fiscal year to promote healthy, drug-free work environments which will, in turn, contribute to the creation of drug-free families, schools and communities. Reduce alcohol availability and access by raising public awareness through a media campaign targeting newspapers, radio stations, and sporting and community events by formulating and disseminating four separate media products concerning the dangers of underage drinking and driving and the penalties for violating laws against the sale of alcohol to or the purchase of alcohol for minors by the end of the fiscal year. Decrease the use of alcoholic beverages among students in Evergreen, AL and influence a change in perception among adults about substance use. Form a Students Against Disruptive Decisions (SADD) Chapter at Sparta Academy by December 2009 and facilitate ongoing participation in SADD chapters at Hillcrest High and Sparta Academy throughout the fiscal year.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
SAYNO	Environmental	Conduct a collaborative summer prevention activity in conjunction with the Montgomery chapter of Mothers Against Drunk Drivers (MADD), local law enforcement authorities and City of Montgomery officials for King Hill youth prior to August 2009. Develop by May 1, 2009, a list of local media contacts (radio, television, newspaper). Reduce access and availability of sales of alcoholic beverages to minors at retail outlets within ½ mile of the King Hill community. Conduct two quarterly awareness campaigns focusing on under-aged to educate and motivate parents, local community leaders and other interested individuals/ agencies of the availability of alcoholic beverages in the immediate vicinity of the King Hill Neighborhood. Meet at least quarterly with local law enforcement, neighborhood leaders, church officials, community center and other interested to identify, assess and evaluate under-aged consumption of alcoholic beverages in the King Hill community.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Council on Substance Abuse (COSA)	Education/ Alternative/ Community/ Information Dissemination	Individual/ Peer/School/ Family	Communities Mobilizing for Change on Alcohol, In My House, Positive Action	YMCA, Boys and Girls' Club	1800	AS, W, SB, S	4^{th} – 6^{th} grades
	Environmental	Although COSA's focus is on alcohol, tobacco and other drugs, COSA's Environmental Program which is a community-organizing program is designed to reduce substance use among youth. In addition, our mission is to reduce youth access to alcohol by changing community policies and practices. It seeks both to effectively limit the access to alcohol of people under legal drinking age and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable. It employs a range of social-organizing techniques to address legal, institutional, social, and health issues in order to reduce youth alcohol use by eliminating illegal alcohol sales to youth by retailers and by obstructing the provision of alcohol to youth by adults. It involves community members in seeking and achieving changes in local public policies and the practices of community institutions that can affect youths' access to alcohol. COSA has been very successful in securing a smoking ban in restaurants in Montgomery County. Our tobacco initiative was modeled after Communities Mobilizing for Change on Alcohol and COSA continues to use this model with alcohol and other drugs.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
East Central	Environmental	Decrease a specific Troy community's acceptance of marijuana usage. Use local media radio station 105.7 to directly/indirectly communicate with Troy County Housing Authority community residents. Facilitate a media campaign which will measurably change the targeted community's acceptance of marijuana. Conduct 2 anti-marijuana campaigns through radio, station 105.7 by July 2010.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Wiregrass	Alternative	Individual/Family	Too Good for Drugs, STARS for Families	Community Center, Boys & Girls Club	74	AS, S, SB	K – 8th graders, parents
	Education	Individual	Safe Dates	Schools	35	DS, AS	9th – 12th graders
	Environmental	By February 2009, identify and seek the participation of 5 core Coalition partners in Geneva County. Speaking engagements in churches, civic organizations, parent groups, and youth groups will be used as means to identify new members. Minutes from Coalition meetings and letters of agreement/support from new partners will be used to evaluate this objective. By April 2009, develop a Coalition information packet that will be used in the recruitment of new coalition partners. The packets will be distributed to community members through faith-based organizations, civic groups, city and county government officials, parent groups, youth groups, etc. By July 2009, develop and maintain a community information clearinghouse for alcohol, tobacco, marijuana, methamphetamine and other drug information, parent resources, and prevention information for churches, businesses, etc. By November 2009, conduct 4 media efforts/campaigns in Geneva Co. to increase awareness of the dangers of underage alcohol, tobacco and other drug use and to promote the healthful benefits of non use. Media efforts/campaigns will be conducted in during the following times of the year: Red Ribbon Week, National Drunk and Drugged Driving Prevention month, FAS awareness week, National Alcohol Screening Day and World No Tobacco Day. By September 15, 2009 contact 4 public groups in Geneva County (civic clubs, city and county government officials, other community agencies, employers, faith-based organizations, etc.) and provide training to increase their knowledge of substance abuse and encourage their sponsorship of, and involvement in, substance abuse prevention activities.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
UAB	Education	Individual	Too Good for Drugs	Middle & High School, YMCA	92	DS, AS, S	5^{th} – 12^{th} graders
	Alternative	Individual	Too Good for Drugs	Middle & High School, YMCA	79	AS	5 – 12^{th} graders
	Environmental	Conduct counter-advertising to inform target population and community of the consequences of using/ abusing drugs and alcohol. UAB/SAP will collaborate with the Tarrant Coalition for a Safe and Drug Free Community in order to determine what other objectives can be used to effectively impact the environment regarding underage drinking and drug use/abuse, specifically marijuana. Decrease arrest rates for drug and alcohol related charges among youth in the Tarrant Community. Conduct media campaigns to inform target population and community of the consequences of abusing/using drugs and alcohol.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Cherokee Co.	Alternative	Individual/Peer/ Community	Al's Pals	Armory	110	S	8 – 13 yr olds
	Alternative	Individual/Peer/ Family	Al's Pals	Middle School	125	AS	10 – 13 yr olds
	Education	Individual	Too Good For Drugs	Elem/Midd. School	280	DS	10 – 13 yr olds
	Education	Individual	Too Good For Drugs	Middle School	310	DS	10 – 13 yr olds
	Environmental	Develop youth advocacy groups to promote alcohol and tobacco free lifestyles in smaller schools in rural areas. Develop parental task force to support and enhance existing youth peer groups. Continue implementing Task Force sponsored Media campaign for community events i.e. Health Fairs, Sporting Events, School events, church events, and SPF trainings. Continue collaboration with key agencies and contacts within the communities. Continue providing PSA's and In-Service trainings for educators, Daycare providers and community members. Continue participation in local and national media campaigns. The overall objective of the Youth Advocacy Group is to engage youth and give them opportunities strategies to send anti-drug/tobacco messages to communities to enable the youth to be a positive role model for peers and to set norms among youth. Our agency utilized the Surgeon General's guideline to under age drinking as a tool for organizing community efforts. Peer and parent sub groups were trained by SPF guidelines in order to assess and identify needs within community. Our environmental strategy has driven by the input from grass roots meetings around SPF. Our agency works closely with churches and civic organizations on an ongoing basis. A strong and positive working rapport within our community is imperative to our prevention efforts.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Alcohol & Drug Abuse Treatment Center	Education	Individual	Too Good for Drugs	Community Center, School, Church	20	DS, AS, W	5^{th} – 9^{th} graders
	Alternative	Individual/ Community	Too Good for Drugs & Violence	Community Center, Summer Camp, Church	30	S	10^{th} – 12^{th} graders
	Environmental	The Prevention Team will partner with 3 local Handipack stores in the Pratt City and West End communities. The Handipack stores will be provided with display materials regarding the effects of underage drinking throughout a 6 month period of time. Adults from the Pratt City and West End communities will provide supervision to sixth grade volunteers while they conduct surveys from adults who are willing to purchase, not purchase, or hesitate to purchase alcohol for minors. Formulate a memorandum of understand or agreement among stakeholders to commit to community involvement with a designated specific task. To mobilize the Pratt City Community to decrease underage drinking among African American children ages 11-16. To determine and identify local stakeholders that will make a commitment around underage drinking of African American children ages 11-16. Create 3 clear consistent no use messages in the Pratt City and West End Communities during the following months: January, May, and September.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Cullman	Environmental	Establish a committee of identified, interested staff and faculty at Wallace St. Comm. College (WSCC) to develop and enhance ATOD school policies and procedures with awareness of the school's ATOD problems. Exploration of data collection system developed and implemented for centralized bank for all alcohol related violations of campus policies, student health data (reported in aggregate) and environmental indicators of alcohol and other drug use by June 2010. Create four instruments to assist in the environmental changes at WSCC through the development of billboards, articles, announcements and publications regarding ATOD awareness and the standards of conduct. Decrease underage drinking and binge drinking among students at WSCC. Develop the capacity for student organizations to promote alcohol-free lifestyles membership to abide by alcohol-free lifestyles. Complete a media campaign to educate students regarding legal and health related consequences of alcohol abuse utilizing at least three different mediums. Promote alcohol-free lifestyle within the on/off campus housing by incorporating a policy for an alcohol-free environment through the apartment complex and/or Director of Auxiliary Services. Promote ATOD-free living with the athletic department (students) at WSCC by obtaining an agreement of at least one team to incorporate a policy to abide by alcohol-free lifestyles when representing their school/sport. Increase sensitivity and awareness of necessary environmental change for future healthcare and social service providers enrolled at WSCC by incorporating ATOD prevention into their course syllabus. Develop ATOD prevention educational tools for WSCC college instructors 2008-09 school year. Increased awareness of ATOD prevention by providing educational resources to faculty and students.						

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Indian Rivers MHC	Alternative	Individual/ Peer/School/ Community	Positive Action	Recreation Center	12	AS	3rd – 5th graders
	Environmental	During the county assessment by the Children's Policy Council one of the biggest problems noted was a lack of parental involvement. We found that many more adults were arrested than juveniles so we felt that we needed to target adults. Conduct 2 media campaigns per year targeting increased parental involvement and alcohol free family activities. Currently we are working on media campaigns that promote sober family related activities. We chose the ones that we like and the advertising campaigns are going to be schedule throughout the year on radios, posters, billboards, newspapers etc. Our hope is that we will be able to increase parental involvement with children in the Aliceville area as well as increase the amount of parental involvement of parents with their children. Reduce alcohol consumption by adults or children ages 10-12 based on the arrest data in the Aliceville Housing Community and the surrounding area. To increase parental involvement in the lives of children ages 10-12 in the Aliceville Housing community and the surrounding area based on the Pickens County Community Needs Assessment to increase the protective factors for the prevention of first time alcohol use. Assess laws and ordinances concerning alcohol in Pickens County and the Aliceville Community by the end of the second quarter. Assess the data on alcohol related arrests by adults and youth in the Aliceville community and establish a target population by the end of the second quarter.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Franklin Primary	Environmental	Develop a parent advocacy group in the Toulminville community by Sept. 1, 2009. Identify, promote, and send invitations to community leaders and key stakeholders concerning the reactivation of the Marijuana Task Force by (which has been inactive for a period of time) by April 1. 2010. Conduct 2 publicity campaigns in Toulminville community to change community norms and perceptions of marijuana usage, one specifically targeting the faith based community. To change community norms and perceptions of the social acceptability and level of risk associated with marijuana usage among parents and youths in the Toulminville community; this will be measured by surveys conducted in the Toulminville community, reports from the local police department, and data from the two area high schools concerning marijuana related disciplinary actions.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Agency for Substance Abuse Prevention (ASAP)	Education	Individual/ Community	Too Good for Drugs	Boys and Girls' Clubs	330	AS, S	6th – 8th graders
	Environmental	Our target area is the West Anniston Area (predominantly African-American Community) and we are attempting to reduce the substance abuse (primarily alcohol and marijuana) in 13-18 year olds. Our focus has been to increase the awareness of parents concerning the dangers/problems associated with drug use/abuse and empower them with the knowledge, whereby they will assist us in reducing deviant attitudes and behaviors in their children. We attempt to do this by conducting: 1. We have facilitated several publicity campaigns promoting the responsible vender program which are geared toward the youth and/or merchants in the West Anniston Area. 2. Through the use of mail-outs, newsletters, etc., information concerning the laws relating to underage drinking, youth related DUI accidents and fatalities, and other drug use/abuse information will be sent to merchants that sell alcohol (beer and wine) in the targeted area, to increase their awareness and understanding of the problems associated with underage drinking. We also plan to collaborate with the local Alabama Beverage Control (ABC) Board to further promote the Responsible Vendor Program. 3. On-going radio media campaigns ("What Is Your Drug IQ?") utilizing ASAP Staff, teachers, parents, and students in our local popular radio stations. These spots are being played on nearly a daily basis to primarily educate parents about not only the dangers of drug use and abuse, but also, the importance of committed, parental involvement in their kid's lives. 4. Utilizing the local school in the target area to display Sports Info Banners (Anti-Drug Messages) at all of the home games, i.e., football, basketball, etc. 5. Working with schools in the target area to increase parental attendance and involvement in the PTO of their child's school.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Aletheia House	Alternative	Individual/Peer	Great Body Shop	A. G. Gaston Boys & Girls Club	50	W	9-13 yr olds
	Education	Community	Great Body Shop	3 Summer camps	30	S	9-13 yr olds
	Environmental	Change how the members of the target population live by organizing a coalition to address the issues relating to substance use and abuse in their communities. Change the level of legal substances (alcohol and tobacco) available to members of the target population by partnering with businesses in the selected communities to decrease sales to minors. Change the messages members of the target communities receive regarding substance use by producing counter-advertising via the radio, print media and through information dissemination at Parent Teacher Association (PTA)/Parent Teacher Organization (PTO) meetings, health fairs, etc. Change the social conditions in the target community by partnering with organizations in the community to sponsor substance free events.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
CED	Education	Individual/ Community	Too Good for Drugs	Boys and Girls' Club	390	AS	6^{th} – 8^{th} graders
	Alternative	Individual/ Community	Too Good for Drugs	Boys and Girls' Club	240	W, S	6^{th} – 8^{th} graders
	Environmental	We will continue our efforts to curb underage drinking by zeroing in on the Media Focus. In this focus we will direct our coalition efforts to reducing advertisements that prey on youth. We also work very closely with the Etowah County Children's Policy Council. Assistance will be given in the following areas: Safe and Healthy Etowah County lead-Town Hall Meetings, Help from our Mayor and City Council Members, Youth letter campaigns to the news editor, and Youth led efforts by our Students against Disruptive Decisions (SADD) organization. Because of the wishes of our coalition we will also work on Policy Changes to counteract the harm of secondhand smoke. We will accomplish this by: Continued participation in the Safe and Healthy Etowah County Coalition Meetings and Committees, Town Hall Meetings against Secondhand Smoke, PSA's to local media, and Support of Mayor and City Council.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Cheaha MHC	Alternative	Individual	Lifeskills, Too Good for Drugs & Violence	School, Church	10	AS	9 – 14 yr olds
	Education	Individual/ Family	Lifeskills, Too Good for Drugs & Violence	Elementary & Middle School	6	W	9 – 14 yr olds; family
	Environmental	Conduct media campaigns to educate parents, schools, businesses, law enforcement and policy makers, regarding legal issues related to sales of alcohol and tobacco to minors. Conduct media campaign to educate youth regarding legal and health related consequences of alcohol sales to minors. Develop community focus groups to increase awareness of alcohol and tobacco sales to minors. Conduct media campaigns to educate parents, schools, businesses, and policy makers, regarding underage alcohol and tobacco use. Conduct media campaigns to educate youth regarding legal and health consequences of alcohol and tobacco use. Develop youth advocacy groups to promote alcohol and tobacco free life styles/alternatives. Establish or strengthen a youth organization that promotes awareness of consequences of alcohol and tobacco use, i.e., S.A.D.D., FOCUS. In November of 2006 we became involved with the Sylacauga High School FOCUS Group. This is a group whose goal was to educate youth so that they can make informed choices regarding drugs, alcohol, tobacco and sex. Our first involvement was a health fair that they sponsored. We invited them to be a part of our coalition and we begin to become involved in their activities as a cosponsor of some of their events and meetings. This arrangement has continued through this year with successful events such as the Bill board contest and school wide educational events that spotlighted sales of alcohol to minors and the consequences of tobacco, alcohol and drugs. These events have been very successful and as a result feed back has been very positive from the FOCUS Group and sponsors. From all indications our partnership with FOCUS has encouraged the group to focus on the difficult issue of underage alcohol; tobacco and drug use and reach the school wide population therefore enhancing their goal of encouraging youth to make informed choices.					

		The Cheaha Prevention Advisory Group includes the following agencies: Sylacauga Police Department, Sylacauga Board of Education, Sylacauga Alliance for Family Enhancement and Cheaha Regional Mental Health Center, local ABC representatives and community citizens. Since that time we have been meeting almost every month and have expanded to include the Mayor of Sylacauga, various ministers, students from the high school, teachers as well as other community members. Our goal was to have a community advisory group that would work with us to gain direction for efforts to combat underage alcohol, tobacco and other drug use. Together we have accomplished several task including , Information dissemination projects such as tail gate parties, community fun events such skateboard competitions, youth involvement activities such as billboard contest with in the high school. School parties for student groups that were involved in Prevention campaigns. Vendor checks on local alcohol and tobacco vendors and vendor training sessions to educate the vendors regarding the sales of alcohol and tobacco to minors. Efforts are underway to pass an ordinance to require all new alcohol and tobacco vendors that apply for a license to have ongoing vendor training and be a part of the Responsible Vendor Program. Recently the coalition voted to start the process of having a comprehensive community wide summer camp for at risk kids in place by 2010.

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Jefferson County Committee for Economic Opportunity (JCCEO)	Education	Individual	Active Relationships for Young Adults (ARYA)	High School	11	DS	9th graders
	Alternative	Individual	Preventing the Abuse of Tobacco, Narcotics, Drugs and Alcohol (PANDA)	Elementary School	10	DS	Pre-school students mentored by 12th grade students
	Alternative	Individual/Group	ARYA	Community Center	45	S	14 – 17 yr olds
	Environmental	To raise community awareness of the seriousness of underage drinking, to motivate the community to change standards that allow for underage drinking, and to reduce underage drinking in the community. Develop youth groups to conduct at least three (2) drug awareness campaigns. Work with law enforcement to ensure merchants act responsibly to underage drinking. Develop two (2) youth group activities promoting alcohol-free lifestyles for students attending the community High School and summer camps. (Spring and summer)Conduct four (4) meetings including community leaders, parents and students, law enforcement, health and school officials to plan strategies.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Baldwin County Mental Health Center (MHC)	Education/ Information Dissemination	Individual	Too Good for Drugs, Stay Connected w/ your Teen	Foley, Fairhope, Daphne	550	DS, AS, S	6th – 7th graders
	Alternative	Individual	Too Good for Drugs & Violence, Stay. Conn. w/ your Teen	YMCAs, Boys and Girls' Club	350	AS	6th – 7th graders
	Alternative	Individual	Positive Action	Boys and Girls' Club, YMCAs	260	S	6th – 7th graders
	Environmental	Develop a youth advocacy group in Daphne and Fairhope within 6 months of plan approval. Maintain the youth advocacy group already in place in Foley. The focus of these groups will be to gather insight into the scope of underage drinking and to implement strategies to decrease underage drinking. The group will meet at least twice during FY08. Form a multi-agency subcommittee to research and implement a mass media campaign, with particular emphasis around Mardi Gras 2009 and Spring Break 2009. Core work group will include schools, youth advocacy groups, law enforcement, civic organizations, and religious entities. Utilize op-ed and/or letters to the editor for publication in newspapers circulated in the targeted communities. Implement a year long campaign to increase awareness among adults and youth regarding the possible negative consequences of using alcohol.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Madison County MHC	Education	Individual/ Parents	Keepin' It Real, LifeSkills	School Community Center	50	DS, S	6th graders
	Alternative	Individual/ Parents	Prevention Activities 101	School	10	AS, W, SB	6th graders
	Environmental	Facilitate at least six (6) public service announcements to educate students, parents, and the community of the access/availability of alcohol to underage drinkers and the risks of underage drinking. Facilitate messages for dissemination campaigns at least three (3) times by September 30, 2009 through churches in the Davis Hills Community. Conduct three (3) meetings of Davis Hills Community stakeholders to establish specific needs and to plan a strategy for the Davis Hills Community by March 2009. Develop an advocacy group of youth and parents to promote an alcohol-free lifestyle by facilitating awareness activities in the Davis Hills Community by January 31, 2009. Develop a strategic merchant education campaign by educating 50% of retailers in the Davis Hills Community by September 30, 2009.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Gateway	Education	Individual/ School/Family	Too Good for Drugs	School	250	DS, AS	10 – 14 yr olds
	Alternative	Individual	PROUD	Church	550	AS, S	10 – 14 yr olds
	Environmental	The environmental strategy will attempt to decrease the use of alcohol by minors in the Brighton community. Develop the capacity of youth to promote alcohol-free lifestyles by facilitating awareness activities. Educate the parents of the target population on the dangers of youth alcohol use. Counter advertise by providing public service announcements on the dangers and negative health effects of alcohol consumption by minors.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Mountain Lakes	Education	Individual	Al's Pals	Pre-school	1168	DS	Head Start Students
	Education	Individual	Here, Now and Down the Road	Community Center	79	AS	Parents
	Environmental	Our environmental plan is focused on Older Adults. Our initial program planning was based on two documents: "A Guide for Developing a Substance Abuse Awareness Program for Older Adults" and "Evidence-Based Practices for Preventing Substance Abuse and Mental Health Problems in Older Adults". In general, these documents support the thesis that the promotion of healthy lifestyles in older adults directly promotes substance abuse prevention. A community "Healthy Aging" workshop will be sponsored in conjunction with other LifeLong members. Continue to develop the lifelonghealthyliving.com website. The long-term goal of our environmental focus is to develop an NREPP recognized program, or programs, with an integrated environmental approach dealing with the reduction of alcohol misuse and medication misuse in older adults. It is noted that significant preparation work will be required in partnership building, program research and development, and community education to achieve this long-term goal.Continue our on-going research to identify effective programs for older adults. Continue to foster the development of LifeLong- the Healthy Aging Partnership of Marshall County which meets quarterly. We will partner with RSVP in the further promotion of the Silver Steppers program. Conduct one presentation each at the eight Senior Centers in Marshall County. These presentations will include appropriate information on alcohol misuse and medication misuse issues in older adults. An information booth on healthy aging in older adults will be sponsored at two senior events in Marshall County.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Cahaba MHC	Education/ Information Dissemination/ Environmental	Community	Closing the Gate	Schools, Churches, Youth Center	30	AS, S, W	Community
	Education	Individual	LifeSkills Training	Schools, Churches	30	DS, AS, S	7^{th} – 8^{th} graders
	Education	Individual	Too Good for Drugs	Schools, Churches	40	DS, AS, S	K – 5^{th} graders
	Education	Individual	Project ALERT	Schools, Churches	40	DS, AS, S	5 – 16 yr olds
	Education	Individual	LifeSkills for Parents	Schools, Churches	40	3 months	Parents
	Environmental	The Perry County Prevention Coalition will partner with the ABC Board to increase compliance checks and to strengthen the message of prohibiting alcohol sales to minors. The Coalition will encourage the local policy makers to establish a zero tolerance position regarding alcohol sales to youth. Closing the Gate will also monitor and report on the external environmental variables that may impact the success and viability of the prevention and intervention program.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
North Central	Education	Indiv/Peer	Safe Dates	School	105/yr	DS	7th-12th graders
	Alternative	Community	Safe Dates	School	17/yr	DS	7th-12th graders
	Environmental	Decrease underage drinking by youth ages 10 – 18 in Morgan, Lawrence, and Limestone County by increasing community awareness. Educate the community through mass media campaigns and awareness activities in targeted areas aimed at community norms related to underage drinking. Decrease sales of alcoholic beverages to minors in targeted areas by promoting responsible alcoholic beverage sales to adults. Assist retail vendors/merchants who sell alcoholic beverages in Morgan, Lawrence and Limestone counties to improve their sales practices.					

Provider	Strategy	Domain	Evidence-based Program	Program Location	# of Service Hours	Timeframe (During School, After School, Weekends, Summer, Spring Break)	Target Population
Lighthouse MHC	Environmental	To prevent underage alcohol use in youth ages 6-16 years old attending the Goode Street Community Center in the Weed and Seed Area. Reduce the accessibility of alcohol to minors by working with approximately 4 vendors within a 5 mile radius of the community center regarding the availability and placement of alcohol products in their stores. To establish 3 media messages from the community participants to air on local radio stations to serve as an anti-drug message for their peers.					

Curricula utilized:

Too Good for Drugs and Violence
Too Good for Drugs and Violence is a curriculum consisting of 14 core lessons and 12 additional lessons that can be integrated into the teaching of other school subjects. The program aims to promote pro-social skills, positive character traits, and violence- and drug-free norms among high school students. It includes a staff development component and optional family and community components.

Life Skills
Life skills Training is a highly rated, recommended and researched substance abuse prevention program today. Life Skills is designed for elementary and junior high school students and has been effective with white middle-class and ethnic-minority students in rural, suburban, and inner-city populations. Life Skills Training consists of three major components: Drug Resistance Skills, Personal Self-Management Skills, and General Social Skills. Drug Resistance Skills enable young people to recognize and challenge misconceptions about tobacco, alcohol, and other drug use.

Second Step
Second Step teaches skills in empathy, impulse control, problem solving, appropriate social behavior, and anger management. For example, in the unit on empathy, students learn to identify and predict the feelings of others and to provide an appropriate emotional response. In the impulse control unit, students learn problem-solving and communication skills, with a focus on how to handle and solve interpersonal conflict. In the anger management unit, students learn techniques for reducing stress and channeling angry feelings into constructive problem solving. The parent education program focuses on teaching these same skills to parents, as applied to parenting situations.

Staying Connected with Your Teen
Five session parenting series teaches parents and teens the skills they need to improve family communication and family bonding. It draws on extensive research that demonstrates the critical importance of parent involvement in reducing or inhibiting adolescent participation in antisocial behaviors.

Safe Dates
The Safe Dates curriculum is a nine-session program that targets attitudes and behaviors associated with dating abuse and violence. The curriculum consist of five components: a nine-session dating abuse curriculum, a play about dating abuse, a poster contest, parent materials, and teacher training outline. Each session is approximately fifty minutes in length. Safe Dates is designed to fit various schedule formats (e.g., daily or weekly programs). Reproducible student handouts are included at the end of each session.

Thirty two (32) community service providers encompass Alabama's prevention provider community. Twenty nine (29) providers are designated as the Alabama Council of Community Mental Health Boards and the remaining four (4) are non-profit 501 © 3 organizations whom provider direct prevention and treatment services. Alabama has four distinct regions. Central Alabama includes the area surrounding Montgomery, Auburn and Tuscaloosa. Recipient services expand around the Talladega National Forest and numerous State Parks. The Gulf Coast region encompasses the southernmost portion of the state, in the southwest Alabama. Mobile is the largest city in the region that houses the South Regional Clearinghouse. North Alabama includes the northern third of the state from Birmingham north. The Southeast portion of the state is referred to as the Wiregrass region that encompasses Dothan, Eufaula, Troy and Andalusia. The Mental Health Board's catchment areas cover the minimum of two to six counties in predominantly rural areas, with the exception of the four largest metropolitan areas of Montgomery, Mobile, Birmingham and Huntsville.

Historical funding continues to be the process by which providers receive funding for the set aside amount for the Block Grant. A Prevention Planning process is utilized to attain service information, goals and objectives from each community provider. Prevention Planning guidelines are required of each provider. **(Attachment 1)** Fifty percent (50%) of the funding allocation must be used for Environmental strategies and the remaining 50% is utilized primarily for Education and Alternative strategy activities. Providers whom receive less than $50,000 in funding primarily undertake goals and objectives around assessing policies and practices for Environmental

Recipients of services capacity to maintain qualified Prevention staff holds many challenges and barriers to service. These challenges include worker turnover, absence of professional Prevention backgrounds, diversity /choice of work-pool applicants, competitive pay/benefits, Organizational support, Organizational structure, low community attachment, transfer of learning/knowledge issues and other compelling barriers, that are specific to the region of the state.

Multiple risk factors exist within the state. The following risk factors are identified by the provider community to decrease in their respective service areas. **(See map in FFY 2010 Intended Use)** Five main priority risk factors encompass the bulk of the goals, objectives and activities represented in the charts.

Family Management Problems that involve curfew/loitering violations and run-away status youth that are considered unruly or have status offenses, meaning that only a youth can be charged with these violations haven risen in recent years. Both vandalism and disorderly conduct are specific delinquency offenses being monitored in all communities throughout Alabama. Prevention providers have increased partnerships and collaboration with community stakeholders to

identify this risk factor as a conduit to serve populations in schools and communities in urban, rural and suburban settings.

The Availability of Drugs in Alabama communities continues to be problematic, especially as noted in the attached Epidemiological Profile Data presented in the summary.

> The community-level epidemiological profile of substance use evaluates the consumption and consequences of alcohol, tobacco, and other drugs (ATOD) in Alabama by planning region. The Department of Mental Health and Mental Retardation has identified four planning regions that encompass the entire state and are used for allocating substance abuse block grant funds from the Substance Abuse and Mental Health Services Administration and identifying priority areas for services.

Alcohol

- The use of alcohol in Alabama is below the national average.
- Overall, alcohol consumption during the past month, alcohol consumption by friends, and binge drinking increased among Alabama youth as grade in school increased.
- Among youth 12-20 years old in Alabama, 25.9% reported consuming alcohol during the past month and 16.1% reported binge drinking.
- Among persons 12 years and older in Alabama, 6.1% abuse or are dependent on alcohol and 5.7% needed but did not receive treatment for alcohol abuse or dependence.

Tobacco

- The use of tobacco in Alabama is above the national average.
- Overall, tobacco use during the past month and tobacco use by friends increased among Alabama youth as grade in school increased.
- Among persons 12 years and older in Alabama, 28.2% reported smoking cigarettes during the past month and 34.4% reported using any tobacco products during the previous month.

- The age-adjusted incidence rate for lung and bronchus cancers was higher for Alabama compared to the national average. The mortality rates for lung and bronchus cancers and chronic lower respiratory diseases were also higher for Alabama compared to the national average.

Other Drugs

- The use of illicit drugs in Alabama is comparable to national averages.
- Marijuana use and current use of any other drugs increased as grade in school increased.
- Non-medical use of prescription drugs also increased as grade in school increased.
- Among persons 12 years and older in Alabama, 8.4% reported marijuana use during the past year; 5.3% reported non-medical use of prescription pain relievers during the past year; and 2.2% reported cocaine use during the past year.
- Among persons 12 years and older in Alabama, 2.9% abuse or are dependent on illicit drugs and 2.3% needed but did not receive treatment for illicit drug abuse or dependence.

Favorable Attitudes toward Problem Behavior is exemplified in rural, urban and suburban areas and those areas that have experienced economic downfalls since the 1970's. Prevention providers continue to mobilize community partners to improve their ability to identify and take responsible actions to address complex community problems. The Single State Authority has strongly recommended that providers collaborate with community partners to accomplish the following:

- Collaborate with community partners to identify key practical solutions that demonstrate sound Prevention practice that would improve a problematic family situation

- Develop strong partnerships to evaluate the consequences of alternatives to promote healthier choices for youth

- Integrate Prevention programming and practice with other available services to augment a comprehensive approach to needed services

- Demonstrate and facilitate the use of sound Prevention practice in community settings

- Demonstrate empathic and interpretive understanding of the family member's perspective feelings, the family as a whole and the community's need to create safe and healthy environments for youth and family members

- Demonstrate, find and use a variety of resources,, community experts, technology, print and media sources to address substance abuse prevention goals and objectives to address family cohesiveness

- Understand and demonstrate the ability to work with people of differing values, work styles, personalities, working through conflicts to complete the overall Prevention tasks in planning, organizing, servicing and evaluating sound prevention practice and services

- Apply principles of didactic learning, adult learning skills to facilitate effective education, awareness and community buy-in

Prevention Planning Guidelines

Prevention Plan Questions

1. Has the planning process changed to identify needs for services since the last fiscal year? If change has occurred, please explain how?
2. Specify the assessment tool(s) and/or data sources utilized to identify needs?
3. Specify if an evaluator was utilized to assist in the identification of needs.
4. What specific changes to the previous plan were made to focus on a smaller target population?
5. What specific enhancement of services will be made to facilitate multiple strategies, policies and practices within the target population?
6. Specify the identify needs which support the implementation of each program proposed.
7. Has it been determined whether community partners can be involved in leveraging service capacity? (capacity may entail personnel, equipment, logistics, funding, expertise, transportation, facilities)
8. How will risk factors be decreased within the target population during the fiscal year?
9. How will protective factors be increased within the target population during the fiscal year?
10. How many times since the inception of the Plan for prevention services (current fiscal year) has the prevention planning committee met? Please give date and meeting composition members.
11. What areas of concern have been discussed and reviewed by the prevention planning committee?
12. Do you have a State Incentive Grant (SIG) Unified Prevention System (UPS) Capacity Building grant in your catchment area? **N/A**
13. If the answer is yes, please specify discuss your involvement and identify the designated county.

14. If one of your counties is designated as an UPS grant, please skip to the Prevention Program Requirement section. Please submit only the Program proposal section only for the aforementioned county (UPS) and the explanation of your involvement with the county's prevention plan. **N/A**
15. Please ensure that the UPS coalition documentation plan reflects the input from the 310 Board. Define how the Substance Abuse Prevention & Treatment block Grant (SAPTBG) funding and UPS funding will be used to leverage, enhance and sustain programs within the catchment area. **N/A**
16. If you have additional counties that do not fall within the catchment area of the UPS grant, please specify your overall Plan updates.
17. Please discuss the Safe & Drug Free Schools funding in your area and how it affects your plan for prevention services.
18. How is the Department of Education "At Risk" funding being utilized? This information may be found at: http://www.alsde.home.asp Please direct your attention to the "Sections" link and proceed to "Prevention & Support Services" webpage.
19. Please identify whether you presently have Drug Free Communities funding in your counties. Please refer to http://www.ondcp.gov/dfc/
20. Does your county catchment area have Safe & Drug Free Schools funding for any prevention programs within any of the school systems. Are the funds being utilized for community programs? Does the prevention director/staff collaborate with the Safe & Drug Free Schools Coordinator? If so, how? Have both parties explored how current prevention programs be enhanced? Please explain.
21. Please attach meeting minutes as APPENDIX 1 (Questions 10 & 11) **N/A**

Attachment 1

Prevention Program Requirements

The Substance Abuse Prevention and Treatment Block Grant require that States give priority to prevention programs for populations that are at risk for developing a pattern of substance abuse. The SASD will provide funding for prevention programs that serve one or more of these priority populations, only:

- Children of Alcoholics/Substance Abusers
- Children with Conduct Disorders
- Delinquent Youth
- Gay/Lesbian/Bisexual/Transgender Youth
- Children with Mental Health Problems
- Children with Academic Problems
- Children Who Have Dropped Out of School
- Children Living in Public Housing
- Children Without Fathers/Mothers
- Children in Protective Services
- Children Who Test Positive for HIV
- Youth who Inject Drugs *(not assessed in need of treatment)
- Youth Who Trade Sex for Drugs
- Homeless Youth
- Youth Who Abuse Alcohol and/or Other Substances
- Pregnant Women/Teens
- Other

The "other" category is defined as the following categories:

- Hard to reach population that exhibit physical and/or mental vulnerability living outside of a formal placement environment.
- Hard to reach populations using English as a second language.
- Rural populations that represent two or more of the federal block grant categories.

- Students who attend "alternative educational settings."
- Students who attend schools those are on "alert" status.
- Special populations being served by specific juvenile justice programs.

Categories not listed above, must be approved before funding is allocated.

General Recommendations

Program Planning

The following program suggestions are described to enhance program structure and facilitate program outcomes:

1. Build comprehensive approaches with high risk populations. Collaborate with other community stakeholders who also service the population. Focus on multiple strategies across the prevention domains.
2. Individual/peer education alone will not produce outcomes. A clear risk factor must be identified within the target population.
3. High risk populations need continuity and intensive approaches.
4. Shared responsibility between and across community stakeholders will leverage resources and enhance program design.
5. Use data to assess what domains have deficiencies and gaps.
6. Have a clear understanding of the domains and risk/protective factors with the identified target population.
7. Use a "layer approach" via working with other community partners to provide needed services.
8. A layered approach may involve several different types of services offered simultaneously to a target population. (i.e. counseling services coupled with family strengthening and alternative programs). Mentoring /tutoring combined with the initiation of a "Safe School policy as an environmental approach.

9. School locations are not the best approach for prevention services; they only have limited effect on the individual/peer domain. In order for the approach to be targeted and comprehensive, other strategies need to be utilized with the same population. Risk and protective factors are always predictive in scope. A broad based school approach will be solely "broad" with low intensity and impact for change.
10. After school patterns and supervision of children and adolescents must always be taken into consideration, especially if communities have high risk attributes.
11. The use of substances occurs before, after, during the weekend and during the summer months.
12. Multiple strategies and policies need to be targeted to a specific population and community to facilitate effective prevention programs. (i.e. smoking education program for children, parents coupled with a strategy for a smoking ordinance/policy).

FFY 2010 (Intended Use)

The two risk factors (Early & Persistent Antisocial Behavior and Community Laws Favorable to Drug Use & Crime are being identified by providers to decrease in their attempt to facilitate Environmental strategies that address access, availability and policies/practices. Historically, Alabama has started and stopped in the areas of 1) Clean Air Laws, 2) Taxes on Products, and 3) Mandated Compliance Checks. Prevention providers are exploring the importance of the history of Environmental strategies (laws, statues, ordinances) that have assisted in the attempt to move "Community Change" toward population based level change versus individual change. Enhancement of Environmental efforts will play an important role in establishing systemic change for the future. This concept is an immensely difficult paradigm shift in the state of Alabama. Historically, prevention staff has spent many manpower hours to engage and join with consumers to provide numerous hours in the Educational strategy areas of service provision. In the past, providers have facilitated numerous services around information/sharing, performing enhanced skills and education and providing support. All of these strategies involve Education and Awareness activities that are individual/peer focused. In order for Alabama providers to evoke population based level change, efforts are slowly moving toward Environmental practices that look at the following areas for sustained community change through:

- Enhancing Access/Availability strategies in communities;
- Changing consequences strategies in communities;
- Changing the physical design of outlets, stores and entertainment venues; and
- Modifying/Changing policies and practices

In addition, it is imperative that providers utilize a comprehensive approach to service provision. This is currently a challenge as "old habits are hard to break". The strength of Environmental strategies for the state of Alabama is to empower communities to utilize the following techniques of Policy, Enforcement, Communication, Collaboration and Education to change the factors in communities that will be more long-standing and sustainable over time. Environmental strategies are not intended to replace prevention efforts targeted at individuals; rather they need to be utilized in conjunction with individual interventions to promote far more positive and sustained outcomes.

Individual Prevention Strategies

- Designed to change the individual's attitudes or behaviors relating to ATOD use.
- Programs may be run in schools, churches, or community-based organizations.
- Educate youth about the harmful effects of ATOD, teach life skills, and build resiliency.

Environmental Prevention Strategies

- Designed to change the social, political, and economic context where ATODs are used.
- Strategies may be developed and implemented through various sectors in the community.
- Involves changing availability of ATODs, laws and policies, and community norms.

The following risk factors represent the array of factors that encompass all communities currently receiving services; however the five (5) aforementioned risk factors are the predominant factors that are currently being addressed and reported in the Alabama Substance Abuse Information System (ASAIS).

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing
- Chronic medical and/or physical condition
- Cognitive and neurological deficits/Low intelligence quotient/Hyperactivity
- Early onset of aggression and/or violence
- Early sexual involvement
- Favorable attitudes toward drug use/Early onset of AOD use/ Alcohol and/or drug use
- Gun possession/Illegal gun ownership and/or carrying
- Lack of guilt and empathy
- Life stressors
- Mental disorder/Mental health problem/Conduct disorder
- Poor refusal skills
- Teen parenthood
- Victimization and exposure to violence

Family

- Broken home
- Child victimization and maltreatment
- Family history of the problem behavior/Parent criminality
- Family management problems/Poor parental supervision and/or monitoring
- Family transitions
- Family violence
- Having a young mother
- Low parent college expectations for child
- Low parent education level/illiteracy
- Maternal depression
- Parental use of physical punishment/Harsh and/or erratic discipline practices

- Pattern of high family conflict
- Poor family attachment/Bonding
- Sibling antisocial behavior

School

- Dropping out of school
- Frequent school transitions
- Identified as learning disabled
- Inadequate school climate/Poorly organized and functioning schools/Negative labeling by teachers
- Low academic achievement
- Low academic aspirations
- Negative attitude toward school/Low bonding/Low school attachment/Commitment to school School suspensions
- Truancy/Frequent absences

Peer

- Association with delinquent and/or aggressive peers
- Gang involvement/Gang membership
- Peer alcohol, tobacco, and/or other drug use
- Peer rejection

Community

- Availability of alcohol and other drugs
- Availability of firearms
- Community crime/High crime neighborhood
- Community instability
- Economic deprivation/Poverty/Residence in a disadvantaged neighborhood
- Feeling unsafe in the neighborhood
- Low community attachment
- Neighborhood youth in trouble
- Social and physical disorder/Disorganized neighborhood

Protective Factors

Individual

- High individual expectations
- Perception of social support from adults and peers
- Positive/Resilient temperament
- Positive expectations/Optimism for the future
- Self-efficacy

- Social competencies and problem-solving skills

Family

- Effective parenting
- Good relationships with parents/Bonding or attachment to family
- Having a stable family
- Healthy/Conventional beliefs and clear standards
- High family expectations
- Opportunities for prosocial family involvement
- Presence and involvement of caring, supportive adults
- Religiosity/Involvement in organized religious activities
- Rewards for prosocial family involvement

School

- Above average academic achievement/Reading and math skills
- High expectations of students
- High-quality schools/Clear standards and rules
- Opportunities for prosocial school involvement
- Presence and involvement of caring, supportive adults
- Rewards for prosocial school involvement
- Strong school motivation/Positive attitude toward school
- Student bonding (attachment to teachers, belief, commitment)

Peer

- Good relationship with peers
- Involvement with positive peer group activities
- Parental approval of friends

Community

- Clear social norms/Policies with sanctions for violations and rewards for compliance
- High community expectations
- Nondisadvantaged neighborhood
- Prosocial opportunities for participation/Availability of neighborhood resources
- Rewards for prosocial community involvement
- Safe environment/Low neighborhood crime

Protective factors are safeguards that enhance a young person's ability to resist risks or hazards and promote resiliency and good decisions. Like risk factors, protective factors are the responsibility of individuals, families, communities and institutions. Prevention providers in Alabama are utilizing stakeholder's

partnerships with colleagues and agencies to work jointly on engaging family and the community at large. The Office of Prevention has stressed the need to engage community wide stakeholders in the overall process of the needs and strengths of community data when tackling problematic issues that overlap all human service agencies.

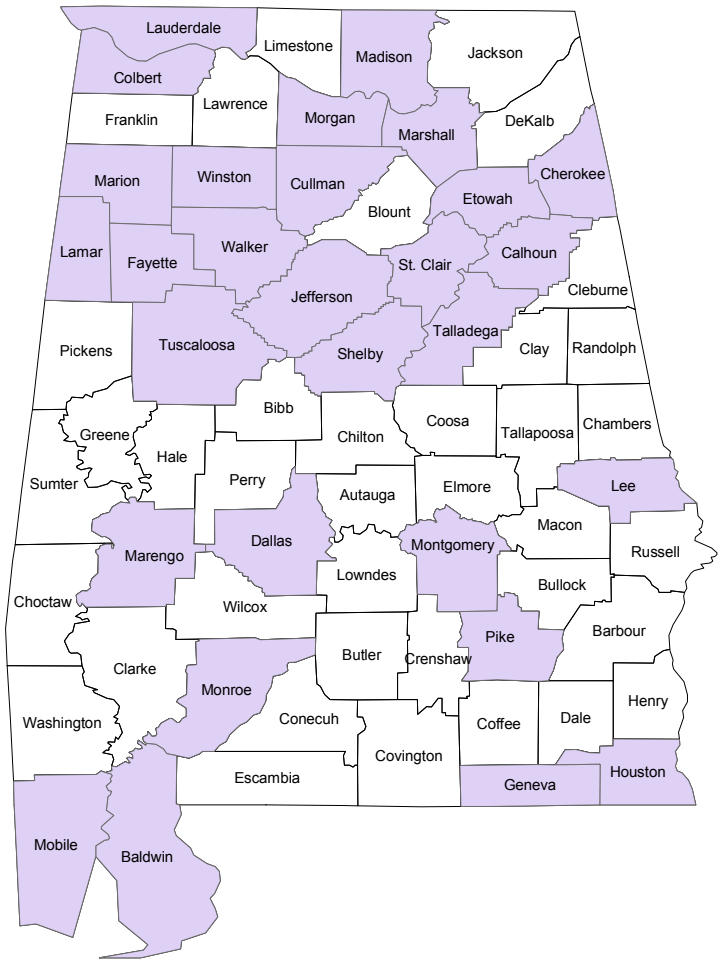
Increasing protective factors helps youth to make better decisions, confront obstacles and find the supports they need. They prevent, diminish or confront risk factors and provide a way back to a healthy lifestyle.

A caring adult and community who take the time to make a real connection can play a very significant role in a young person's life and others. "Facilitating Prevention in a vacuum does not promote wise decisions around funding and service provision. The Systems Improvement Initiative has identified several areas that have led to the technical assistance of Johnson, Bassin & Shaw to assist the state with assessing the entire Prevention system (state & community infrastructure & capacity). This process will undoubtedly impact how Providers facilitate services in the future and how services will be expanded and definitely how they will be enhanced to serve areas that currently receive no services.

A review of all Community service providers of prevention programs have exhibited that the majority of set-aside funding designated for Education and Alternatives strategies (50%) is currently utilized predominantly with children and youth. Providers have been exposed to the need to assess Prevention needs "Across the Lifespan". Again, traditional methods to provide Prevention services have been much ingrained in communities across Alabama. Those youth whom received ongoing services whereas a "comprehensive approach" is evident have shown positive youth development, exhibited significantly fewer school absences; better school attitudes and behavior; less drug and alcohol use, especially minority youth; less likelihood of hitting others; less likelihood of committing crimes; more positive attitudes toward their elders and toward helping; and improved parental relationships and support from peers. Research shows that youth who feel more supported and connected to caring adults in a community program are more likely to make healthy decisions around substance issues. Alabama has special populations whom need Prevention services; however the following issues first must be addressed to move the Systems Improvement Initiative in Prevention forward:

- Workforce Development Priorities
- Funding Mechanism of allocating funding
- Community Awareness & Buy-in for Mobilization efforts
- State Infrastructure Assessment
- Formulation/Finalization of a State Prevention Plan
- Transfer of Knowledge and Prevention Practice to the communities/organization
- State Capacity

Prevention Services
County-by-County
2008-2009



Shaded areas indicate Prevention Services

Prevention Providers by Region

M - 1	Region 1	Counties: Lauderdale, Colbert, Franklin	1. Riverbend MHC
M - 2	Region 1	Counties: Limestone, Lawrence, Morgan	1. MHC of North Central AL (QUEST)
M - 3	Region 1	Counties: Madison	1. Huntsville-Madison MHC
M - 4	Region 1	Counties: Fayette, Lamar, Marion, Walker, Winston	1. Northwest Alabama MHC
M - 5	Region 2	Counties: Jefferson, Blount, St. Clair	1. Aletheia House, Inc. 2. ARS 3. Gateway 4. JCCEO 5. Mental Health Authority 6. Oakmont Center 7. UAB
M - 6	Region 1	Counties: Dekalb, Cherokee, Etowah	1. CED MHC 2. Cherokee County SA Council
M – 7	Region 2	Counties: Calhoun, Cleburne	1. ASAP 2. Calhoun-Cleburne MHC
M – 8	Region 2	Counties: Bibb, Pickens, Tuscaloosa	1. Indian Rivers MHC (Insight Center)
M – 9	Region 2	Counties: Talladega, Clay, Randolph, Coosa	1. Cheaha MHC
M – 10	Region 3	Counties: Choctaw, Greene, Hale, Marengo, Sumter	1. West Alabama MHC
M – 11	Region 2	Counties: Chilton, Shelby	1. Chilton Shelby MHC
M – 12	Region 3	Counties: Chambers, Lee, Tallapoosa, Russell	1. East Alabama MHC
M – 13	Region 3	Counties: Dallas, Perry, Wilcox	1. Cahaba Center for Mental Health
M – 14	Region 3	Counties: Montgomery, Autauga, Elmore, Lowndes	1. Council on SA 2. Lighthouse 3. Montgomery Area Mental Health Authority
M – 15	Region 3	Counties: Macon, Pike, Bullock	1. East Central MHC
M – 16	Region 4	Counties: Mobile, Washington	1. Drug Education Council 2. Altapointe Health Systems 3. Franklin Primary
M – 17	Region 4	Counties: Clarke, Conecuh, Escambia, Monroe	1. Southwest Alabama MHC
M – 18	Region 4	Counties: Butler, Coffee, Covington, Crenshaw	1. South Central MHC **
M – 19	Region 4	Counties: Dale , Geneva, Henry, Barbour, Houston	1. Wiregrass MHC
M – 20	Region 1	Counties: Jackson, Marshall	1. Mountain Lakes Behavioral Healthcare
M – 21	Region 4	County: Baldwin	1. Baldwin County MHC
M - 22	Region 1	County: Cullman	1. Cullman MH Authority 2. North Central Alabama SA Council

** Provider no longer provides prevention services

State: Alabama

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

(●) Yes ( ) No ( ) Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

(●) Yes ( ) No ( ) Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
(●) Yes	( ) Yes	(●) Yes
( ) No	(●) No	( ) No
( ) Unknown	( ) Unknown	( ) Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

(●) Yes ( ) No ( ) Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	(●) Yes	( ) No	( ) Unknown
Dissemination of materials?	(●) Yes	( ) No	( ) Unknown
Media campaigns?	(●) Yes	( ) No	( ) Unknown
Product pricing strategies?	(●) Yes	( ) No	( ) Unknown
Policy to limit access?	(●) Yes	( ) No	( ) Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

(●) Yes ( ) No ( ) Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as:

(HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○ Yes ◉ No ○ Unknown
New product pricing:	○ Yes ◉ No ○ Unknown
New taxes on alcoholic beverages:	○ Yes ◉ No ○ Unknown
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○ Yes ◉ No ○ Unknown
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○ Yes ◉ No ○ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	◉	○	○
Alcohol	○	◉	○	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older?	0.08
Motor vehicle drivers under age 21?	0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 4

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

○ Yes ◉ No ○ Unknown

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the SAPT BG 2007 expenditure period. The SASD continued to support a network of substance abuse treatment programs and services designed to meet the needs of pregnant women and women with dependent children.

The following activities were identified in the 2007 SAPT BG application.

Reported Activity: Identify $2,252,822 of the SAPT BG for the provision of specific services to pregnant women and women with dependent children.

Result: Accomplished. A total of $2,556,405 was identified in fund code 0001-217-8061-1297-1100 and expended through contracts for Special Women's Services to the following certified community programs.

IOP = Intensive Outpatient
RES = Residential
PREG = Pregnant
POST = Post Partum

Program	Service	County	Region
Bibb, Pickens, Tuscaloosa MHC	IOP	Tuscaloosa	2
Cahaba MHC	IOP	Dallas	3
East Alabama MHC	IOP	Lee	3
Mobile MHC	IOP	Mobile	4
Alcohol and Drug Treatment	RES/PREG/POST	Jefferson	2
Aletheia House	RES/PREG/POST	Jefferson	2
UAB	IOP	Jefferson	2
Lighthouse Counseling	IOP	Montgomery	3
North Central MHC	IOP	Morgan	1
Southwest MHC	IOP	Monroe	4
SA Council of N.W. SL	IOP/RES/PREG/POST	Franklin	1

Reported Activity: Identify the services that are to be purchased with the funding for Special Women's Services.

Result: Accomplished. The following specific services for pregnant women and women with dependent children were defined and included in the SASD Contract Billing Manual (Goal #1-Attachment #1) and included in the Billing and Accounting System since 1993. The definitions are modified as needed. The following definitions were included in the Contract Billing Manual that applied to the SAPT BG 2007 expenditure period.

1. Residential Treatment for Pregnant and Post Partum Women: A residential service for pregnant and post partum women and their children that provides around the clock awake staff, continuously available on-site emergency medical assistance, a structured and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day, seven day per week full-time living arrangement which offers child dare, linkages with educational opportunities, job placement and referral.

2. Residential Rehabilitation – Pregnant Women: A residential service for pregnant women that provides around the clock awake staff, monitoring by a LPN or equivalent or higher credentialed individual, a peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day seven day a week full-time living arrangement which offers child care, linkage with educational opportunities, job placement and referral.

3. Intensive Outpatient/Outpatient Services Specialized Women's Program's Only: Chemical dependency treatment services and intensive therapeutic activities provided to pregnant women and women with dependent children which are

designed to initiate and promote a client's status free of chemicals of abuse. The program must provide a standard psycho-social assessment, gender-specific substance abuse education, gender specific substance abuse therapy , group, family and individual, supportive counseling/education and detoxification, if needed.

4. Ancillary Services Specialized Women's Programs Only: Other services that must be provided or made available along with therapeutic activities for pregnant women and women with dependent children. These services include a combination of : 1. parenting, 2. child care, 3. transportation, if needed.

5. In-home Intervention Pregnant Women and Women w/Dependent Children: Time limited, home based services provided by a treatment team (two-person team, one master's level substance abuse professional and one person with a bachelor's level degree) to diffuse an immediate crisis situation, stabilize the family unit, and prevent out-of-home placement of the client. Key service function include as necessary:

a. individual/family counseling;
b. crisis management (24 hour availability);
c. parent/guardian significant other training;
d. linkage to other community resources;
e. education and reinforcement of recovery skills; and
f. didactic substance abuse education.

Reported Activity: Specify this funding by creating separate funding and service codes.

Result: Accomplished. Funding for Special Women's Services is distinguished in the Accounting System as 0001-217-8061-1297-1100. "1297" indicates SAPT BG, Special Women's Services funding and the last digit indicates the SAPT BG award year.

The following service codes were used to specify Special Women's Services in the SASD Billing and Reporting System (SUDS).

Residential Treatment	5991 & 5992
Residential Rehabilitation	5331 & 5332
Intensive Outpatient	5411 plus fund code 601
	5412 plus fund code 601
Ancillary Services	6001 & 6002
In-Home Intervention	5901 & 5902

Reported Activity: Enter into contracts for the provision of the specified services.

Result: Accomplished. Contracts were developed, agreed to and implemented which clearly defined Special Women's Services, service codes, reimbursement rates and clinical and financial eligibility criteria (SASD Contract Exhibits, Goal #1-Attachment #2). During the SAPT BG 2007 expenditure period the following contracts were implemented.

Program	Amount	County	Region
Alcohol and Drug Treatment	$ 692,232	Jefferson	2
Aletheia House	409,729	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	126,031	Tuscaloosa	2
Cahaba MHC	157,068	Dallas	3
East Alabama MHC	142,601	Lee	3
Lighthouse Counseling	140,346	Montgomery	3
Mobile MHC	136,320	Mobile	4
North Central MHC	224,025	Morgan	1
Riverbend MHC	187,996	Lauderdale	1
Southwest MHC	99,145	Monroe	4
SA Council of N.W. AL	103,746	Franklin	1
UAB	137,166	Jefferson	2

Total $2,556,405

Reported Activity: Monitor service provision through the normal contracting and service reporting systems.

Result: Accomplished. During the 2007 SAPT BG expenditure period, all contracts were monitored through the SASD Billing and Reporting System (SUDS). However, the monitoring was limited to billing and reporting data elements and specific identified financial and clinical criteria that could be identified in SUDS.

FY 2009 (PROGRESS)

Reported Activity: Identify $2,556,405 of the SAPT BG for the provision of specific services to pregnant women and women with dependent children.

Current Status: A total of $2,556,405 was identified in fund code 0001-217-8061-1299-1100 and contracted for Special Women's Services to the following certified community programs.

IOP = Intensive Outpatient
RES = Residential
PREG = Pregnant
POST = Post Partum

Program	Service	County	Region
Bibb, Pickens, Tuscaloosa MHC	IOP	Tuscaloosa	2
Cahaba MHC	IOP	Dallas	3
East Alabama MHC	IOP	Lee	3
Mobile MHC	IOP	Mobile	4
Alcohol and Drug Treatment	RES/PREG/POST	Jefferson	2
Aletheia House	RES/PREG/POST	Jefferson	2
UAB	IOP	Jefferson	2
Lighthouse Counseling	IOP	Montgomery	3
North Central MHC	IOP	Morgan	1
Southwest MHC	IOP	Monroe	4
SA Council of N.W. SL	IOP/RES/PREG/POST	Franklin	1

Reported Activity: Identify the services that are to be purchased with the funding for Special Women's Services.

Current Status: The following specific services for pregnant women and women with dependent children were defined and included in the SASD Contract Billing Manual (Attachment #1) and included in the Billing and Accounting System since 1993. The definitions have been modified as needed. The following definitions were included in the Contract Billing Manual that applied to the SAPT BG 2009 expenditure period.

1. Residential Treatment for Pregnant and Post Partum Women: A residential service for pregnant and post partum women and their children that provides around the clock awake staff, continuously available on-site emergency medical assistance, a structured and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day, seven day per week full-time living arrangement which offers child dare, linkages with educational opportunities, job placement and referral.

2. Residential Rehabilitation – Pregnant Women: A residential service for pregnant women that provides around the clock awake staff, monitoring by a LPN or equivalent or higher credentialed individual, a peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day seven day a week full-time living arrangement which offers child care, linkage with educational opportunities, job placement and referral.

3. Intensive Outpatient/Outpatient Services Specialized Women's Program's Only: Chemical dependency treatment services and intensive therapeutic activities provided to pregnant women and women with dependent children which are designed to initiate and promote a client's status free of chemicals of abuse. The program must provide a standard psycho-social assessment, gender-specific substance abuse education, gender specific substance abuse therapy , group, family and individual, supportive counseling/education and detoxification, if needed.

4. Ancillary Services Specialized Women's Programs Only: Other services that must be provided or made available along with therapeutic activities for pregnant women and women with dependent children. These services include a

combination of : 1. parenting, 2. child care, 3. transportation, if needed.

5. In-home Intervention Pregnant Women and Women w/Dependent Children: Time limited, home based services provided by a treatment team (two-person team, one master's level substance abuse professional and one person with a bachelor's level degree) to diffuse an immediate crisis situation, stabilize the family unit, and prevent out-of-home placement of the client. Key service function include as necessary:
a. individual/family counseling;
b. crisis management (24 hour availability);
c. parent/guardian significant other training;
d. linkage to other community resources;
e. education and reinforcement of recovery skills; and
f. didactic substance abuse education.

Reported Activity: Specify this funding by creating separate funding and service codes.

Current Status: Funding for Special Women's Services is distinguished in the Accounting System as 0001-217-8061-1299-1100. "1299" indicates SAPT BG, special Women's funding and the last digit indicates the SAPT BG award year.

The following service codes are used to specify Special women's Services in the SASD Alabama Substance Abuse Information System (ASAIS).

Residential Treatment	5990/H2036 HD
Residential Rehabilitation	5330/H2034 HD
Intensive Outpatient	5410/H0015
Ancillary Services	6000/T1009
In-Home Intervention	5900/H2011 HF

Reported Activity: Enter into contracts for the provision of the specified services.

Current Status: Contracts were developed, agreed to and implemented which clearly defined Special Women's Services, service codes, reimbursement rates and clinical and financial eligibility criteria. During the SAPT BG 2009 expenditure period the following contracts were implemented.

Program	Amount	County	Region
Alcohol and Drug Treatment	$1,043,716	Jefferson	2
Aletheia House	421,201	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	129,560	Tuscaloosa	2
Cahaba MHC	161,466	Dallas	3
East Alabama MHC	146,594	Lee	3
Lighthouse Counseling	144,276	Montgomery	3
Mobile MHC	140,137	Mobile	4
North Central MHC	230,298	Morgan	1
Southwest MHC	101,921	Monroe	4
SA Council of N.W. AL	299,911	Franklin	1
UAB	141,007	Jefferson	2
Total	$2,960,087		

Reported Activity: Monitor service provision through the normal contracting and service reporting systems.

Current Status: During the 2009 SAPT BG expenditure period all contracts are being monitored through ASAIS. However, the monitoring is limited to billing and reporting data elements and specific identified financial and clinical criteria that are identified in ASAIS.

FY 2010 (INTENDED USE)

Introduction: The goal during FY 2010 is to treat more pregnant women and women with dependent children, expand the levels of care available and expend more than was spent in FY 1994 for this population. The SASD will implement expanded ASAM levels of care, encourage evidence-based services and promote easy access for substance abusing women who are pregnant and/or have dependent children. Services will include: Residential Treatment for Pregnant and Post Partum Women, Residential Rehabilitation-Pregnant Women, Intensive Outpatient/Outpatient Services Specialized Women's Programs Only, Ancillary Services Specialized Women's Programs Only, and In-home Intervention Pregnant Women and Women w/Dependent Children. The SASD's contracts, billing manual and certification standards will continue to require funded providers to recognize individual client treatment needs and ensure treatment interventions are congruent with needs consistent with race, ethnicity, age, gender, sexual preference, religious affiliation, housing, employment, as well as physical and sexual abuse histories.

Who will be served: It is anticipated that approximately two hundred and fifty pregnant women and women with dependent children will be treated in all the programs throughout the state.

What Activities/Services will be Provided: The following services for pregnant women and/or women with dependent children will be provided through contracts with certified providers during FY 2010.

1. Residential Treatment for Pregnant and Post Partum Women: A residential service for pregnant and post partum women and their children that provides around the clock awake staff, continuously available on-site emergency medical assistance, a structured and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day, seven day per week full-time living arrangement which offers child dare, linkages with educational opportunities, job placement and referral.

2. Residential Rehabilitation – Pregnant Women: A residential service for pregnant women that provides around the clock awake staff, monitoring by a LPN or equivalent or higher credentialed individual, a peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day seven day a week full-time living arrangement which offers child care, linkage with educational opportunities, job placement and referral.

3. Intensive Outpatient/Outpatient Services Specialized Women's Program's Only: Chemical dependency treatment services and intensive therapeutic activities provided to pregnant women and women with dependent children which are designed to initiate and promote a client's status free of chemicals of abuse. The program must provide a standard psycho-social assessment, gender-specific substance abuse education, gender specific substance abuse therapy , group, family and individual, supportive counseling/education and detoxification, if needed.

4. Ancillary Services Specialized Women's Programs Only: Other services that must be provided or made available along with therapeutic activities for pregnant women and women with dependent children. These services include a combination of : 1. parenting, 2. child care, 3. transportation, if needed.

5. In-home Intervention Pregnant Women and Women w/Dependent Children: Time limited, home based services provided by a treatment team (two-person team, one master's level substance abuse professional and one person with a bachelor's level degree) to diffuse an immediate crisis situation, stabilize the family unit, and prevent out-of-home placement of the client. Key service function include as necessary:

g. individual/family counseling;
h. crisis management (24 hour availability);
i. parent/guardian significant other training;
j. linkage to other community resources;
k. education and reinforcement of recovery skills; and
l. didactic substance abuse education.

When will the Activities/Services be Implemented: The FY 2010 funding cycle is October 1, 2009 through September

30, 2010.

Where in the State will the Activities/Services be Undertaken:

Program	Amount	County	Region
Alcohol and Drug Treatment	$1,043,716	Jefferson	2
Aletheia House	421,201	Jefferson	2
Bibb, Pickens, Tuscaloosa MHC	129,560	Tuscaloosa	2
Cahaba MHC	161,466	Dallas	3
East Alabama MHC	146,594	Lee	3
Lighthouse Counseling	144,276	Montgomery	3
Mobile MHC	140,137	Mobile	4
North Central MHC	230,298	Morgan	1
Southwest MHC	101,921	Monroe	4
SA Council of N.W. AL	299,911	Franklin	1
UAB	141,007	Jefferson	2
Total	$2,960,087		

These services for pregnant women and women with dependent children will be operationalized as follows. All contract providers will utilize the SASD’s placement, procurement and data reporting criteria including: screening, assessment, level of care determination, priority populations, and service definitions as required in the Contract Billing Manual, Contract, and Certification Standards. All requirements will be monitored through on-site visits and data reporting requirements.

In addition to the previously mentioned monitoring processes, the SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2). This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG application.

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds: Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2007. In a narrative of **up to two pages**, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependent Children.

Part I: Description of Services Provided in FFY 2007.

1. The following programs are listed on FORM 06.

NFR ID# AL750405 Alcoholism Recovery Service, Birmingham $ 692,232
NFR ID# AL300037 Aletheia House, Birmingham 409,729
NFR ID# AL900091 Bibb, Pickens, Tuscaloosa, 126,031
NFR ID# AL302108 Cahaba MHC, Selma 157,068
NFR ID# AL900612 East Alabama MHC, Opelika 142,601
NFR ID# AL301407 Lighthouse Counseling, Montg. 140,346
NFR ID# AL901206 Mobile MHC, Mobile 136,320
NFR ID# AL900117 North Central MHC, Decatur 224,025
NFR ID# AL900513 Southwest MHC, Monroeville 99,145
NFR ID# AL100668 SA Council NW AL 103,746
NFR ID# AL900778 Riverbend MHC, Florence 187,996
NFR ID# AL100049 UAB, Birmingham 137,166
Total $ 2,556,405

In the 1997 Block Grant Application, FORM 06, the Entity Inventory included the programs as identified previously. The only program that provided services that qualified to be considered Special Services for Pregnant Women and Women with Dependent Children¿ prior to SFY 1996-97 was Aletheia House, NFR ID # AL 300037. Aletheia House received $92,200 for the provision of residential services to pregnant women and women with dependent children, although this was not the only service Aletheia House provided. This $92,200 provided to Aletheia House established the base upon which Special Services to Pregnant Women and Women with Dependent Children were expanded.

The Aletheia House in Birmingham provides supportive housing to meet the unique needs of pregnant addicted women. While living in this housing the women attend sixty days of intensive outpatient treatment and are also provided prenatal care and special instruction on nutrition, health care, basic education, parenting, the development of daily living skills and are transported to support group meetings. The women are allowed to remain in the pregnancy program for up to three months after the birth of the baby. Special rooms are provided for mother and child.

1. The data for programs for FY 2007 are above.

2. Alabama ensured compliance with Section 1916 (c) (14) by funding these programs, and by exploring implementation of additional services.

3. The State monitored the programs through on-site visits, evaluation of the service data submitted and through the statewide waiting list for residential treatment. In addition, a Women¿s Services Task Group was established to keep abreast of innovative treatment methods, effective outreach and retention for women in treatment as well as effective prevention programs for women. The Task Group, consisting of treatment providers, prevention providers, and state personnel, also functioned as an advisory committee to the SASD.

4. The SASD established a statewide waiting list for residential treatment. This information is compared to the number of bed days required in residential treatment and the number of beds allocated to women by the program description of each of our providers of residential services. These methods provide an estimate of treatment capacity and utilization. Pregnant women are given a priority status on waiting lists.

5. The State created a priority treatment rating scale establishing pregnant women as a number one priority and women with dependent children as a number two priority to assure access to treatment for these women.

Attachment B: Programs for Women (contd.)

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2007 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2007 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B: Programs for Pregnant Women and Women with Dependent Children.

Part I: Description of Services Provided in FFY 2007.

1. The following programs are listed on FORM 06.

NFR ID# AL750405 Alcoholism Recovery Service, Birmingham $ 692,232
NFR ID# AL300037 Aletheia House, Birmingham 409,729
NFR ID# AL900091 Bibb, Pickens, Tuscaloosa, 126,031
NFR ID# AL302108 Cahaba MHC, Selma 157,068
NFR ID# AL900612 East Alabama MHC, Opelika 142,601
NFR ID# AL301407 Lighthouse Counseling, Montg. 140,346
NFR ID# AL901206 Mobile MHC, Mobile 136,320
NFR ID# AL900117 North Central MHC, Decatur 224,025
NFR ID# AL900513 Southwest MHC, Monroeville 99,145
NFR ID# AL100668 SA Council NW AL 103,746
NFR ID# AL900778 Riverbend MHC, Florence 187,996
NFR ID# AL100049 UAB, Birmingham 137,166
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In the 1997 Block Grant Application, FORM 06, the Entity Inventory included the programs as identified previously. The only program that provided services that qualified to be considered Special Services for Pregnant Women and Women with Dependent Children prior to SFY 1996-97 was Aletheia House, NFR ID # AL 300037. Aletheia House received $92,200 for the provision of residential services to pregnant women and women with dependent children, although this was not the only service Aletheia House provided. This $92,200 provided to Aletheia House established the base upon which Special Services to Pregnant Women and Women with Dependent Children were expanded.

The Aletheia House in Birmingham provides supportive housing to meet the unique needs of pregnant addicted women. While living in this housing the women attend sixty days of intensive outpatient treatment and are also provided prenatal care and special instruction on nutrition, health care, basic education, parenting, the development of daily living skills and are transported to support group meetings. The women are allowed to remain in the pregnancy program for up to three months after the birth of the baby. Special rooms are provided for mother and child.

1. The following programs are listed on Form 6 in column 5a.

The Alcohol and Drug Abuse Treatment Program is registered as NFR ID# AL750405, is located in Birmingham, which is in SASD Planning Region #2. Residential special women's services are provided to women and their children through Olivia's House, which is a component of the total program. The SASD has a contract with the Alcohol and Drug Abuse Treatment Program for the provision of special women's residential services for SFY 2009-2010 of $692,232. Olivia's House has the capacity to house 30 individuals on any day.

The Aletheia House is registered as NFR ID# AL300037, is located in Birmingham, which is in SASD Planning Region #2. Residential services are provided to pregnant women and women with dependent children. The SASD has a contract with Aletheia House for the provision of special women's residential services for SFY 2009-2010 of $409,729. Aletheia House has the capacity to house 10 individuals on any day.

The Substance Abuse Council of Northwest Alabama is registered as NFR ID# AL100668, is located in Rogersville, which is in SASD Planning Region #1. Residential services are provided to women and their children through the Freedom House, which is a component of the Substance Abuse Council of Northwest Alabama. The Council also provides special women's outpatient services. The SASD has a contract with the Council for the provision of outpatient and residential services for SFY 2009-2010 of $103,746. Freedom House has the capacity to house 22 individuals on any day.

The Bibb, Pickens, Tuscaloosa Mental Health Board is registered as NFR ID# AL900091, is located in Tuscaloosa, which is in SASD Planning Region #2. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the Bibb, Pickens, Tuscaloosa Mental Health Board for the provision of outpatient special women's services for SFY 2009-2010 of $126,031.

The Cahaba Mental Health Center is registered as NFR ID# AL302108, is located in Selma, which is in SASD Planning Region #3. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the Cahaba MHC for the provision of outpatient special women's services for SFY 2009-2010 of $157,068.

The East Alabama Mental Health Center is registered as NFR ID# AL900612, is located in Opelika, which is in SASD Planning Region #3. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the East Alabama MHC for the provision of outpatient special women's services for SFY 2009-2010 of $142,601.

The Greater Mobile (Altapointe) is registered as NFR ID# AL901206, is located in Mobile, which is in SASD Planning Region #4. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the Greater Mobile (Altapointe) for the provision of outpatient special women's services for SFY 2009-2010 of $136,320.

The University of Alabama at Birmingham is registered as NFR ID# AL100049, is located in Birmingham, which is in SASD Planning Region #2. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the University of Alabama at Birmingham for the provision of outpatient special women's services for SFY 2009-2010 of $137,166.

The Lighthouse Counseling is registered as NFR ID# AL301407, is located in Montgomery, which is in SASD Planning Region #3. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the Lighthouse Counseling for the provision of outpatient special women's services for SFY 2009-2010 of $140,346.

The North Central Mental Health Board is registered as NFR ID# AL900117, is located in Decatur, which is in SASD Planning Region #1. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the North Central MHB for the provision of outpatient special women's services for SFY 2009-2010 of $224,025.

The Southwest Mental Health Center is registered as NFR ID# AL900513, is located in Mobile, which is in SASD Planning Region #4. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD has a contract with the Southwest MHC for the provision of outpatient special women's services for SFY 2009-2010 of $99,145.

2. Alabama's efforts to ensure compliance with 42 U.S.C. 300x-22 (b)(1)(c) include contracting $2,556,405 with community providers for special women's services. This amount for exceeds the required special women's base of $1,366,290. In addition, Block Grant requirements are included in each contract, services are defined in the Contract Billing Manual, individual client services are billed monthly and appropriate services are reimbursed through a fee-for-service reimbursement system.

3. The State monitored the programs through on-site visits, evaluation of the service data submitted and through the statewide waiting list for residential treatment. In addition, a Women¿s Services Task Group was established to keep abreast of innovative treatment methods, effective outreach and retention for women in treatment as well as effective prevention programs for women. The Task Group, consisting of treatment providers, prevention providers, and state personnel, also functioned as an advisory committee to the SASD.

4. The SASD contractually requires the following priority populations for admission preference.
   1. Pregnant Women

2. Women with Dependent Children
3. Injectable Drug Users
4. Psychoactive Substance Dependence-Severe
5. Psychoactive Substance Dependence-Moderate
6. Psychoactive Substance Dependence-Mild
7. Psychoactive Substance Abuse

Waiting list data was analyzed by priority population as part of the Treatment Access Project (T.A.P.). The T.A.P. was discontinued and is being replaced with the ASAIS wait list management component. In addition, the "System Improvement Initiative" includes an assessment and a level of care placement determination process which will improve the SASD's ability to monitor need, capacity, and utilization of all services, including special women's services. The assessment/placement and wait list modules are scheduled to be fully operational before the close of SFY 2010.

5. The SAPT Block Grant Funds are used to maintain Alabama's capacity for existing programs to serve pregnant women and women with dependent children. No expansions were made except for cost of living rate adjustments.

REVISION REQUEST:

The Alcohol and Drug Abuse Treatment Program is located in Birmingham, which is in SASD Planning Region #2. Special Women’s residential services are provided to women and their children through Olivia’s House, which is a component of the total program. Olivia’s House has the capacity, determined by the number of beds, to house thirty-two individuals on any day.

The Aletheia House is located in Birmingham, which is in SASD Planning Region #2. Residential services are provided to pregnant women and women with dependent children. Aletheia House has the capacity, determined by the number of beds, to house
thirty-two on any day.

The Substance Abuse Council of Northwest Alabama is located in Rogersville, which is in SASD Planning Region #1. Residential services are provided to women and their children through the Freedom House, which is a component of the Substance Abuse Council of Northwest Alabama. The Council also provides special women’s outpatient services. Freedom House has the capacity, determined by the number of beds, to house twenty-two individuals on any day.

The Bibb, Pickens, Tuscaloosa Mental Health Board is located in Tuscaloosa, which is in SASD Planning Region #2. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The Cahaba Mental Health Center is located in Selma, which is in SASD Planning Region #3. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The East Alabama Mental Health Center is located in Opelika, which is in SASD Planning Region #3. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The Greater Mobile Mental Health Board (AltaPointe) is located in Mobile, which is in SASD Planning Region #4. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The University of Alabama at Birmingham is located in Birmingham, which is in SASD Planning Region #2. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The Lighthouse Counseling Center is located in Montgomery, which is in SASD Planning Region #2. Intensive, gender

specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The North Central Alabama Mental Health Board is located in Cullman, which is in SASD Planning Region #1. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The Southwest Alabama Mental Health Center is located in Monroeville, which is in SASD Planning Region #4. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

The Riverbend Mental Health Center is in Florence, which is in SASD Planning Region #1. Intensive, gender specific outpatient services are provided to pregnant women and women with dependent children. The SASD does not calculate capacity for outpatient or intensive outpatient treatment providers.

Please describe the source of funding for rate adjustments.

Since the Substance Abuse Prevention and Treatment Block Grant has been relatively flat, the referenced rate adjustment was funded with additional State funding. The increased State funding made it possible to provide a cost of living rate adjustment for all services while maintaining the same level of service provision.

Please indicate the "levels of care" provided by each individual program.

The "levels of care" for each program offering special women's services (along with all programs and all services) are described in Goal #1. The "levels of care" for special women's programs are also described in Goal #3.

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007(COMPLIANCE)

This goal was met during the FY 2007 SAPT BG expenditure period. The SASD continued to clearly identify SAPT BG IVDU requirements in the services procurement process. All community treatment providers signed contracts including exhibits (Goal #1-Attachment #2) that define the 90% capacity reporting, 14-120 day performance requirement, interim services and outreach activity requirements.

IVDU's have access to any substance abuse service included in the continuum of care (as defined in the Contract Billing Manual, Goal #1-Attachment #1).

- Outpatient;
- Intensive Outpatient, including: psycho-social assessment, diagnostic testing, case management, individual counseling, group counseling, family counseling and didactic group education;
- Detoxification;
- Short-term Residential;
- Long-term Residential;
- Special Women's Services;
- Methadone Treatment; and
- HIV Early Intervention Services.

IVDU's are priority #3 as identified in the SASD Contract Billing Manual (Goal #1-Attachment #1), contract exhibit pages (Goal #1-Attachment #2, page #38) in regard to admission into substance abuse treatment. During the 2007 SAPT BG expenditure period, a total of 1,114 of the clients admitted reported "IV" as their primary route of ingestion. The total is compared to other fiscal years below.

Fiscal Year	IVDU's
FY 2000-2001	710
FY 2001-2002	868
FY 2003-2004	1,094
FY 2004-2005	1,583
FY 2005-2006	1,114
FY 2006-2007	936
FY 2007-2008	1,447

The Treatment Access Project (TAP) was designed to emphasize the priority populations to be served as identified in the SAPT BG, i.e., Pregnant Women, Women with Dependent Children, and IVDU's. TAP also highlighted the necessity of providing interim services to those populations. During the 2007 SAPT BG expenditure period the TAP was functioning as the SASD's only process for managing system capacity, wait lists and priority population admissions. However, the system had deteriorated to the point it was not collecting adequate data regarding capacity, wait lists or priority populations. The SASD was only sporadically receiving wait list data, bed availability and correlating priority population data. During this period the SASD was developing the Alabama Substance Abuse Information System (ASAIS). ASAIS is described in Attachment G and other attachments of the 2010 SAPT BG Application. ASAIS includes the required determination and reporting of all SAPT BG priority populations, including IVDU's (ASAIS was implemented statewide on July 1, 2008). Priority populations are also emphasized in on-going training and technical assistance sessions.

The SASD conducted a blitz of training events and technical assistance opportunities when the TAP was implemented and immediately thereafter. Unfortunately, the number and frequency of those opportunities decreased as providers became accustomed to the operation of the TAP. Since the beginning of the development phase of ASAIS in 2004 many training and technical assistance events have been conducted concerning all aspects of ASAIS including screening, enrollment, waiting list and priority population management.

System Development Sessions (JAD Sessions) involving community providers were conducted on the following dates.

October 18-20, 2005
November 2-4, 2005

Bi-weekly conference calls began in February 2006 and ended in November 2008. Participation varied from thirty to sixty providers on each conference call.

Provider on-site visits were conducted on the following dates.

March 27-29, 2006
April 10-13, 2006
April 25-27, 2006
May 8-11, 2006

A Pilot Provider Training was conducted in March 2007.

Regional Training Sessions were conducted on the following dates.

October 29-31, 2007
November 1, 2007
November 13-16, 2007
November 27-29, 2007

FY 2009(PROGRESS)

All community contracts continue to require funded providers to comply with all SAPT BG requirements including those related to IVDU's. Alabama continues to require provider adherence with the procurement process including the billing manual (Goal #1-Attachment #1), contract exhibits identifying priority populations (Goal #1-Attachment #2) and ASAIS.

ASAIS, as described in Attachment G of this application, is operational. Access to treatment through ASAIS is driven by the priority populations as established by the SAPT BG and passed along to providers in contract language. The major components of ASAIS include screening, assessment, level of care determination, access to care and waiting list management.

Training and on-site assistance continue regarding all aspects of ASAIS including priority population access and interim service requirements. The following provider training sessions were conducted during SFY 2008-2009.

Second Round of Claims Training:

December 1-4, 2008

Training on Version 6.1:

February 5-6, 2009
February 9-13, 2009
February 18-20, 2009

To enter any substance abuse treatment program in Alabama a person must first meet the clinical criteria for psychoactive substance abuse or dependence contained in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Priorities are given to clients as follow: 1) Pregnant Women, 2) Women with Dependent Children, 3) Injectable Drug User (6-month history of injectable drug use and use of injectable drug within last 30 days.), 4) Psychoactive Substance Dependence, Severe, 5) Psychoactive Substance Dependence Moderate, 6) Psychoactive Substance Dependence, Mild, and 7) Psychoactive Substance Abuse.

FY 2010(INTENDED USE)

All contracts developed by the SASD will include a provision requiring the State to be notified when any IVDU program reaches 90 percent of its capacity and when IVDU's can not be admitted to treatment within 14-120 days.

All contracts developed by the SASD include a prohibition regarding the distribution of sterile needles and a prohibition of the provision of AIDS testing without appropriate pre-test counseling.

All contracts developed by the SASD will include a requirement that all programs conduct outreach activities for IVDU's.

ASAIS will be continued as the single point within the State for information regarding available services, capacity of those services as well as the level of current capacity of those services. ASAIS is designed to track the length of wait for admittance. It is through the analysis of the central waiting list and the admission data that the State is assured that IVDU's are admitted for service within specified periods.

The SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2) designed to enhance the current contractual and certification standard's requirements, including IVDU. This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG application.

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))
For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2007 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

1. How did the State define IVDU's in need of treatment services?

Alabama defines an IVDU in need of treatment as any person meeting the diagnostic criteria of substance abuse or dependence and reports their route of ingestion as intravenous. To enter any substance abuse treatment program in Alabama a person must first meet the clinical criteria for psychoactive substance abuse or dependence contained in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. The following priorities are given to clients: 1) Pregnant Women, 2) Women with Dependent Children, 3) Injectable Drug User (6-month history of injectable drug use and use of injectable drug within last 30 days.), 4) Psychoactive Substance Dependence, Severe, 5) Psychoactive Substance Dependence Moderate, 6) Psychoactive Substance Dependence, Mild, and 7) Psychoactive Substance Abuse.

Alabama's Needs Assessment indicates that 6,459 IVDU's in Alabama need treatment and that 969 would seek treatment. During FY 2006 Alabama served 1,114 IVDU's.

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2007 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

All substance abuse community treatment contracts (Goal #1-Attachment #2) include a provision requiring that the State be notified when an IVDU program reaches 90 percent of its capacity. In addition, ASAIS provides a single point within the State for information regarding available services, capacity of those services as well as the level of current capacity of those services. ASAIS is designed to track the length of wait for admittance. It is through the analysis of the central waiting list and the admission data that the State is assured that IVDU's are admitted for service within specified periods.

No programs reported reaching 90 percent capacity during the 2007 SAPT BG expenditure period.

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

ASAIS allows for the review of the length of wait for admittance. It is through the analysis of the wait list component of ASAIS that the SASD monitors IVDU admittance to service within the specified parameters.

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDU's was accomplished (See 45 C.F.R. 96.126(e)).

All contracts developed by the SASD include a requirement (Goal #1-Attachment #2) that all programs conduct outreach activities for IVDU's

During the 2007 SAPT BG expenditure period the SASD relied on the contract language requiring service providers to report 90 percent capacity, 14-120 day admittance performance, and outreach activities. Financial audits are required for every contract provider. Audit reports must be submitted to the DMH. The audit reports are reviewed by the Contracts Office and follow-up is conducted regarding any finding. The auditors review compliance with contract requirements. In addition, through ASAIS, the SASD has the capacity to continually monitor capacity, priority population admittance, wait list (including length of wait) through standard report generation.

In addition to the previously described monitoring processes, the SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2). This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG application.

REVISION REQUEST:
Number of IVDU's served in SFY 2007 = 936
Number of IVDU's served in SFY 2008 = 1,447

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2008) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Description of Strategies:

IVDU:

The following statement is included in each contract issued by the SASD.

Programs designed specifically for treating injectable drug users agree:

1. To notify SASD, DMH any time 90% capacity is reached.
2. Assist SASD, DMH to ensure that all injectable drug users requesting treatment shall be enrolled within 14 days if a program has beds available or within 120 days if no beds are available and to provide interim services within 48 hours of service request.
3. To carry out outreach activities to encourage injectable drug users to seek help.

Verification of completion of the terms of the contract is accomplished three ways:

1. ASAIS wait list management process;
2. On-site monitoring visits; and
3. Independent contractual reviews that are conducted during annual provider fiscal audits.

Tuberculosis Counseling, Testing, and Treatment:

Compliance with Section 1924 (a) was achieved by including in Alabama Substance Abuse Program Standards a requirement which states that each program shall demonstrate that it provides tuberculosis counseling, testing, and treatment for each person entering substance abuse treatment, either directly by the agency or indirectly by another provider. Before an agency can be licensed (certified) to provide treatment services, it must comply with the standards. All agencies that receive SAPT BG funds must be certified prior to being awarded a contract.

Capacity of IVDU Treatment Programs:

To date no treatment agency has informed the SASD of their inability to serve this population as required by contract. Monitoring of the waiting list process, on-site monitoring or CPA audits have not identified incidences where contract requirements were not met.

Verification of completion of the terms of the contract is accomplished three ways:

1. The ASAIS wait list management process;
2. On-site monitoring visits; and
3. Independent contractual reviews that are conducted during annual provider fiscal audits.

Tuberculosis Counseling, Testing and Treatment.

The anticipated added costs involved in testing and treating all substance abuse treatment clients posed the greatest challenge to implementation of this requirement. SASD met the challenge through the development of a cooperative relationship with the Alabama Public Health Department, whereby the county health departments supplied the serum and needles to treatment agencies that had nurses assigned and provided the testing for agencies that did not have nurses assigned. SASD treatment agencies completed the counseling, testing (where nurses were available), required documentation, and made referrals for chest X-rays and tuberculosis treatment as needed. Public Health provided X-rays, medications, and statistical analysis for the program. In addition, the county health departments and treatment agencies worked cooperatively to administer the medication for the required period of treatment. Once the cooperative agreement was worked out, a five-person team, composed of representatives of SASD and Public Health toured the State, providing guidance and implementing instructions to all organizations involved in the project. After one full year of operation the glitches were worked out and the system was fully operational.

Modifications have been made to Alabama's approach to T.B. testing based on data collected by the Department of Public Health. October 1, 1993, to September 30, 1995, the Department of Public Health screened 13,556 substance abuse clients for T.B.. A total of two new cases were discovered. The Department of Public Health recommended that due to the very low number of new cases and the very high cost of testing every admission, that Alabama cut back on the requirement for testing all admissions and provide T.B. test only to those clients exhibiting symptoms.

The SASD implemented a policy beginning October 1, 1995, requiring that intake clinicians observe and refer only those clients showing symptoms of T.B. for testing at their local health departments.

Since the implementation of the change beginning in October 1995, most of the community programs are only testing the clients that show symptoms of T.B., however, some of the programs still test all admissions and provide testing on-site using trained staff. It is the professional opinion of the staff with the Alabama Department of Public Health and the substance abuse community treatment programs that the current approach adequately detects T.B. clients receiving substance abuse treatment.

Treatment Service for Pregnant Women:

The SASD does not think adequate numbers of pregnant women or women with dependent children are being reached. Traditional barriers remain insurmountable for many women; stigma, household and child rearing responsibilities, shortage of willing providers, shortage of skilled practitioners, shortage of resources, etc.

The SASD continues efforts to reduce stigma, increase the numbers of programs offering services that allow women to bring their children with them, encourage providers to serve women, provide training opportunities for staff currently working in special women's programs, and continue to enhance resources when possible. Although these efforts continue, overall progress is slow and successes are few.

Verification of completion of the terms of the contract is accomplished in three ways:

1. The ASAIS wait list management process;
2. On-site monitoring visits; and
3. Independent contractual reviews that are conducted during annual provider fiscal audits.

The SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2) designed to enhance the current contractual and certification standard's requirements. This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG application.

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

Goal # 5: TB Services

FY 2007 (COMPLIANCE)

In accordance with the description provided in Attachments D&E, the SASD continued the policy of including the contractual requirement regarding the screening and provision/referral for TB services.

Exhibit SA-3 (Goal #1-Attachment #2)
Provision specific to Block Grant and other regulatory requirements

A. Tuberculosis
   1. The Contractor and its Subcontractor(s) will have, directly or through arrangements with other public or nonprofit entities, infection control procedures to prevent the transmission of tuberculosis. These procedures must include:

      a. A screening process for identification of high risk individuals;
      b. Referral for testing, if indicated by the screening process;
      c. Case Management, as indicated; and
      d. A reporting process to appropriate state agencies as required by law.

All contract providers receive financial audits which include "Contract Compliance" reviews. The DMH/MR receives a copy of all audit reports which are reviewed by the Contracts Office. All identified areas of non-compliance or questioned costs must be identified by the completion of a corrective action plan which must be approved by the Contracts Office. No programs were identified as non-compliant with the TB requirement.

The SASD also continued the inclusion of a TB related standard in the Community Certification Standards (Goal #5-Attachment #1)

#7105 Programs should demonstrate that the person(s) exposed to or appears to be affected by a contagious disease are to be treated by a competent medical staff person from that agency or referred to an outside agency for treatment.

This standard is applicable to every certified substance abuse provider in Alabama (more than 100). Certified programs receive an on-site visit at least every two years, some annually. During the on-site visit all standards are reviewed for compliance, including client record review and interviews with program staff and clients.

The SASD does not collect the number of clients tested or referred for TB services. Collection of this data would require a modification to ASAIS or the conducting of a special survey annually.

During the 2007 SAPT Block Grant expenditure period, the SASD visited the following programs to conduct certification on-site visits and applied standard #7105.

Program	County	Region	Date
Birmingham Fellowship House	Jefferson	2	10/2/06
Walker County Recovery Program	Walker	1	10/5/06
Kaliedescope	Montgomery	3	10/6/06
Mt View IOP	Etowah	1	11/3/06
Riverbend MHC	Lauderdale	1	11/3/06
Outpatient Recovery Group	Etowah	1	11/7/06
New Choices	Randolph	2	11/21/06
The Bridge	Etowah	1	12/5/06
Mountain Lakes MHC	Marshall	1	1/3/07
Mt View Hospital IOP	Etowah	1	1/3/07
New Choices	Tallapoosa	3	1/22/07
St Ann's	Jefferson	2	2/15/07
Phoenix City Court Referral Wings	Lee	3	3/14/07
Rapha Christian Home	Etowah	1	3/14/07
Shelby County Treatment	Shelby	2	3/29/07
Mobile Metro Treatment Center	Mobile	4	4/4/07
Tuscaloosa Treatment Center	Tuscaloosa	2	4/5/07
Shoals Treatment Center	Colbert	1	4/24/07
Mobile MHC	Mobile	4	5/8/07
Montgomery Metro Treatment Center	Montgomery	3	6/5/07
Pathfinder	Madison	1	6/12/07
Starting Over	Autauga	3	6/14/07
Tri County treatment	Jefferson	2	6/14/07
Oakmont	Jefferson	2	6/18/07
Marion County Treatment Center	Marion	1	6/26/07
UAB Methadone	Jefferson	2	7/6/07
Northwest Treatment Center	Jefferson	2	8/13/07
North Central Alabama MHC	Morgan	1	8/15/07
Sandy's Place	Etowah	1	9/10/07
Madison County Mental Health Center	Madison	1	9/24/07

All programs visited were compliant with standard #7105.

FY 2009 (PROGRESS)

The SASD continued the TB referral process as described in Attachments D&E in the 2010 SAPT Block Grant application.

The process includes specific TB requirements in the annual contract signed by all SAPT Block Grant funding recipient agencies (Goal #1-Attachment #2). All contract providers

receive financial audits which include "Contract Compliance" reviews. The DMH/MR receives a copy of all audit reports which are reviewed by the Contracts Office. All identified areas of non-compliance or questioned costs must be identified by the completion of a corrective action plan which must be approved by the Contracts Office. No programs have been identified as non-compliant with the TB requirement.

In addition, the specific certification standard related to TB, #7105 (Goal #5-Attachment #1) is currently effective and was applied during the on-site visits conducted during the 2009 SAPT Block Grant expenditure period as identified below.

Program	County	Region	Date
Chemical Addictions Program	Montgomery	3	10/08
New Life Counseling Services		3	10/08
Chilton Shelby Mental Health Center	Chilton	2	11/08
Gulf Coast Counseling Services		4	11/08
East Central Alabama Mental Health Ctr.	Pike	3	12/08
Freedom Rain Ministries		2	12/08
New Centurions	Etowah	1	12/08
Rapha Christian Ministries	Etowah	1	12/08
The Bridge	Cullman	1	12/08
The Bridge	Etowah	1	12/08
The Bridge	St.Clair	2	12/08
The Bridge	Tuscaloosa	2	12/08
The Bridge	Mobile	4	12/08
Agency for Substance Abuse Prevention	Calhoun	1	1/09
Anniston Fellowship House	Calhoun	1	1/09
The Right Turn	Montgomery	3	1/09
Riverbend Mental Health Center	Lauderdale	1	1/09
Sumter County Treatment Center	Sumter	2	1/09
CED Mental Health Center	Etowah	1	2/09
COSA Prevention	Montgomery	3	2/09
New Pathways	St. Clair	2	2/09
Pneuma Christian Ministries		1	2/09
Alabama Abuse Counseling		2	3/09
Bradford Health Services	Houston	4	3/09
Bradford Health Services	Montgomery	3	3/09
Bradford Health Services	Shelby	2	3/09
Bradford Health Services	Tuscaloosa	2	3/09
Calhoun Cleburne Mental Health Center	Calhoun	1	3/09
Pearson Hall	Jefferson	2	3/09
St. Anne's Home	Jefferson	2	3/09
Birmingham DUI Action Program	Jefferson	2	4/09
Family Life Center		1	4/09
Birmingham Health Care for the Homeless	Jefferson	2	5/09
Dothan-Houston Co.	Houston	4	5/09
East Alabama Mental Health Center	Lee	3	5/09
Gateway (Family & Child Services)	Jefferson	2	5/09
JCCEO	Jefferson	2	5/09
Phoenix House	Tuscaloosa	2	5/09

SpectraCare	Houston	4	5/09
T.E.A.R.S.		3	5/09
Aletheia House	Jefferson	2	6/09
Lighthouse of Tallapoosa County	Tallapoosa	3	6/09
AltaPointe Health Systems	Mobile	4	7/09
Cahaba Mental Health Center	Dallas	3	7/09
Gulf Coast Counseling Services	Mobile	4	7/09
Indian Rivers Mental Health Center	Tuscaloosa	2	7/09
Therapeutic Resources		4	7/09
UAB	Jefferson	2	7/09
Cheaha Mental Health Center	Talladega	2	8/09
Drug Education Council	Mobile	4	8/09
Marwin Counseling		1	8/09
Oakmont Center	Jefferson	2	8/09
The Pathfinder	Madison	1	8/09
JCCEO (follow-up)	Jefferson	2	9/09

Two of the programs (as highlighted) receiving on-site certification visits were cited for non-compliance with standard #7105. The New Life Counseling Center and T.E.A.R.S., Inc. developed corrective actions plans and compliance was restored.

FY 2010 (INTENDED)

The SASD will continue the TB referral process as described in Attachments D&E in the 2010 SAPT Block Grant application.

The process includes specific TB requirements in the annual contract signed by all SAPT Block Grant funding recipient agencies (Goal #1-Attachment #2). All contract providers receive financial audits which include "Contract Compliance" reviews. The DMH/MR receives a copy of all audit reports which are reviewed by the Contracts Office. All identified areas of non-compliance or questioned costs must be identified by the completion of a corrective action plan which must be approved by the Contracts Office.

In addition, the specific certification standard related to TB, #7105 (Goal #5-Attachment #1), is currently effective and being applied during the on-site visits conducted during the 2010 SAPT Block Grant expenditure period as identified below.

Treatment Facility	Cert Exp Date	Review Date
Bibb, Pickens Tuscaloosa. MHC PREVENTION	09/30/09	9/15/09
JCCEO	10/04/09	9/15/09
Drug Education Council	10/30/09	9/9/09
Northwest Treatment Center.	10/30/09	9/15/09
Dothan/Houston Drug Treatment Center	11/30/09	10/15/09

Hamilton Economic Development	11/30/09	10/01/09
Lighthouse of Cullman	11/30/09	10/5/09
Mental Health Center of Madison County	11/30/09	10/15/09
Mt. Lakes Mental Health Center	11/30/09	10/22/09
Phoenix City Court Referral Program	11/30/09	10/15/09
Sandy's Place	11/30/09	10/15/09
AIDS Alabama	12/30/09	11/06/09
Alabama Recovery Center	12/30/09	11/19/09
Baldwin County Mental Health Center	12/30/09	11/16/09
Mental Health Center of North Central	12/30/09	11/05/09
The Bridge	12/30/09	11/23/09
Aletheia House	01/30/10	To Be Scheduled
Freedom Rain TLC	01/30/10	To Be Scheduled
New Choices Interventions	01/30/10	To Be Scheduled
Rapha Christian Ministries	01/30/10	To Be Scheduled
Southwest Mental Health Center	01/30/10	To Be Scheduled
Substance Abuse Council of Northwest Alabama	01/30/10	To Be Scheduled
Teen Empowerment Awareness with Resolutions	01/30/10	To Be Scheduled
The Bridge, Westwood Program	01/30/10	To Be Scheduled
Bradford Health Services Anniston	02/28/10	To Be Scheduled
Bradford Health Services Boaz	02/28/10	To Be Scheduled
Insight Treatment Program	02/28/10	To Be Scheduled
South Central Mental Health Center	02/28/10	To Be Scheduled
Infinity Counseling Services	02/28/10	To Be Scheduled
AL Abuse Counseling Center	03/30/10	To Be Scheduled
Bradford Health Services Shelby County	03/30/10	To Be Scheduled
Bradford Health Services Decatur	03/30/10	To Be Scheduled
Bradford Health Services Birmingham	03/30/10	To Be Scheduled
Bradford Health Services. Florence	03/30/10	To Be Scheduled
Bradford Health Services. Huntsville	03/30/10	To Be Scheduled
Bradford Health Services Madison	03/30/10	To Be Scheduled
Bradford Health Services Mobile	03/30/10	To Be Scheduled
Herring Houses of Dothan	03/30/10	To Be Scheduled
Cullman Treatment Center	4/30/10	To Be Scheduled
Second Choice	04/30/10	To Be Scheduled
Bradford Health Services. Warrior	05/30/10	To Be Scheduled
Huntsville Recovery Center	05/30/10	To Be Scheduled
Mobile Metro Treatment Center	05/30/10	To Be Scheduled
Shelby County Treatment	05/30/10	To Be Scheduled
Shoals Treatment Center	05/30/10	To Be Scheduled
Birmingham Health Care for the Homeless	06/30/10	To Be Scheduled
Birmingham Metro	06/30/10	To Be Scheduled
Calhoun County Treatment	06/30/10	To Be Scheduled
Cherokee County Substance Abuse Council	06/30/10	To Be Scheduled
Gulf Coast Treatment	06/30/10	To Be Scheduled
Huntsville Metro Treatment Center	06/30/10	To Be Scheduled
The Shoulder	06/30/10	To Be Scheduled
Tuscaloosa Treatment Center	06/30/10	To Be Scheduled

West Alabama Mental Health Center	06/30/10	To Be Scheduled
Bibb, Pickens Tuscaloosa Mental Health Center	07/30/10	To Be Scheduled
Cullman Area Mental Health Authority	07/30/10	To Be Scheduled
ECD Treatment Center	07/30/10	To Be Scheduled
Gulf Coast Counseling	07/30/10	To Be Scheduled
Marion County Treatment Center	07/30/10	To Be Scheduled
Montgomery Metro Treatment Center	07/30/10	To Be Scheduled
Outpatient Recovery Group	07/30/10	To Be Scheduled
Salivation Army	07/30/10	To Be Scheduled
Therapeutic Resources	07/30/10	To Be Scheduled
Marwin Counseling Services	08/30/10	To Be Scheduled
Franklin Primary Health	08/30/10	To Be Scheduled
Lighthouse Counsel Center	08/30/10	To Be Scheduled
Spectra Care	08/30/10	To Be Scheduled
Tri-Co. Treatment	08/30/10	To Be Scheduled
West Alabama Mental Health Center	08/30/10	To Be Scheduled
CED Fellowship House	09/30/10	To Be Scheduled
Gadsden Treatment Center	09/30/10	To Be Scheduled
Hope House	09/30/10	To Be Scheduled
SAYNO	09/30/10	To Be Scheduled
Walker Recovery	09/30/10	To Be Scheduled

The SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2) designed to enhance the current contractual and certification standard's requirements, including TB. This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG Application.

FY 2009 (PROGRESS)

The SASD continued the TB referral process as described in Attachments D&E in the 2010 SAPT Block Grant application.

The process includes specific TB requirements in the annual contract signed by all SAPT Block Grant funding recipient agencies (Goal #1-Attachment #2). All contract providers receive financial audits which include "Contract Compliance" reviews. The DMH/MR receives a copy of all audit reports which are reviewed by the Contracts Office. All identified areas of non-compliance or questioned costs must be identified by the completion of a corrective action plan which must be approved by the Contracts Office. No programs have been identified as non-compliant with the TB requirement.

In addition, the specific certification standard related to TB, #7105 (Goal #5-Attachment #1) is currently effective and was applied during the on-site visits conducted during the 2009 SAPT Block Grant expenditure period as identified below.

Program County Region Date
Chemical Addictions Program Montgomery 3 10/08
New Life Counseling Services 3 10/08
Chilton Shelby Mental Health Center Chilton 2 11/08
Gulf Coast Counseling Services 4 11/08
East Central Alabama Mental Health Ctr. Pike 3 12/08
Freedom Rain Ministries 2 12/08
New Centurions Etowah 1 12/08
Rapha Christian Ministries Etowah 1 12/08
The Bridge Cullman 1 12/08
The Bridge Etowah 1 12/08
The Bridge St.Clair 2 12/08
The Bridge Tuscaloosa 2 12/08
The Bridge Mobile 4 12/08
Agency for Substance Abuse Prevention Calhoun 1 1/09
Anniston Fellowship House Calhoun 1 1/09
The Right Turn Montgomery 3 1/09
Riverbend Mental Health Center Lauderdale 1 1/09
Sumter County Treatment Center Sumter 2 1/09
CED Mental Health Center Etowah 1 2/09
COSA Prevention Montgomery 3 2/09
New Pathways St. Clair 2 2/09
Pneuma Christian Ministries 1 2/09
Alabama Abuse Counseling 2 3/09
Bradford Health Services Houston 4 3/09
Bradford Health Services Montgomery 3 3/09
Bradford Health Services Shelby 2 3/09
Bradford Health Services Tuscaloosa 2 3/09
Calhoun Cleburne Mental Health Center Calhoun 1 3/09
Pearson Hall Jefferson 2 3/09
St. Anne's Home Jefferson 2 3/09
Birmingham DUI Action Program Jefferson 2 4/09
Family Life Center 1 4/09
Birmingham Health Care for the Homeless Jefferson 2 5/09
Dothan-Houston Co. Houston 4 5/09
East Alabama Mental Health Center Lee 3 5/09
Gateway (Family & Child Services) Jefferson 2 5/09
JCCEO Jefferson 2 5/09
Phoenix House Tuscaloosa 2 5/09
SpectraCare Houston 4 5/09

T.E.A.R.S. 3 5/09
Aletheia House Jefferson 2 6/09
Lighthouse of Tallapoosa County Tallapoosa 3 6/09
AltaPointe Health Systems Mobile 4 7/09
Cahaba Mental Health Center Dallas 3 7/09
Gulf Coast Counseling Services Mobile 4 7/09
Indian Rivers Mental Health Center Tuscaloosa 2 7/09
Therapeutic Resources 4 7/09
UAB Jefferson 2 7/09
Cheaha Mental Health Center Talladega 2 8/09
Drug Education Council Mobile 4 8/09
Marwin Counseling 1 8/09
Oakmont Center Jefferson 2 8/09
The Pathfinder Madison 1 8/09
JCCEO (follow-up) Jefferson 2 9/09

Two of the programs (as highlighted) receiving on-site certification visits were cited for non-compliance with standard #7105. The New Life Counseling Center and T.E.A.R.S., Inc. developed corrective actions plans and compliance was restored.

FY 2010 (INTENDED)

The SASD will continue the TB referral process as described in Attachments D&E in the 2010 SAPT Block Grant application.

The process includes specific TB requirements in the annual contract signed by all SAPT Block Grant funding recipient agencies (Goal #1-Attachment #2). All contract providers receive financial audits which include "Contract Compliance" reviews. The DMH/MR receives a copy of all audit reports which are reviewed by the Contracts Office. All identified areas of non-compliance or questioned costs must be identified by the completion of a corrective action plan which must be approved by the Contracts Office.

In addition, the specific certification standard related to TB, #7105 (Goal #5-Attachment #1), is currently effective and being applied during the on-site visits conducted during the 2010 SAPT Block Grant expenditure period as identified below.

Treatment Facility Cert Exp Date Review Date
Bibb, Pickens Tuscaloosa. MHC PREVENTION 09/30/09 9/15/09
JCCEO 10/04/09 9/15/09
Drug Education Council 10/30/09 9/9/09
Northwest Treatment Center. 10/30/09 9/15/09
Dothan/Houston Drug Treatment Center 11/30/09 10/15/09
Hamilton Economic Development 11/30/09 10/01/09
Lighthouse of Cullman 11/30/09 10/5/09
Mental Health Center of Madison County 11/30/09 10/15/09
Mt. Lakes Mental Health Center 11/30/09 10/22/09
Phoenix City Court Referral Program 11/30/09 10/15/09
Sandy's Place 11/30/09 10/15/09
AIDS Alabama 12/30/09 11/06/09
Alabama Recovery Center 12/30/09 11/19/09
Baldwin County Mental Health Center 12/30/09 11/16/09
Mental Health Center of North Central 12/30/09 11/05/09
The Bridge 12/30/09 11/23/09
Aletheia House 01/30/10 To Be Scheduled
Freedom Rain TLC 01/30/10 To Be Scheduled
New Choices Interventions 01/30/10 To Be Scheduled
Rapha Christian Ministries 01/30/10 To Be Scheduled
Southwest Mental Health Center 01/30/10 To Be Scheduled
Substance Abuse Council of Northwest Alabama 01/30/10 To Be Scheduled
Teen Empowerment Awareness with Resolutions 01/30/10 To Be Scheduled
The Bridge, Westwood Program 01/30/10 To Be Scheduled
Bradford Health Services Anniston 02/28/10 To Be Scheduled
Bradford Health Services Boaz 02/28/10 To Be Scheduled
Insight Treatment Program 02/28/10 To Be Scheduled
South Central Mental Health Center 02/28/10 To Be Scheduled
Infinity Counseling Services 02/28/10 To Be Scheduled
AL Abuse Counseling Center 03/30/10 To Be Scheduled
Bradford Health Services Shelby County 03/30/10 To Be Scheduled
Bradford Health Services Decatur 03/30/10 To Be Scheduled
Bradford Health Services Birmingham 03/30/10 To Be Scheduled
Bradford Health Services. Florence 03/30/10 To Be Scheduled
Bradford Health Services. Huntsville 03/30/10 To Be Scheduled
Bradford Health Services Madison 03/30/10 To Be Scheduled
Bradford Health Services Mobile 03/30/10 To Be Scheduled

Herring Houses of Dothan 03/30/10 To Be Scheduled
Cullman Treatment Center 4/30/10 To Be Scheduled
Second Choice 04/30/10 To Be Scheduled
Bradford Health Services. Warrior 05/30/10 To Be Scheduled
Huntsville Recovery Center 05/30/10 To Be Scheduled
Mobile Metro Treatment Center 05/30/10 To Be Scheduled
Shelby County Treatment 05/30/10 To Be Scheduled
Shoals Treatment Center 05/30/10 To Be Scheduled
Birmingham Health Care for the Homeless 06/30/10 To Be Scheduled
Birmingham Metro 06/30/10 To Be Scheduled
Calhoun County Treatment 06/30/10 To Be Scheduled
Cherokee County Substance Abuse Council 06/30/10 To Be Scheduled
Gulf Coast Treatment 06/30/10 To Be Scheduled
Huntsville Metro Treatment Center 06/30/10 To Be Scheduled
The Shoulder 06/30/10 To Be Scheduled
Tuscaloosa Treatment Center 06/30/10 To Be Scheduled
West Alabama Mental Health Center 06/30/10 To Be Scheduled
Bibb, Pickens Tuscaloosa Mental Health Center 07/30/10 To Be Scheduled
Cullman Area Mental Health Authority 07/30/10 To Be Scheduled
ECD Treatment Center 07/30/10 To Be Scheduled
Gulf Coast Counseling 07/30/10 To Be Scheduled
Marion County Treatment Center 07/30/10 To Be Scheduled
Montgomery Metro Treatment Center 07/30/10 To Be Scheduled
Outpatient Recovery Group 07/30/10 To Be Scheduled
Salivation Army 07/30/10 To Be Scheduled
Therapeutic Resources 07/30/10 To Be Scheduled
Marwin Counseling Services 08/30/10 To Be Scheduled
Franklin Primary Health 08/30/10 To Be Scheduled
Lighthouse Counsel Center 08/30/10 To Be Scheduled
Spectra Care 08/30/10 To Be Scheduled
Tri-Co. Treatment 08/30/10 To Be Scheduled
West Alabama Mental Health Center 08/30/10 To Be Scheduled
CED Fellowship House 09/30/10 To Be Scheduled
Gadsden Treatment Center 09/30/10 To Be Scheduled
Hope House 09/30/10 To Be Scheduled
SAYNO 09/30/10 To Be Scheduled
Walker Recovery 09/30/10 To Be Scheduled

The SASD is implementing an on-site SAPT Block Grant monitoring process (as described in Goal #5-Attachment #2) designed to enhance the current contractual and certification standard's requirements, including TB. This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the 2011 SAPT BG Application.

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).
FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

Alabama was a HIV designated State for 2007 with an AIDS rate of 10.3 per 100,000 population. The service provision and expenditure requirements of a designated State were met during the 2007 SAPT BG expenditure period.

The SASD defines HIV Early Intervention Services in the Contract Billing Manual (Goal #1-Attachment #1) as follows.

HIV Medical Assessment: Consultative services provided by a licensed physician regarding the test results or physical condition of a substance abuse treatment client participating in HIV Early Intervention Services.

Orasure HIV Test: An oral fluid (OraSure) test given to consenting (in writing) substance abuse treatment clients designed to confirm the presence of HIV of AID's. OraSure draws antibodies out of the cheek and gum in oral mucosal transudate.

HIV Pre-test Counseling: Pre-test counseling to prepare the client to take the HIV test and for the possible results of such a test.

HIV Individual Counseling: A one-on-one interaction between an individual substance abuse treatment client and a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Group Counseling: A structured interaction of two or more substance abuse treatment clients with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in preparing for HIV testing, dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Family Counseling: A structured interaction of the client and/or his family member(s) with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients and their family members in dealing with positive test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Case Management: Case management is a service designed to assist substance abuse treatment clients who have tested positive for HIV/AID's, in accessing a broader array of both physical and mental services, as appropriate, designed to prevent and treat the affects of HIV/AID's. Case management includes needs assessment, case planning, crisis intervention, transportation, linkage, advocacy, client and significant other education, and follow-up.

HIV Early Intervention Services are also identified in the contract Exhibit SA-3, IV (Goal #1-Attachment #2).

In 1993 The SASD developed the Contract Billing Manual which includes billable HIV Services with their respective fee-for-service rates. These rates were developed based on an early Rate Setting Model developed by James E. Sorenson, Ph.D., CPA, William N. Zelman, Ph.D., CPA and Sasha Loring, M.Ed., for the State of Tennessee. The model required the identification of the cost of providing the care driven by staff and administrative overhead costs. The total cost was then divided by the anticipated level of production yielding a fee-for-service rate.

The following rates were in effect and used to reimburse for HIV EIS services during the 2007 SAPT BG expenditure period.

Service	Code	Rate
HIV Medical Assessment	5981/5982	$104/hr.
Orasure HIV Test & Counseling	5971/5972	$59.02/test
HIV Individual Counseling	5951/5952	$72.80/hr.
HIV Group Counseling	5931/5932	$20.80/hr.
HIV Family Counseling	5941/5942	$20.80/hr.
HIV Case Management	5961/5962	$37.44/hr.

The following table identifies the catchment areas with the highest AID's rate as applicable to the 2007 SAPT BG.

CATCHMENT AREAS RANKED
BY
AID'S RATES PER 100,000 POPULATION
2004
(applicable to the 2007 SAPT BG)

Rank	Catchment Area*	Counties	AID's Rate**
1	14	Autauga, Lowndes, Elmore, Montgomery	23.92
2	16	Washington, Mobile	17.94
3	15	Macon, Bullock, Pike	16.99
4	19	Barbour, Henry, Dale, Houston, Geneva	13.36
5	5	Jefferson, Blount, St. Clair	12.41
6	13	Perry Dallas, Wilcox	9.94
7	12	Tallapoosa, Chambers, Lee, Russell	8.99
8	3	Madison	8.39
9	17	Clarke, Monroe, Conecuh, Escambia	7.72
10	2	Limestone, Lawrence, Morgan	7.47

* Counties combined based on population to define mental health areas of responsibility. Alabama has twenty-two catchment Areas.

** 2004 AIDS rate per 100,000 by county as reported by the Alabama Department of Public Health.

*** Shaded areas represent HIV EIS contracts.

Six of the top ten catchment areas received eight of the nine contracts identified below.

During the 2007 SAPT BG expenditure period the SASD provided HIV Early Intervention Services through contracts with the following programs.

Catchment Area	Program	2007 Expenditures
15	East Central MHC	$ 4,325
14	CAP	80,055
14	Lighthouse Counseling	62,999
5	Alcohol and Drug Treat.	373,826
5	UAB	242,498
16	Mobile MHC	271,996
3	Huntsville Madison MHC	3,910
13	Cahaba MHC	104,000
9	Cheaha MHC	44,749
	Total	$1,188,358

During the 2007 SAPT BG expenditure period the SASD monitored compliance for HIV Early Intervention Services through the billing and reporting system (SUDS), financial audit reviews and on-site certification visits.

Every contract provider was required to bill monthly services to the SASD for reimbursement. The Contract Billing

Manual (Goal #1-Attachment #1) included a definition of the HIV Early Intervention Services, corresponding service codes and established unit rates.

SASD staff reviewed each monthly billing for appropriateness prior to approval for payment. Adjustments are made to provider billings every month. The SASD has not had any audit findings in many years.

The DMH/MR required every contract agency to submit an annual financial audit conducted by an independent CPA. Each audit included a contract compliance report. The audits were submitted to the DMH/MR Contracts Office for review and follow-up if necessary. No recent audits included non-compliance reports regarding the provision of HIV Early Intervention Services. However, the Contracts Office routinely requires follow-up on deficiencies cited in audit reports.

HIV Early Intervention Services are monitored during every certification on-site visit through the application of the Certification Standards which include the following pertinent sections.

- Program Descriptions;
- Policies;
- Client Protection;
- Client Records;
- Quality Assurance Plan;
- Treatment and Rehabilitation Services;
- Intensive Outpatient; and
- General Outpatient.

HIV Early Intervention Services are documented in the individual client record and reviewed for compliance with all promulgated standards. Areas of non-compliance are identified for each program in a written report. Corrective actions are promptly identified by each program. If actions are satisfactory, certification is continued. During the 2007 SAPT BG expenditure period, the following on-site reviews were conducted and all non-compliant areas were corrected, therefore, certification was continued.

Program	County	Region	Date
Mobile MHC	Mobile	4	5/07
UAB	Jefferson	2	6/07
Huntsville Madison MHC	Madison	1	9/07

FY 2009 (PROGRESS)

Alabama was a HIV designated State for 2009 with an AIDS rate of 10.1 per 100,000 population. The service provision and expenditure requirements of a designated State are being met during the 2009 SAPT BG expenditure period.

The SASD defines HIV Early Intervention Services in the Contract Billing Manual (Goal #1-Attachment #1) as follows.

HIV Medical Assessment: Consultative services provided by a licensed physician regarding the test results or physical condition of a substance abuse treatment client participating in HIV Early Intervention Services.

Orasure HIV Test: An oral fluid (OraSure) test given to consenting (in writing) substance abuse treatment clients designed to confirm the presence of HIV of AID's. OraSure draws antibodies out of the cheek and gum in oral mucosal transudate.

HIV Pre-test Counseling: Pre-test counseling to prepare the client to take the HIV test and for the possible results of such a test.

HIV Individual Counseling: A one-on-one interaction between an individual substance abuse treatment client and a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Group Counseling: A structured interaction of two or more substance abuse treatment clients with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in preparing for HIV testing, dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Family Counseling: A structured interaction of the client and/or his family member(s) with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients and their family members in dealing with positive test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

HIV Case Management: Case management is a service designed to assist substance abuse treatment clients who have tested positive for HIV/AID's, in accessing a broader array of both physical and mental services, as appropriate, designed to prevent and treat the affects of HIV/AID's. Case management includes needs assessment, case planning, crisis intervention, transportation, linkage, advocacy, client and significant other education, and follow-up.

HIV Early Intervention Services are also identified in the contract Exhibit SA-3, IV (Goal #1-Attachment #2).

In 1993 The SASD developed the Contract Billing Manual which includes billable HIV Services with their respective fee-for-service rates. These rates were developed based on an early Rate Setting Model developed by James E. Sorenson, Ph.D., CPA, William N. Zelman, Ph.D., CPA and Sasha Loring, M.Ed., for the State of Tennessee. The model required the identification of the cost of providing the care driven by staff and administrative overhead costs. The total cost was then divided by the anticipated level of production yielding a fee-for-service rate. Several cost-of-living rate adjustments have been made since the initial rates were established. Alabama is currently in the process of conducting a rate analysis.

The following rates are in effect and used to reimburse for HIV EIS services for the 2009 SAPT BG expenditure period.

Service	Code	Rate
HIV Medical Assessment	5980/99205 U6	$106.91/hr.
Orasure HIV Test & Counseling	5970/86689 U6	$60.67/test
HIV Individual Counseling	5950/H0047 U6 HR	$74.84/hr.
HIV Group Counseling	5930/H0047 U6 HQ	$21.38/hr.
HIV Family Counseling	5940/H0047 U6	$21.38/hr.
HIV Case Management	5960/H0006 U6	$38.52/hr.

The following table identifies the catchment areas with the highest AID's rate as applicable to the 2009 SAPT BG.

CATCHMENT AREAS RANKED
BY
AID'S RATES PER 100,000 POPULATION
2006
(applicable to the 2009 SAPT BG)

Rank	Catchment Area*	Counties	AID's Rate**
1	14	Autauga, Lowndes, Elmore, Montgomery	20.77
2	13	Perry, Dallas, Wilcox	19.56
3	16	Washington, Mobile	19.21
4	15	Macon, Bullock, Pike	15.86
5	5	Jefferson, Blount, St. Clair	12.86
6	19	Barbour, Henry, Dale, Houston	10.67
7	8	Bibb, Pickens, Tuscaloosa	9.13
8	17	Clarke, Monroe, Conecuh, Escambia	9.00
9	12	Tallapoosa, Chambers, Lee, Russell	8.98
10	2	Limestone, Lawrence, Morgan	8.51

* Counties combined based on population to define mental health areas of responsibility. Alabama has twenty-two Catchment Areas.

** 2006 AIDS rate per 100,000 by county as reported by the Alabama Department of Public Health.

*** Shaded areas represent HIV EIS contracts.

Five of the top ten catchment areas received seven of the nine contracts identified below.

Catchment Area	Program	2008-2009 Contract Amount
15	East Central MHC	$ 4,624
14	CAP	101,957
14	Lighthouse Counseling	106,912
5	Alcohol and Drug Treat.	400,920
5	UAB	254,451
16	Mobile MHC	285,455
3	Huntsville Madison MHC	16,652
13	Cahaba MHC	106,912
9	Cheaha MHC	80,184
	Total	$1,358,067

During the 2009 SAPT BG expenditure period the SASD monitored compliance for HIV Early Intervention Services through the billing and reporting system (SUDS) through June 30, 2008 and the Alabama Substance Information System (ASAIS) for the months of July through September. In addition, financial audit reviews and on-site certification visits are used to monitor HIV EIS services.

Every contract provider is required to bill monthly services to the SASD for reimbursement. The Contract Billing Manual (Goal #1-Attachment #1) includes a definition of the HIV Early Intervention Services, corresponding service codes and established unit rates.

SASD staff review each monthly billing for appropriateness prior to approval for payment. Adjustments are made to provider billings every month. The SASD has not had any audit findings in many years.

The DMH/MR requires every contract agency to submit an annual financial audit conducted by an independent CPA. Each audit includes a contract compliance report. The audits are submitted to the DMH/MR Contracts Office for review and follow-up if necessary. No recent audits included non-compliance reports regarding the provision of HIV Early Intervention Services. However, the Contracts Office routinely requires follow-up on deficiencies cited in audit reports.

HIV Early Intervention Services are monitored during every certification on-site visit through the application of the Certification Standards which include the following pertinent sections.

- Program Descriptions;
- Policies;
- Client Protection;
- Client Records;
- Quality Assurance Plan;
- Treatment and Rehabilitation Services;
- Intensive Outpatient; and
- General Outpatient.

HIV Early Intervention Services are documented in the individual client record and reviewed for compliance with all promulgated standards. Areas of non-compliance are identified for each program in a written report. Corrective actions are promptly identified by each program. If actions are satisfactory, certification is continued. During the 2009 SAPT BG expenditure period, the following on-site reviews were conducted and all non-compliant areas were corrected, therefore, certification was continued.

Program	County	Region	Date
Chemical Addictions Program	Montgomery	3	10/08
East Central MHC	Pike	3	12/08
Alcohol and Drug Treatment	Jefferson	2	3/09
Mobile MHC	Mobile	4	7/09
Cahaba MHC	Dallas	3	7/09
UAB	Jefferson	2	7/09
Cheaha MHC	Talladega	2	8/09

FY 2010 (INTENDED USE)

Alabama is not a designated State since the AIDS rate for 2007 is 8.5 per 100,000 population. Alabama has dropped below the required rate of 10.0 per 100,000 population before but has always returned to designated status the following year. Data provided by the Alabama Department of Public Health, HIV AIDS Division, indicate that Alabama AIDS rate for 2008 is 7.4 per 100,000 population. This means that for the first time Alabama will not be a HIV designated State for two consecutive years. Therefore, the SASD does not plan to expend any of the 2010 SAPT BG funds for HIV Early Intervention Services.

The SASD will coordinate the termination of service with community providers, the Alabama Department of Public Health and local AIDS Coalitions. The key elements of the transition will address the conversion of HIV EIS funding back to substance use disorder treatment services and the continued availability of HIV EIS through local AIDS Coalitions.

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2007 Uniform Application, Section III.4, FY 2007 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
• the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
• the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:
• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
• the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

By October 1, 1992, initial contacts had been made by the Division of Substance Abuse Services with the Tuberculosis Control Branch of the Alabama Department of Public Health. Planning meetings began in early November with the focus being to deliberately address preventing and treating tuberculosis for those accessing the substance abuse service system while making implementation of testing procedures of minimal disruption to programs. Immediately the issues of staff health, confidentiality regulations and consistent reporting were identified. As a result of discussions, the decision was made to train supervisors separately from clinicians and nurses in order to address administrative considerations. All staff would need training on tuberculosis and reporting procedure, etc., however, for those programs with nursing staff, retraining on placing and reading the skin test would be advisable.

Once the dilemma of both departments honoring separate sets of confidentiality regulations was identified, a detailed comparison of the laws was compiled. The end result was to find the laws basically the same with no significant areas of conflict. Both however, required individual client releases to be signed if information was to be divulged to another agency not covered under their law. Since both agencies are advocates of the client, a cooperative agreement could be developed to omit the need for releases. Another problem in this area related to the contracting arrangement with local substance abuse service providers, meaning the cooperative agreements used by the state departments would not cover substance abuse program communications to the local Health Department. To resolve this issue, a sample local interagency agreement at state level is reinforced by local agreements resulting in the elimination of individual releases when reporting the need for test results and other basic information between substance abuse and public health agencies on behalf of clients requesting services.

In order to maximize the resources of both agencies, the Division of Substance Abuse Services agreed to use the current Public Health tuberculosis reporting system and develop guidelines for all substance abuse providers in fulfilling the TB requirements. The Department of Public Health provides all supplies and equipment needed for testing except alcohol swabs and needed disposal boxes. For those programs with nursing staff, the Public Health local TB managers are available to assist on questionable test results and following up on positive results. For those programs without nursing staff, cooperative arrangements can be made for TB managers to come to the program when testing is needed by a number of clients.

Programs are also strongly encouraged to do testing of staff, although this is not a stated requirement within the Block Grant. The need for a staff testing system was obvious to the planners, along with policies and procedures of how staff TB status/issues would be accommodated.

Between February 2 and April 6, 1993, training was conducted in the four Substance Abuse Services Regions to three audiences: administrative, clinicians and nurses. The training was segmented based on the informational needs and prominent concerns of each group. The training team was made up of the SASD Chiefs of the Office of Training and the Office of Treatment Improvement along with the Director of the Public Health Department's Tuberculosis Control Branch, his assistant RN and a consultant M.D. All programs were given the option of attending any of the scheduled events, however, local Tuberculosis managers were available at meetings encompassing their district of supervision only. 56 administrators, 42 clinicians, and 54 nurses, totaling 152 participants attended the training. The training was approved for CEU credit hours for nurses, psychologists, social workers and counselors. After all training was completed a list of programs not represented at any event was compiled. The list was given to local TB managers for personal contact and technical assistance in adhering to the Block Grant testing requirements and state guidelines. Substance abuse programs have also been encouraged to contact the Division of Substance Abuse Services or the Tuberculosis Control Branch of Public Health regarding problems that are experienced in fulfilling the grant requirements while serving clients in the most time efficient manner.

Modifications were made in Alabama's approach to TB testing based on data collected by the Department of Public. From October 1, 1993, to September 30, 1995, the Department of Public Health screened 13,556 substance abuse clients for TB. A total of two new cases of TB were discovered. The Department of Public Health recommended that due to the very low number of new cases and the very high cost of testing every admission that Alabama cut back on the requirement for testing all admissions and provide TB tests only for those clients who show symptoms.
The Alabama Substance Abuse Services Division implemented a policy beginning October 1, 1995, requiring that intake clinicians observe and refer only those clients who show symptoms.

Since the implementation of the change beginning in October 1995, most of the community programs are only testing the clients that show symptoms of TB, however, some of the programs still test all admissions. The programs that still require tests of all admissions provide testing on site using trained staff. It is the professional opinion of the staff with the Health Department and the substance abuse community treatment programs that the current approach will adequately detect TB infected clients receiving substance abuse treatment.

The Alabama Public Health Department estimates that approximately 6% of state funds expended for tuberculosis services are attributable to substance abusers. Therefore, the estimate of state TB expenditures for substance abusing citizens is calculated by multiplying the state expenditures, reported by the Public Health Department's Tuberculosis Branch, by 6%. In addition to these state expenditures the Alabama Department of Mental Health and Mental Retardation, Substance Abuse Services Division spends state funding to pay for screening/assessments for adolescents that include TB screening. The inclusion of these expenditures was approved.

TB EXPENDITURES

Alabama received a Center for Substance Abuse Treatment Core Review in April 2008. The following represents a modification to the T. B. State Expenditure Table that was prepared in consultation with the review team.

FFY TB ST Exp. X .06 SA Exp. + Adol./Assess. Total

FFY 1991 $2,470,000 x .06 $148,200 0 $148,200
FFY 1992 $2,470,000 x .06 $148,200 0 $148,200
FFY 1993 $2,880,000 x .06 $172,800 0 $172,800
FFY 1994 $2,600,000 x .06 $156,000 0 $156,000
FFY 1995 $2,600,000 x .06 $156,000 0 $156,000
FFY 1996 $2,675,905 x .06 $160,554 0 $160,554
FFY 1997 $2,739,148 x .06 $164,348 0 $164,348
FFY 1998 $2,740,997 x .06 $164,459 0 $164,459
FFY 1999 $1,400,665 x .06 $ 84,039 + $130,537 = $214,576
FFY 2000 $1,552,233 x .06 $ 93,134 + $140,560 = $233,694
FFY 2001 $1,827,974 x .06 $109,678 + $147,760 = $257,438
FFY 2002 $2,012,030 x .06 $120,721 + $147,640 = $268,361
FFY 2003 $1,767,116 x .06 $106,026 + $132,905 = $238,931
FFY 2004 $2,609,454 x .06 $156,567 + $128,987 = $284,987
FFY 2005 $2,450,783 x .06 $147,046 + $144,815 = $291,861
FFY 2006 $2,873,796 x .06 $172,427 + $118,795 = $246,440
FFY 2007 $2,159,415 x .06 $129,564 + $ 88,219 = $217,784
FFY 2008 $2,119,052 x .06 $127,143 + $246,734 = $373,877

HIV Early Intervention Efforts:

During FFY 1995 the Substance Abuse Services Division (SASD), using information provided by the Alabama Department of Public Health, identified the mental health catchment areas that had the highest HIV and AIDS positivity rate per 100,000 citizens. The catchment area (M-16) including Mobile and Washington counties ranked number one. The catchment area (M-5) including Jefferson, Blount, and St. Clair counties ranked number two. The catchment area (M-14) including Montgomery, Elmore, Autauga, and Lowndes counties ranked number three.

During FFY 1995 contracts were entered into with the Alcoholism Recovery Service and the University of Alabama Substance Abuse Program to provide HIV Early Intervention Services in the M-5 catchment area. A contract was entered into with the Mobile Mental Health Center to provide HIV Early Intervention Services in the M-16 catchment area. Contracts were entered into with the Lighthouse Counseling Center and the Chemical Addictions Program to provide HIV Early Intervention Services in the M-14 catchment area.

During FFY's 1996 & 1997 contracts were entered into with the East Central Mental Health Center for the M-15 catchment area, the Cahaba Mental Health Center for the M13 catchment area, and the Huntsville-Madison Mental Health Center for the M-3 catchment area for the provision of HIV Early Intervention Services.

The AIDS positivity rate per 100,000 population for 1998, as reported by the Alabama Public Health Department, showed the following ranking of mental health catchment areas.

1. M-14 Montgomery catchment area
2. M-16 Mobile catchment area
3. M-5 Birmingham catchment area
4. M-19 Dothan catchment area
5. M-21 Baldwin County catchment area
6. M-2 North Central catchment area*
7. M-15 East Central catchment area

* Catchment Area #2 is an anomaly. Limestone Prison is located in Cullman County and is used to segregate HIV/AIDS positive inmates for the entire state. The Alabama Public Health Department is working to resolve this reporting problem.

During FFY's 1999, 2000 and 2001 the SASD contracted with four of the top ranking seven catchment areas (M-14, M-16, M-5, and M-15) for the provision of HIV Early Intervention Services.

According to 2002 HIV/AIDS surveillance reports, the mental health catchment areas ranked as follows regarding rates of HIV/AIDS per 100,000 population.

1. M - 15
2. M - 14
3. M - 5
4. M - 19
5. M - 16
6. M - 7
7. M - 12

During FFY 2002, 2003, 2004 and 2005 contracts with four of the top ranking catchment areas were continued (M-15, M-14, M-5 And M-16). The contracted services include pre-test counseling, testing and post-test counseling.

During FFY 2006 the SASD contracted with six of the top ranking mental health catchment areas (M-5, M-12, M-13, M-14, M-15 and M-16) in rate of new AIDS cases per 100,000 population.

During FFY 2007 and 2008 the SASD contracted with community service providers in seven mental health catchment areas with the highest rate of new AIDS cases per 100,000 population. Contracts are planned to be continued through FFY 2009.

Alabama became a HIV designated state in 1995. At that time there were no funds under the control of the Alabama Department of Mental Health or the Alabama Legislature being spent to provide HIV services for substance abuse treatment clients. Therefore, the M.O.E. base for HIV has always been reported as zero.

All HIV services purchased by the Substance Abuse Services Division for substance abuse treatment clients have been reimbursed with SAPT Block Grant funds.

HIV Early Intervention Expenditures

Federal Fiscal Year	State Funds	SAPT Funds

FFY 1995	0	$ 826,677.90
FFY 1996	0	$ 851,081.00
FFY 1997	0	$ 974,542.45
FFY 1998	0	$ 974,542.45
FFY 1999	0	$1,083,342.00
FFY 2000	0	$1,109,865.00
FFY 2001	0	$1,149,732.95
FFY 2002	0	$1,191,400.00
FFY 2003	0	$1,157,343.63
FFY 2004	0	$1,248,910.00
FFY 2005	0	$1,039,630.00
FFY 2006	0	$1,185,861.00
FFY 2007	0	$1,188,387.00
FFY 2008	0	$1,188,837.00*

* Estimated at time of document preparation.

REVISION REQUEST:

Please describe the State’s activities during FY 2007 regarding TB services.

The Alabama Public Health Department does not track the number of TB infected individuals that self report problematic drug and alcohol use.

The SASD does not track the number of individuals receiving substance use disorder treatment that are referred for additional TB services.

The Alabama Public Health Department partnered with the SASD to develop and implement the TB initiative. All treatment providers depend on the County Health Departments to receive TB referrals. The SASD does not require copies of Memorandums of Understanding from providers.

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2007 (Compliance): (Reporting REQUIRED if State chose to participate)
FY 2009 (Progress): (Reporting REQUIRED if State chose to participate)
FY 2010 (Intended Use): (State participation is OPTIONAL)

FY 2007 (COMPLIANCE)

The loan has defaulted and efforts to collect were fruitless. Alabama decided to discontinue the project. Refer to Attachment F for a full explanation.

FY 2009 (PROGRESS)

The loan has defaulted and efforts to collect were fruitless. Alabama decided to discontinue the project. Refer to Attachment F for a full explanation.

FY 2010 (INTENDED USE)

The history of Alabama's operation of the "Revolving Loan Fund" is described in Attachment F. Based on previous experiences, Alabama chooses to not participate in the development of group homes through the "Revolving Loan Fund" process.

Attachment F: Group Home Entities and Programs

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in FY 2007 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund, then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2007 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:
• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year ;
• the source of funds used to establish and maintain the revolving fund ;
• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered ;
• the private, nonprofit entity selected to manage the fund ;
• any written agreement that may exist between the State and the managing entity ;
• how the State monitors fund and loan operations ; and
• any changes from previous years' operations.

During 1990, $100,000 from the FFY 1989 ADMS Block Grant was allocated to initiate a revolving loan fund by contract with Aletheia House, Inc., a substance abuse provider in Birmingham. Aletheia House advertised the funding and the application process as available for any non-profit, private group. To qualify for the loan, the groups must agree that:

1. The housing would be offered to four or more recovering individuals.
2. The housing would be maintained as an alcohol and drug free environment.
3. That the residents violating this rule would be expelled.
4. That the residents would pay rent which would repay the loan.
5. That the program would be operated as a self-managed democracy.

The loans would be made to non-profit, private groups, i.e., churches, civic groups, social service agencies, associations and other interested non-profit groups are eligible loan recipients.

The loans would be for no more than $4,000. This would bear an interest of 5% and must be repaid within two years. A late fee would be charged for past due payments.

A committee of alcohol/drug abuse professionals would review all loan applications. The committee would attempt to distribute loans throughout Alabama, including rural and urban areas. Loans to programs that provide housing to under served populations (e.g. pregnant women, addicts/alcoholics with physical disabilities, women and children, homeless individuals, etc.) would be given special consideration.

Aletheia House, Inc., the administrator for the revolving loan fund, made a total of twenty-three loans. All of the loans were for the development of Group Homes for recovering substance abusers.

Following is a list of the entities that received loans from the revolving fund:

Program Name	Location
1. Recovery Is Possible I	Birmingham
2. Recovery Is Possible II	Birmingham
3. CARSO	Montgomery
4. Goodwin-Herring	Birmingham
5. Hedges & Highways	Birmingham
6. Oakmont Cottage	Birmingham
7. Oakmont Center	Birmingham
8. Sunlife Services	Dothan
9. Community Service Organization	Birmingham
10. Alabama Youth Life Line	Birmingham
11. Recovery for Women	Birmingham
12. The Recovery Home	Birmingham
13. Living Sober	Birmingham
14. Mcgahee Recovery Home	Birmingham
15. The Master's House	Flat Rock
16. Miracles Happen	Birmingham
17. New Murray Temple (for women)	Anniston
18. New Murray Temple (for men)	Anniston
19. The Master’s House #2	Flat Rock
20. WHIP (Where Hope Is Possible)	Birmingham
21. Back On Track	Birmingham
22. One Day At A Time	Birmingham
23. Pass It On	Birmingham

During FY 1991-92, Aletheia House, Inc., stopped managing the Revolving Loan Fund. A balance of $30,000 was

returned to the DMH/MR. At that time twenty-three loans had been made from the Revolving Loan Fund, 11 have been turned over to a collection agency and 12 have been written off.

The SASD developed a mechanism to manage the remaining balance of the Revolving Loan Fund. The following loans were made since DMH/MR assumed the management of the fund.

1. September 28, 1994, a loan was made to Oxford House Perryhill Road, Montgomery the loan of $4,000 was repaid in full.

2. September 13, 1994, a loan was made to Oxford House Locust, Montgomery, The loan of $3,000 was defaulted after nine payments, leaving an uncollected balance due of $1,793.48.

3. June 20, 1996, a loan was made to the Quad Cities Oxford, Sheffield, the loan of $4,000 is being repaid. The last payment was received May 27, 1998, in the amount of $354.26. The current remaining balance is $170.42.

4. May 14, 1997, a loan was made to Grandview Oxford House, Sheffield, the loan of $4,000 was made, and no payments have been made thus far. Collection efforts have been fruitless.

5. June 22, 2001, a loan was made to We Are Women in Recovery. The loan of $4,000 is being repaid at a rate of $177.28 per month. The first payment was received on 8/17/2001. The current balance is $3,540.78.

The loan has defaulted. Collection efforts have been fruitless. The project was discontinued.

Goal #8: Tobacco Products

GOAL # 8.

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2010 Annual Synar Report included with the FY 2010 uniform application? (Yes/No)

- If No, please indicate when the State plans to submit the report: (mm/dd/2009)

Note: The statutory due date is December 31, 2009.

The State's FY 2010 Annual Synar Report was submitted December 7, 2009.

Alabama has already established a State Law, which makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 19. Alabama has developed a methodology for the enforcement of the law that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age 19.

Objective: Reduce the availability of tobacco and tobacco products to minors in Alabama.
FFY 2007 (Compliance):

Result: Accomplished. Refer to Appendix B, for a complete description of the activities.

Activity: The compliance, enforcement and reporting plan will be implemented.

Current Status: Accomplished.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.

Current Status: Accomplished.

Activity: The appropriate reports will be submitted to the Center for Substance Abuse Prevention.
Current Status: The report is being compiled for inclusion with the 2005 Block Grant Application. Accomplished.

FFY 2009 (Progress):

Result: Accomplished. Refer to Appendix B, for a complete description of the activities.

Activity: The compliance, enforcement and reporting plan will be implemented.

Current Status: Accomplished.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.
Current Status: Accomplished.

Activity: The appropriate reports will be submitted to the Center for Substance Abuse Prevention.

Current Status: The report is being compiled for inclusion with the 2008 Block Grant Application.

FFY 2010 (Intended Use):

Activity: The compliance, enforcement and reporting plan will be implemented.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.

Activity: The appropriate reports will be submitted to the Center for Substance Abuse Prevention.

REVISION REQUEST:
The State's FY 2010 Annual Synar Report was submitted December 7, 2009 and the Revisions were submitted on January 25, 2010.

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

Goal #9: Pregnant Women Preferences

FY 2007(COMPLIANCE)

This goal was met during the SAPT BG 2007 expenditure period.

Reported Activity: All contracts will contain a prioritization listing of clients for admission. Pregnant women will be the first priority.

Result: Accomplished. SASD Contract Exhibit SA-3 (Goal #1-Attachment #2) includes the following.

A. Pregnant Women

1. The Contractor and its Subcontractor(s) exclusive of programs operating for males only, will give preference to pregnant women in admissions to substance abuse treatment.
2. If the Contractor and its Subcontractor(s) have insufficient capacity to provide treatment services for a pregnant woman, who seeks services from the facility, the woman will be referred to the Substance Abuse Services Division (SASD) of DMH/MR.

SASD Contract Exhibit SA-4 (Goal #1-Amendment #2) includes the following.

B. Clinical Criteria for treatment services:

1. It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons (and their family members when appropriate) who, in addition to the financial criteria stated above, also meet the Diagnostic and Statistical Manual of Mental Disorders, latest edition, clinical criteria of psychoactive substance dependency or abuse, in the following order of priority.
    a. Pregnant women.
    b. Women with dependent children.
    c. Injectable drug users (6 months history of injectable drug use and use-of injectable drugs within the last 30 days).
    d. Psychoactive substance dependence, severe.
    e. Psychoactive substance dependence, moderate
    f. Psychoactive substance dependence, mild
    g. Psychoactive substance abuse.

Reported Activity: The Treatment Access Project (TAP), which is driven by priorities for admission set by the block grant requirements will be operational. The TAP is fully explained in the SAPT Block Grant Application.

Reported Activity: System capacity will be managed through TAP. This activity is combined with the next for result reporting.

Reported Activity: Waiting list will be managed through TAP.

Result: Not Accomplished. During the 2007 SAPT BG expenditure period the TAP was functioning as the SASD's only process for managing system capacity and wait lists. However, the system had deteriorated to the point it was not collecting adequate data regarding capacity, wait list or priority populations. The SASD was only sporadically receiving wait list data, bed availability data and correlating priority population data. During this period the SASD was developing the Alabama Substance Abuse Information System (ASAIS). ASAIS is described in Goal #9-Attachment #'s 1&2 of the 2010 SAPT BG Application. ASAIS includes the required determination and reporting of all SAPT BG priority populations, including pregnant women and women with dependent children. Priority populations are also emphasized in on-going training sessions.

Reported Activity: Training and technical assistance will be made available regarding TAP.

Result: Not Accomplished. No training or technical assistance was provided regarding TAP. However, the development phase of ASAIS required meetings and biweekly conference calls including representatives from provider organizations. Even though ASAIS is a billing and reporting system, much discussion and planning involved waiting list, capacity and priority population management since the SAPT BG requirements are embedded in ASAIS.

The following meetings or conference calls took place during the 2007 SAPT BG expenditure period regarding the development of ASAIS.

Systems development meetings (JAD Sessions) including providers occurred on October 18-20, 2005 and November 2-4, 2005.

Bi-weekly conference calls regarding the development of ASAIS, which were usually participated on by fifty to sixty provider representatives, began in February 2006 and continued through November 2008.

Provider on-site visits, regarding ASAIS, were conducted on the following dates:

March 27-29, 2006
April 10-13, 2006
April 25-27, 2006
May 8-11, 2006

Regional training sessions were conducted on the following dates:

October 29-31, 2007
November 1, 2007
November 13-16, 2007
November 27-29, 2007

FY 2009 (PROGRESS)

Reported Activity: All contracts will contain a prioritization listing of clients for admission. Pregnant women will be the first priority.

Result: Accomplished. SASD Contract Exhibit SA-3 (Goal #1-Attachment #2) includes the following.

B. Pregnant Women

1. The Contractor and its Subcontractor(s) exclusive of programs operating for males only, will give preference to pregnant women in admissions to substance abuse treatment.
2. If the Contractor and its Subcontractor(s) have insufficient capacity to provide treatment services for a pregnant woman, who seeks services from the facility, the woman will be referred to the Substance Abuse Services Division (SASD) of DMH/MR.

SASD Contract Exhibit SA-4 (Goal #1-Attachment #2) includes the following.

B. Clinical Criteria for treatment services:

2. It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons (and their family members when appropriate) who, in addition to the financial criteria stated above, also meet the Diagnostic and Statistical Manual of Mental Disorders, latest edition, clinical criteria of psychoactive substance dependency or abuse, in the following order of priority.
    a. Pregnant women.
    b. Women with dependent children.
    c. Injectable drug users (6 months history of injectable drug use and use-of injectable drugs within the last 30 days).
    d. Psychoactive substance dependence, severe.
    e. Psychoactive substance dependence, moderate
    f. Psychoactive substance dependence, mild
    g. Psychoactive substance abuse.

Reported Activity: Alabama Substance Abuse Information System (ASAIS), which is driven by priorities for admission set by the block grant requirements, will be operational. ASAIS is fully explained in Goal # 9-Attachment #'s 1&2 of the 2010 SAPT BG Application.

Current Status: ASAIS began operation on July 1, 2008 on a statewide basis. All Contractors participate by submitting enrollment, wait list, admission, client demographic, billing, service, discharge and outcome data through ASAIS.

Reported Activity: System capacity will be managed through ASAIS.

Current Status: System capacity information is currently being submitted by all contracting providers through ASAIS. Management reports are being refined.

Reported Activity: Waiting list will be managed through ASAIS.

Current Status: The SASD waiting list is managed through ASAIS. Goal #9-Attachment #3 is a preliminary residential program wait list report generated from ASAIS.

Reported Activity: Training and technical assistance will be made available regarding ASAIS.

Current Status: The following meetings or conference calls took place during the 2009 SAPT BG expenditure period regarding the development of ASAIS.

Training and on-site assistance continue regarding all aspects of ASAIS including priority population access and interim service requirements. The following provider training sessions were conducted during SFY 2008-2009.

Second Round Claims Training:

December 1-4, 2008

Provider Training on Version 6.1:

February 5-6, 2009
February 9-13, 2009
February 18-20, 2009

The most recent training schedule and other pertinent information related to ASAIS are provided on the DMH/MR website, www.mh.alabama.gov . In addition to these training events technical assistance visits are on-going including the following.

9/2-4/2008	Montgomery
10/8/2008	Mobile
10/7/2008	Birmingham
11/17/2008	Daphne
11/20/2008	Birmingham
12/8/2008	Decatur
2/11-12/2009	Birmingham
2/9-10/2009	Anniston
2/18-19/2009	Mobile

The SASD is implementing an on-site SAPT BG grant monitoring process (as described in Goal #5-Attachment # 2) designed to enhance the current contractual monitoring. This process will be implemented during SFY 2009-2010. Progress of the new implemented process will be reported in the 2011 SAPT BG application.

FY 2010 (INTENDED USE)

The SASD will continue emphasis on access to substance abuse treatment services for pregnant women and women with dependent children during the 2010 SAPT BG expenditure period. This goal will be accomplished through the following activities.

1. All contracts will contain a prioritized listing of clients for admission. Pregnant women will be the first priority. Women with dependent children will be the second priority.

2. ASAIS will be continued as the screening, enrollment, assessment, wait list and admission process which is driven by the SAPT BG priority populations.

3. System capacity will be managed through ASAIS.

4. Contractor compliance will be monitored by the SASD.

FY 2009 (PROGRESS)

Reported Activity: All contracts will contain a prioritization listing of clients for admission. Pregnant women will be the first priority.

Result: Accomplished. SASD Contract Exhibit SA-3 (Goal #1-Attachment #2) includes the following.

B. Pregnant Women

1. The Contractor and its Subcontractor(s) exclusive of programs operating for males only, will give preference to pregnant women in admissions to substance abuse treatment.
2. If the Contractor and its Subcontractor(s) have insufficient capacity to provide treatment services for a pregnant woman, who seeks services from the facility, the woman will be referred to the Substance Abuse Services Division (SASD) of DMH/MR.

SASD Contract Exhibit SA-4 (Goal #1-Attachment #2) includes the following.

B. Clinical Criteria for treatment services:

2. It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons (and their family members when appropriate) who, in addition to the financial criteria stated above, also meet the Diagnostic and Statistical Manual of Mental Disorders, latest edition, clinical criteria of psychoactive substance dependency or abuse, in the following order of priority.
a. Pregnant women.
b. Women with dependent children.
c. Injectable drug users (6 months history of injectable drug use and use-of injectable drugs within the last 30 days).
d. Psychoactive substance dependence, severe.
e. Psychoactive substance dependence, moderate
f. Psychoactive substance dependence, mild
g. Psychoactive substance abuse.

Reported Activity: Alabama Substance Abuse Information System (ASAIS), which is driven by priorities for admission set by the block grant requirements, will be operational. ASAIS is fully explained in Goal # 9-Attachment #'s 1&2 of the 2010 SAPT BG Application.

Current Status: ASAIS began operation on July 1, 2008 on a statewide basis. All Contractors participate by submitting enrollment, wait list, admission, client demographic, billing, service, discharge and outcome data through ASAIS.

Reported Activity: System capacity will be managed through ASAIS.

Current Status: System capacity information is currently being submitted by all contracting providers through ASAIS. Management reports are being refined.

Reported Activity: Waiting list will be managed through ASAIS.

Current Status: The SASD waiting list is managed through ASAIS. Goal #9-Attachment #3 is a preliminary residential program wait list report generated from ASAIS.

Reported Activity: Training and technical assistance will be made available regarding ASAIS.

Current Status: The following meetings or conference calls took place during the 2009 SAPT BG expenditure period regarding the development of ASAIS.

Training and on-site assistance continue regarding all aspects of ASAIS including priority population access and interim service requirements. The following provider training sessions were conducted during SFY 2008-2009.

Second Round Claims Training:

December 1-4, 2008

Provider Training on Version 6.1:

February 5-6, 2009
February 9-13, 2009
February 18-20, 2009

The most recent training schedule and other pertinent information related to ASAIS are provided on the DMH/MR website, www.mh.alabama.gov . In addition to these training events technical assistance visits are on-going including the following.

9/2-4/2008	Montgomery
10/8/2008	Mobile
10/7/2008	Birmingham
11/17/2008	Daphne
11/20/2008	Birmingham
12/8/2008	Decatur
2/11-12/2009	Birmingham
2/9-10/2009	Anniston
2/18-19/2009	Mobile

The SASD is implementing an on-site SAPT BG grant monitoring process (as described in Goal #5-Attachment # 2) designed to enhance the current contractual monitoring. This process will be implemented during SFY 2009-2010. Progress of the new implemented process will be reported in the 2011 SAPT BG application.

FY 2010 (INTENDED USE)

The SASD will continue emphasis on access to substance abuse treatment services for pregnant women and women with dependent children during the 2010 SAPT BG expenditure period. This goal will be accomplished through the following activities.

1. All contracts will contain a prioritized listing of clients for admission. Pregnant women will be the first priority. Women with dependent children will be the second priority.

2. ASAIS will be continued as the screening, enrollment, assessment, wait list and admission process which is driven by the SAPT BG priority populations.

3. System capacity will be managed through ASAIS.

4. Contractor compliance will be monitored by the SASD.

Attachment G: Capacity Management and Waiting List Systems

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2008) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

1992-1997:

In the summer of 1992 more than 800 citizens were included on waiting lists for residential substance abuse treatment in Alabama. At that time action was taken by the SASD to improve the situation and work toward equal access to treatment for appropriate substance abuse clients. Thus, the Treatment Access Project (TAP) was launched on October 1, 1992.

The capacity management system was developed at no extra cost.

The SASD training team traveled around the State informing providers, soliciting their input, providing technical assistance and training in the new automated admissions system which included the TAP. A cross section of volunteers was recruited from the substance abuse provider network and the Alabama Council of Community mental Health Centers. The TAP volunteers work group began its work in January 1992.

Over a period of ten months, the TAP workgroup diligently developed standardized waiting list protocols, assessment procedures, adult crisis residential referral criteria, and uniform state wide release of confidential information. A large portion of the TAP workgroup's efforts were focused on the development of a model for internal prioritization, waiting list and capacity management systems as required by the Block Grant. TAP's first statewide training seminar was conducted in September 1993. The seventy-five participants included program directors and coordinators, assessment specialists, and waiting list specialists, representing mist of the State's contracted assessment centers (IOP's) and residential treatment providers. A TAP Training and Procedures Manual was developed and made available to providers. TAP maintained a statewide directory of service providers that was also available to all providers.

In 1994 the TAP workgroup developed the standardized assessment package required by treatment centers prior to placing a client on the waiting list. In 1995 the workgroup undertook the task of revising the standardized psychosocial assessment instrument including elements from the nationally endorsed Addiction Severity Index (ASI) instrument. The revised instrument was implemented October 1, 1995.

1997-2008:

The Office of Research, Evaluation and Information was assigned to manage Alabama's TAP which includes capacity management and management of waiting list systems. In 1997 the TAP process was modified. On a weekly basis, a statewide window was obtained from all of the State's contracted residential substance abuse treatment providers. TAP maintained a current record of the number of clients on waiting lists by priority codes. This report was made available on the department's website. This information was used by referral agencies for speedier placement of priority population clients. A monthly survey of provider waiting lists was conducted to ascertain an accurate count of unduplicated clients waiting for residential treatment. TAP's Capacity Management Program required providers receiving Block Grant funds, who provided services to injectable drug users, to report to the State when they reached 90 percent capacity. TAP's Waiting List Management Program provided systematic reporting of treatment demand to the SASD. TAP required each provider to establish and maintain an internal Waiting List/Capacity Management System, and to give pregnant women, women with dependent children and injectable drug users priority for residential treatment services. Providers were required to offer interim services to top priority clients while they were waiting for residential treatment. TAP was designed on the basis of the SAPT BG requirements.

2009:

Since 2004 the SASD has been developing a new automated system for implementation of screening, assessment, level of care determination, unique identifier, capacity management, priority population, wait list management, billing, payment processing, outcome measurement and data warehousing. The system, the Alabama Substance Abuse Information System (ASAIS), was implemented July 1, 2008, however, all components will not be fully operational until the spring of 2010. A full description of ASAIS is attached in the form of the Provider Training Manual and the Provider Claims/Finance Training Manual (Goal #9-Attachment #'s 1&2.). ASAIS is designed to meet the capacity management, wait list and priority population requirements of the SAPT BG.

During the 2007 SAPT BG expenditure period Alabama expended a total of $1,154,821, in State funds, on development training and provider infrastructure development for ASAIS.

Data System Development	$410,138
Expert Consultation	316,441
Provider Infrastructure	328,242
Provider Pilot Sites	100,000
Total State Expenditures	$1,154,821

All community providers are required to utilize the SASD billing, reporting, capacity management, screening, assessment, patient placement and outcome management system. During the 2007 SAPT BG expenditure period Alabama contracted with approximately forty-five providers including all of the Block Grant recipient programs. Since ASAIS has bee implemented, the SASD provides for approximately two hundred and twenty-five user licenses representing all contracted providers.

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the 2007 SAPT BG expenditure period.

The SASD developed a standardized assessment, referral and admission process in 1992 which included a psycho-social assessment, priority placement requirements, residential waiting list protocols, etc. This process was named the Treatment Access Project (TAP). As previously stated, the TAP including its many components went through numerous revisions over the years. For example, the core elements of the original assessment instrument are still required in current certification standards #5203 (Goal #5-Attachment #1). TAP, in its evolved state, was functioning during the 2007 SAPT BG expenditure period. Also during the 2007 SAPT BG expenditure period the SASD began the development of a new screening, assessment, enrollment, level of care determination process. The new process will replace TAP and is a systematic change in the standardization of addressing the clinical pathway (Screening, Assessment, and Treatment Planning) designed to identify psychiatric and substance disorders, levels of care, and stages of motivation and change. The assessment utilizes DSM-IV-TR criteria and American Society of Addiction Medicine criteria (ASAM PPC-2R). The assessment also folds in the Human Service Needs Assessment and the questions to determine Specialized Women's Services.

In summary, these improvements coupled with the enhanced referral capabilities incorporated in ASAIS are evidence the SASD met the goal by continuing to improve the State referral process.

FY 2009 (PROGRESS)

Reported Activity: Specific referral criteria will be developed for each service available, i.e. crisis residential, residential rehabilitation, intensive outpatient, etc.

Current Status: The SASD is expanding the levels of care available in Alabama. The expanded levels of care (included in Goal #1, 2010 INTENDED USE section), assessment and placement criteria are guided by American Society of Addiction Medicine criteria (ASAM PPC-2R). The screening and assessment process utilizes DSM-IV-TR criteria. CSAT has participated in this process through funding of a Technical Assistance Contract with Dr. David Mee-Lee. The new process will be implemented during FY 2009-2010.

Reported Activity: The referral criteria will be incorporated as a part of the Treatment Access Project (TAP).

Current Status: The TAP was replaced by the new referral criteria which is an integral component of the ASAIS.

FY 2010 (INTENDED USE)

The SASD will continue to improve the process for referring individuals to the treatment modality that is most appropriate for the individual. The use of standardized assessment and ASAM PPC-2r will enhance accuracy of length of stay directly impacting referral. Also individualized treatment and varying length of stay will impact access and referral. Utilization of length of stay in ASAIS will also allow for review and documentation to support expansion of services in areas that may have waiting list.

Implementation of monitoring in the area of priority populations and wait list protocol will also affect referral and access.

Consideration is also being explored for having centralized assessment centers and a state maintained wait list.

Activity: The SASD will utilize a screening, assessment and placement process that supports the adopted ASAM levels of care.

Activity: The SASD will provide training regarding the screening, assessment and placement process.

Activity: The SASD will modify the screening, assessment and placement process as needed to assure appropriate and timely placement of individuals.

Activity: The SASD will monitor the effectiveness of the screening, assessment and placement process through on-site monitoring visits.

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FFY 2007 (Compliance)

Activity: The Substance Abuse Services Division has provided continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services.
SASD partnered with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has positions on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, and Southern Coast ATTC. These board positions have allowed SASD to participate in the planning and development of conferences that have addressed the workforce needs of the treatment and prevention professionals across the state. The goal of SASD was to offer prevention and treatment courses at every conference.

Current Status: Accomplished. SASD, Office of Certification and Training conducted training for substance abuse program staff in various locations throughout the State. There were 24 training events reaching 2205 participants throughout the state of Alabama .They are as follows: 1.) 3- HIPPA with an AOD Twist trainings offered in partnership with the University of Alabama at Birmingham AIDS Education Training Center, Alabama Alcohol and Drug Abuse Association (AADAA), Alabama Mental Health Counselors Association and SAMHSA 2.) Alabama School of Alcohol and Other Drug Studies 3.) 2- AADAA - Fall Conference and Prevention Conference 4.) Southeastern School of Alcohol and Other Drug Studies 5.) 3- Substance Abuse Case Management 6.) Training for SASD Site Reviewers 7.) 4- FEMA Crisis Counseling Training 8.) 2 - Substance Abuse Advocacy 9.) Deaf Interpreters Training 10.) IdentiFFYing Drugged People 11.) Client Centered Treatment Planning 12.) 2 - Documentation Training A1 13.) Appalachian School of Alcohol and Other Drugs Studies 14.) – Alabama Methadone Treatment Association 2007 Training.

The Substance Abuse service Division has provided on site technical assistance to substance abuse providers regarding the Matrix Model, Evidence Based Practices, and Co-Occurring.

The Office of Certification and Training conducted a treatment and prevention workforce survey in conjunction with SCATTC. A 3 SASD Workforce Committee has been formed with members from the certiFFYing boards, 2 and 4 years colleges, SCATTC, and treatment and prevention providers. They have begun to work on a workforce plan for the state.

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Alabama School of Alcohol and Other Drug Studies was held in Tuscaloosa AL in March. Continuing education units were offered.

Treatment courses offered: 1.) THE METHAMPETAMINE CRISIS - This course helped participants understand methamphetamine addiction and its unique qualities that brought it to epidemic levels in rural America and why it is now showing up in urban areas. 2.) THE JUVENILE SEXUAL OFFENDER: WHAT THE DATA ARE TELLING US, WHAT WE'RE DOING ABOUT IT, AND WHAT WE'D LIKE TO DO ABOUT IT – This course provided an overview of juvenile sexual offending and an introduction to the treatment and case management of the juvenile sexual offender. 3.) HEALING AN ANGRY HEART: TREATING ANGER AND AGGRESSION IN EARLY RECOVERY – This skills training event described treatment planning based on the variables of environment, medication and empirically proven psychotherapeutic approach. 4.) BULLIES FROM THE PLAYGROUND TO THE BOARDROOM – This course focused on "bullying" in the workplace. 5.) ADVOCACY – WHAT'S THE MESSAGE? – This course discussed ways to reduce the stigma associated with substance abuse and substance use, how to initiate funding sources, and how to effectively communicate with your legislators, community leaders and the media. 6.) WILL YOUR RECORD'S DOCUMENTATION STAND UP IN COURT? – This workshop explained the importance of accurate and timely health record documentation. 7.) POSTTRAUMATIC STRESS DISORDER (PTSD) AND SUBSTANCE ABUSE – This course discussed key biological, social, and clinical issues related to the case management and treatment of individuals diagnosed with PTSD and substance use disorders. 8.) CONFIDENTIALITY AND PRIVACY PROTECTIONS UNDER FEDERAL STATUTES FOR PARTICIPANTS IN THE CRIMINAL JUSTICE SYSTEM – An intensive 1-day workshop that covered Federal confidentiality and privacy regulations affecting criminal justice programs that refer substance abuse patients. 9.) ETHICS AND HIV/AIDS FOR THE PROFESSIONAL – Allowed professionals to learn more about why they have codes of ethics, how to make ethical decisions, how to avoid malpractice suits and information to help the recovering professional maintain well established boundaries. 10.) SPIRITUALITY AND THE 12 STEPS – This course was designed to explore the spiritual aspects of the 12-Steps of recovery. 11.) MARIJUANA-THE

METH ADDICT'S CALMATIVE – A comprehensive overview of the neurobiology and pharmacology of both methamphetamine and marijuana. 12.) WHO ETCHED ON YOUR SKETCH – Using a series of thought-grams and concepts of personal journaling, this course refreshed our spirits towards encouraging the human side of life and work. 13.) ATTRIBUTES OF EFFECTIVE COUNSELORS -This training sought to assist in clariFFYing the attributes to improve the counselors functioning in a therapeutic setting. It discussed the skills and insights necessary for effective counseling in a multi-cultural setting. 14.) EFFECTIVE APPROACHES TO GANG, YOUTH VIOLENCE & DRUG DEALING: Part One: Developing a Plan that has a Chance to Succeed – Part 1 was designed to give information on identiFFYing real gang involvement and the gang sub-culture; how to impact youth drug dealing; and research based strategies for addressing these issues. 15.) MANAGING STRESS IN THE WORKPLACE –This session addressed concerns about workplace stress, some causes of stress in the workplace and ways to reduce or manage stress. 16.) INTENSIVE SKILL TRAINING IN MOTIVATIONAL INTERVIEWING – The objective of this course was to help participants understand the underlying concepts of Motivational Interviewing. 17.) TRANSFORMING TREATMENT APPROACHES FOR PREGNANT, POST-PARTUM AND PARENTING WOMEN AND THEIR CHILDREN – This workshop focused on the current state of women's treatment, examined what is known on the basis of evidence-based treatment and clinical experience, and suggested effective practices for substance abuse staff working with female clients with children. 18.) DRUG TESTING-HOW TO TURN YOUR DRUG TESTING INTO A FUNDING SOURCE FOR YOUR PROGRAM – This course discussed the major goals of establishing a drug testing program; how to promote accurate and reliable drug testing and establish a method for programs to turn their drug testing into a profit center for their organization. 19.) UNDERSTANDING DOMESTIC VIOLENCE AND SUBSTANCE ABUSE – This course was designed to educate professionals as to the nature and extent of domestic violence and the increase in complexity of dealing with domestic violence and substance abuse. 20.) BASIC GROUP COUNSELING SKILLS FOR THE SUBSTANCE ABUSE PROFESSIONAL – This course was a combination of didactic and experiential learning. We focused on basic group skills such as the development of group and the appropriate intervention in different stages of growth. 21.) THE TROUBLED EMPLOYEE – This course focused on the many ways employees can be troubled in their own mind and spirit and/or body. 22.) EVOLUTION OF MEDICATION ASSISTED TREATMENT FOR OPIATE DEPENDENCY – History and systems of medication for treatment of opiate dependency was reviewed with emphasis on the use of opiate replacement medications such as methadone, LAAM, and Buprenorphine. 23.) THE METH ADDICT'S BRAIN-THE NEUROBIOLOGY AND PHARMACOLOGY OF METHAMPHETAMINE – Participants gained an understanding of the short and long term effects of methamphetamine. 24.) FAMILY TREATMENT OF ADDICTIVE DISORDERS – This course identified the important variables that have been isolated as instrumental in the early development of chemical dependency. 25.) EFFECTIVE APPROACHES TO GANG, YOUTH VIOLENCE & DRUG DEALING: Part Two: Executing a Successful Plan that is Effective – Participants learned to implement outcome oriented plans. They also learned a four-step evaluation process for evaluating the effectiveness of their community plans. 26.) PRE AND POST RELEASE DYNAMICS OF THE SUBSTANCE ABUSING OFFENDER – This training was designed to aid counselors in developing an understanding of the multiple dynamics that may occur while working with offenders in a residential and out-patient setting. 27.) PREPARING FOR THE SUBSTANCE ABUSE COUNSELOR'S EXAM – This course included an in-depth study of the five Performance Domains of Substance Abuse Counseling, as well as a study of the 12 core functions of the substance abuse counselor. 28.) INTRODUCTION TO THE CANNABIS YOUTH TREATMENT SERIES – This training introduced professionals to the SAMHSA recognized curriculum designed to be an effective brief treatment approach for cannabis-abusing adolescents. 29.) COMING SOON TO AN AGENCY NEAR YOU! A MAJOR CHANGE IN HOW WE DO ONTO OTHERS; GETTING READY TO BECOME A CERTIFIED CLINICAL SUPERVISOR – This course introduced the prospective Clinical Supervisor to an overview of critical information needed to successfully complete and pass the ICRC Clinical Supervisor Exam as well as providing a forum for discussing the business of supervision. 30.) HEALING THE HEALER - CREATING NEW FIRE OUT OF THE EMBERS OF BURNOUT – Participants identified additional sources of stress that can compromise wellness. Participants also learned to recognize signs and symptoms of burnout. 31.) CROSSING THE BORDER: CLINICAL AND CULTURAL ISSUES WITH HISPANIC CLIENTS – This course was designed to assist participants in improving their service delivery efforts with limited English proficiency (L.E.P.) Hispanic population. The course also addressed the cultural and clinical concerns experienced in providing quality treatment and case management services across the language barrier. 32.) ADVANCED GROUP COUNSELING SKILLS FOR THE SUBSTANCE ABUSE PROFESSIONAL – This course was a combination of didactic and experiential learning. The focus was to learn advanced group facilitation skills, paired with the development of relationships as a way of working with diverse and or difficult populations in a variety of settings. 33.) SO YOU HAVE A DEAF CONSUMER. NOW WHAT? – This course looked into the psycho-social implications of hearing loss, with emphasis on working with consumers who are deaf. 34.) MANAGING STRESS IN THE WORKPLACE –This session addressed concerns about workplace stress, some causes of stress in the workplace and ways to reduce or manage stress. 35.) ADOLESCENT GROUP TECHNIQUES

THAT REALLY WORK – The objective was for participants to understand the core theories of group dynamics. 36.) BASIC COUNSELING SKILLS – Eight basic communication skills were described; attending, paraphrasing, reflection of feelings, summarizing, probing, counselor self disclosure, interpreting and confrontation. All of the fore-mentioned were developed to assist the counselor with their interacting with the individual. 37.) THE SCIENCE OF RECOVERY: APPLYING NEUROPSYCHOLOGY AND NEUROSCIENCE TO YOUR PRACTICE – This skills training event gave the clinician an understanding of the neuroscience and neuropsychology of addiction and recovery.

Prevention courses offered: 1.) EXPLORING PREVENTION ETHICS FOR THE 21ST CENTURY –This course provided prevention professionals with a model for ethical decision-making and practice. 2.) HARD CHOICES: PARENTING THE ADOLESCENT CHILD – This course examined adolescent behavior in light of current neurological research, and offered practical strategies for modiFFYing self-defeating behaviors. 3.) HIV/AIDS 101 FOR MENTAL HEALTH/PREVENTION/SUBSTANCE ABUSE PROFESSIONALS –This course provided participants with a foundation of knowledge about HIV/AIDS. 4.) PREPARING FOR THE SUBSTANCE ABUSE PREVENTION CERTIFICATION EXAM –This course provided learning and practice within the five prevention competency domains covered on the written test (i.e., the IC&RC exam) for certification. 5.) HEPATITIS C: WHAT YOU NEED TO KNOW... –This course discussed Hepatitis C, what it is and how it is treated. 6.) THE ABC'S OF STD'S FOR ADDICTION AND MENTAL HEALTH WORKERS – This course provided an overview of current developments in STD/HIV diagnosis and management to the lay (non-STD) professional in the counseling and education of individuals living with a dual diagnosis, i.e., alcohol/drug addiction and a sexual transmitted disease/infection including HIV/AIDS. 7.) PSYCHOLOGY OF ADDICTION –This course examined theory connected to the psychology of human beings, and how this affects drug addiction and other impulse-control disorders.

Current Status: Accomplished. Total attendees: 712

The Alabama School of Alcohol and other Drug Studies (ASADS) was sponsored by more than 10 other agencies. The Alabama Department of Mental Health Substance Abuse Services Division does not totally sponsor ASADS, therefore, the final courses to be offered are ultimately determined by the entire planning committee. Substance Abuse Services Division will continue to seek and expand the prevention focus during each of the ASADS.

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Southeastern School of Alcohol and Drug Studies, which is held in Athens, Georgia in Oct 2006. Continuing education units were offered.

Courses offered: 1.) Prevention Institute Track 1.) SAVING LIVES: PREVENTING UNDERAGE DRINKING THROUGH ENVIRONMENTAL STRATEGIES AD ENFORCEMENT - This track offered courses all week long around Under Aged Drinking and Environmental Strategies, 2.) MOTIVATIONAL INTERVIEWING - This course helped the participants understand the underlying concepts of Motivational Interviewing 3.) THE GREY DANCE: CELEBRATING OUR SPIRITUAL JOURNEY – This course helped participants understand and express their spiritual ideas and concepts. 4.) INNOVATIVE INTERVENTIONS: A NEW MODEL FOR ADDICTION TREATMENT - This was an interactive course involving instruction and role play regarding intervention and assessment 5.) ADVENTURES IN COUNSELING: AN EXPERIENTIAL APPROACH TO GROUP COUNSELING - This was an experimental activities based course that taugh participants to use games and other fun activities to enhance groups. 6.) EFFECTIVE YOUTH TREATMENT MODELS: YOU'VE GOT ME HERE, NOW WHAT? – This taught strategies for measuring the effectiveness of program and recruiting and retaining youth in treatment. 7.) SILENT SONS & PERFECT DAUGHTERS: APPRECIATING GENDER DIFFERENCES IN TREATMENT AND RECOVERY - This workshop focused on an appreciation for gender differences in treatment and the recovery process. 8.) CLINICAL SUPERVISION: SKILLS FOR THE FUTURE – This course provided the foundation for supervision of personnel. 9.) S.M.A.R.T. TREATMENT PLANNING - This course examined how ASI information can be used for clinical applications. 10.) RELATIONSHIPS, SEXUALITY AND RECOVERY - This course helped professionals improve services to client dealing with relationships and sexual issues. 11.) METHAMPHETAMINES This course presented up to date information on the epidemiology of meth. 12.) CORE ADDICTION TREATMENT SKILLS - This course provided an opportunity for professionals to receive up-to-date educational the delivery of services. 12.)CO-OCCURRING DISORDERS: CHILD AND ADOLESCENT ONSET DISRUPTIVE DISORDERS - This course focused on the interplay between addictive and disruptive disocrder.13.) CULTURALLY COMPETENT SERVICES DELIVERY - This course helped participants identiFFY aspects of culture among staff and clients. 14.) STRATEGIC PREVENTION FRAMEWORK - Participants gained basic understanding of the Strategic Prevention Framework Step 1-5. 15.) DEALING WITH FAMILIES IN TREATMENT – This session addressed the

characteristic and crisis of families in recovery. 16.) DEALING EFFECTIVELY WITH GANGS - This course covered the basics of gangs from the historical perspective. 17.) PREVENTION ETHICS - This course identified standards of conduct for prevention professionals.18.) BEST PRACTICES IN ADDICTION TREATMENT - This course identified a number of current evidenced based practices. 19.) KEYSTONES FOR SUCCESS: ASSETS BASED PROCESS FOR POSITIVE YOUTH DEVELOPMENT - This course taught participants how to identiFFY youth cased assets by examining their own pathways to success. 20.) DRUGS OF ABUSE AND TRAFFICKING TRENDS - This training provided knowledge around recognitions, behavior and psychological and physical signs 22.) HOW TO AVOID FALLING OFF THE WAGON: RELAPSE PREVENTION RELAPSE PREVENTION – This course discussed an alternative view on the nature of relapse. 23). YOUTH ISSUES IN ADDICTION TREATMENT – This course helped the participants be able to list the core characteristics of resilience. 24.) THE SCIENCE OF RECOVERY: APPLYING NEUROSYCHOLGY AND NEUROSCIENCE TO YOUR PRACTICE – This course gave clinicians an understanding of the neuroscience and neuropsychology of addiction and recovery. 25.) SPECIAL POPULATIONS - WOMEN IN THE JUSTICE SYSTEM – This course familiarized the participants with the special challenges and needs of the female substance abuser.

Current Status: Accomplished. Total attendees 398

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Alabama Alcohol and Drug Abuse Prevention Conference held in Jacksonville AL in Aug. Continuing education units were offered.

Courses offered: 1.) ETHICS FOR PREVENTION SPECIALIST PART- Participants became familiar with the IRCR Ethical prevention Guidelines' I 2.) ADOLESCENT SUBSTANCE ABUSE DEVELOPMENTAL ISSUES AND FAMILY DYNAMICS - This workshop addressed adolescent substance abuse from a number of perspectives, parenting styles and developmental changes. 3.) EARLY INTERVENTION IN SUBSTANCE ABUSE: BRIDGING PREVENTION AND TREATMENT – THIS course looked at how we intervene with youth in the justice system that are experiencing drugs. 4.) FAMILY STRENGTHENING WEEKEND - Participant learned the history and purpose of the family strengthening weekend. 6.) ENVIRONMENTAL STRATEGIES - Participants in this group participated in group discussions about how environmental strategies are changing the focus of prevention work. a7.) THINKING OUTSIDE OF THE BOX - This workshop explored innovative youth programs. 8.) MANAGING DISRUPTIVE AUDIENCES – This course taught effective ground rules for use in prevention programs, 9.) HIV-AIDS FOR PREVENTION SPECIALIST – This course gave a overview of the HIV/AIDS statistics in Alabama and basic facts. 10.) ADVOCACY: WHAT'S THE MESSAGE – This course discussed ways to reduce the stigma associated with substance abuser and hoe it initiate funding sources. 11.) OUT OF THE BOX – This course demonstrated techniques use with at risk youth and adult in treatment settings. 12.) METHAMPHETAMINES – This course discussed meth addiction. 13.) PREVENTIONS CERTIFICATION WRITTEN REVIEW COURSE – This course help participants get ready for the exam. 14.) ENGAGING PARENTS IN PREVENTION – This course provide effective and easy to implement strategies for engaging ad empowering parents.15.) GETTING THE LAW ON YOUR SIDE – This course examine ways to pass civil ordinances around addiction. 16.) SPLASHY AND RIPPLE: USING OUTCOMES TO DESIGN AND MANAGE COMMUNITY ACTIVITIES - This course strengthened the participant's ability to write goals and objective statements and to measure outcomes and make changes. 17.) PSYCHOLOGY OF ADDICTION –This course examined theory connected to the psychology of human beings, and how this affects drug addiction and other impulse-control disorders.

Current Status: Accomplished Total attendees 95 .

REVISION REQUEST:

The Alabama School of Alcohol and other Drug Studies (ASADS) was sponsored by more than 10 other agencies. The Alabama Department of Mental Health Substance Abuse Services Division does not totally sponsor ASADS, therefore, the final courses to be offered are ultimately determined by the entire planning committee. Substance Abuse Services Division will continue to seek and expand the prevention focus during each of the ASADS.

FFY 2009 (Progress)

The Substance Abuse Services Division (SASD) will provide continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services.
SASD will partner with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has a position on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, and Southern Coast ATTC. These board positions allow SASD to participate in the planning and development of conferences to address the workforce needs of the treatment and prevention professionals across the state. The goal of SASD is to offer prevention and treatment courses at every conference.

Current Status: Accomplished. SASD, Office of Certification and Training conducted training for substance abuse program staff in various locations throughout the state. There were 26 training events reaching 1222 participants though the state of Alabama. . They are as follows: 1.) 4 – New provider orientation 2.) SASD Site Reviewers Training 3.) 2- Co-occurring Disorders 4.) Training of Trainers – ASAM 5.) Professional Ethics 6.) Opening Doors to Sobriety, Safety and Stability 7.) Motivational Interviewing 8.) Motivational Interviewing Coaching Sessions 9.) 2 - 42 CFR and HIPPA 10.) Training of Trainers - Screening, Assessment, Placement and Beyond 11.) Groups Techniques 12.) 3 Training of Trainers - train back sessions 13.) Understanding the Basics of ASAM: Concept and Theory 14.) Annual Prevention Conference in partnership with the Alabama Alcohol and Drug Abuse Association

SASD has provided on site technical assistance to substance abuse provider. They are as follows 1.) Client center treatment planning 2.) Certification issues 3.) Developing Policy and Procedures

Activity: Accomplished: The Substance Abuse Services Division (SASD) will assist in the planning, participate in the conducting and provide scholarships to the annual Alabama School of Alcohol and Drug Studies, which will be held in Tuscaloosa, Alabama in March.

Alabama School of Alcohol and Other Drug Studies Treatment courses offered: 1.) ACCIDENTAL ADDICTION: A LOOK AT PAIN PILL ADDICTION AND SUBOXONE THERAPY – Participants learned how Suboxone therapy provides a way to treat pain pill addiction with benefits of efficacy, privacy, confidence, control, freedom and flexibility. 2.) THE ETHICS OF CLINICAL SUPERVISION – Participants were trained for readiness to be a clinical supervisor, professional development and legal/ethical concerns.
3.) A RECOVERY REVOLUTION: HOW TO DEVELOP A RECOVERY-ORIENTED SYSTEM OF CARE – This workshop focused on helping clients achieve long-term recovery by shifting from an acute-care model to a recovery-oriented system of care. 4.) WELLNESS FOR THE PROFESSIONAL – This course discussed the importance of maintaining balance in our professional and personal lives by exploring ways to process traumatic exposure and identiFFY ways to reduce the impact of daily stressors. 5.) HOW TO DEAL WITH DIFFICULT PEOPLE: WORKING WITH PEOPLE MAY BE DIFFICULT-NOT IMPOSSIBLE! – This course reviewed the background theory, research and rationale behind the LifeSkills Training program. 6.) BREAKING THE CYCLE OF ADDICTION – This course focused on understanding deprivation and dependency as precursors to experiencing a substance abuse problem. 7.) ILLICIT DRUGS 101 – This course provided participants with an understanding of the difficult illicit drugs and their side effects, as well as the latest statistics and trends. 8.) ALABAMA PRISONER RE-ENTRY PROGRAMS – An ethical decision model was taught and participants were intensely involved in working through relevant case studies using the model. 9.) THE TROUBLED EMPLOYEE – This course focused on the many ways employees can be troubled in their own mind and spirit and/or body. Also, an overview of different case management styles and what has worked and has not worked for the business world was discussed. 10.) TRAUMA IN ADDICTION/SURVIVORS – This workshop was designed to assist participants in recognizing and understanding "core issues" that are often barriers to recovery. 11.) MOTIVATIONAL ENHANCEMENT COGNITIVE BEHAVIORAL THERAPY: AN EFFECTIVE ADOLESCENT TREATMENT APPROACH – This twelve to fourteen-hour curriculum was designed to provide alcohol and other drug counselors with the knowledge and tools necessary for motivational interviewing. 12.) ALABAMA'S DRUG COURTS: PARTNERING ADVOCACY AND ACCOUNTABILITY – This course provided an overview of the unique relationship between the justice system and the treatment community created by Drug Courts and examined what interventions work best when serving drug-affected offenders. 13.) CLINICAL COMPETENCIES – THE "NUTS & BOLTS" – This training outlined the knowledge, skills and attitudes needed in achieving

and practicing the competencies as an addictions counselor. 14.) ANGER AND ADDICTION: DOUBLE TROUBLE IN RELAPSE PREVENTION – This session provided tools for clinicians to work more effectively with clients who are experiencing concurrent addiction and anger problems. 15.) PSYCHOLOGY, SPIRITUALITY AND TRUE HAPPINESS – Developed from the lost discipline of Christian contemplative practice, this powerful approach incorporated current understandings of psychology, neurobiology and monastic contemplative approaches to permanently dissolve aspects of the false-self (ego) 16.) AN OVERVIEW OF THE CURRENT SUBSTANCE ABUSE SERVICES STANDARDS 2009 – This two-day course was designed to provide an up-to-date overview of current Department of Mental Health and Intellectual Disabilities, Substance Abuse Services Division Certification Standards. 17.) ISSUES IN SUPERVISION: NEW DOMAINS, NEW EXPECTATIONS AND ETHICAL CHALLENGES – Participants learned, through lecture and interaction, about the ongoing challenges and expectations of clinical supervision. 18.) SUICIDE PREVENTION – Participants learned various aspects of prevention strategy including environment, psychotherapy and pharmacotherapy. 19) WHAT WORKS IN TEACHING ADDICTION AS A BRAIN DISEASE: SNAP, CRACKLE AND POP…! – Workshop helped participants to understand "What Works" psychoeducation principles for motivating treatment engagement and recovery. 20.) EMBRACING A NEW MEDICATION OPTION – COUNSELING MEETS NEUROSCIENCE – This course presented how medicine and neuroscience can work with the counseling professional to help the client to recover from addiction successfully. 21.) UNDERSTANDING AND UTILIZING ASAM PLACEMENT CRITERIA IN THE TREATMENT SETTING – This course was a combination of didactic and experiential learning. The primary focus was to gain a comprehensive understanding of both the five basic levels of care and the criteria dimensions outlined in ASAM PPC-2R in order to provide better treatment strategies and enhanced outcomes for the substance abuser. 22.) ADDRESSING CO-OCCURRING ISSUES OF DOMESTIC VIOLENCE AND SUBSTANCE ABUSE IN VICTIMS – This course explored ways in which to develop and enhance collaborations between substance abuse treatment providers and domestic violence services programs in addressing the co-occurring issues of domestic violence and substance abuse in ways that promote safety and sobriety. 23.) BAILING OUT MADE GOOD: MOTIVATIONAL INTERVIEWING – Participants identified the key elements related to change and success, research related to the model's efficacy, application of The Five Stages of change, and the Ten MI Consistent Items along with the Five MI Inconsistent Items. 24.) AN ADVANCED PRIMER ON ADDICTION PHARMACY: WHAT BEHAVIORAL HEALTHCARE PRACTITIONERS NEED TO KNOW – Participants were taught to understand the neurobiology and pharmacology of the current psychotropic medications used in the co-occurring treatment industry and learned the latest clinical diagnostic criteria for anxiety, mood, and psychotic disorders. 25.) ADOLESCENT GROUP TEHNIQUES THAT REALLY WORK – Participants were taught to understand the core theories of group dynamics and learned practical use of "Reality Therapy" for acting out clients (adolescents and adults).

Prevention courses offered: 1.) DISRUPTIVE AUDIENCE MANAGEMENT FOR THE PREVENTION PROFESSIONAL - Description: This course focused on helping the prevention professional meet program objectives and obtain desired outcomes when working with groups of high-risk/at-risk children, youth and adults. 2.) LIFESKILLS TRAINING CURRICULUM OVERVIEW – This course was designed to review the background theory, research and rationale behind the LifeSkills Training program. 3.) PREPARING FOR THE SUBSTANCE ABUSE PREVENTION CERTIFICATION EXAM – This workshop provided learning and practice within the five prevention competency domains covered on the written test (i.e., the IC&RC exam) for certification. 4.) PREVENTION ETHICS – An ethical decision model was taught and participants were intensely involved in working through relevant case studies using the model. 5.) SOCIAL AND MULTICULTURAL DIVERSITY AWARENESS IN SPECIAL POPULATIONS OF SUBSTANCE ABUSERS – This course provided a comprehensive multicultural overview on diversity issues and gender responsive strategies for addressing the social needs of special populations of substance abusers. 6.) DOUBLE TROUBLE: THE HIV SUBSTANCE ABUSE CONNECTION – This 2-day skills building workshop provided participants with an overview of HIV transmission, and explored the unique relationship between substance abuse, chemical dependency, and HIV infection.

The Alabama School of Alcohol and other Drug Studies (ASADS) is sponsored by more than 14 other agencies. The Alabama Department of Mental Health Substance Abuse Services Division does not totally sponsor ASADS, therefore, the final courses to be offered are ultimately determined by the entire planning committee. Substance Abuse Services Division will continue to seek and expand the prevention focus during each of the ASADS.

Activity: Accomplished: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the Agency for Substance Abuse Prevention for the Annual Alabama Alcohol and Drug Abuse Association annual treatment and prevention conferences held Sept and Oct. See above.

Activity: Accomplished: The Substance Abuse Services Division will conduct training for substance abuse program staff in various locations throughout the State. Topics include, Understanding the ASAM Theory, Screening, Assessment, Placement and Beyond: Embracing Recovery Oriented System of Care Utilizing and Integrated Approach, and Case Management, Best Practices approaches, Adolescent treatment issues, and Client Center Treatment Planning, etc. See above

REVISION REQUEST:

The Alabama School of Alcohol and other Drug Studies (ASADS) is sponsored by more than 14 other agencies. The Alabama Department of Mental Health Substance Abuse Services Division does not totally sponsor ASADS, therefore, the final courses to be offered are ultimately determined by the entire planning committee. Substance Abuse Services Division will continue to seek and expand the prevention focus during each of the ASADS.

Activity: Accomplished: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the Agency for Substance Abuse Prevention for the Annual Alabama Alcohol and Drug Abuse Association annual treatment and prevention conferences held Sept and Oct. See above.

FFY 2010 (Intended Use)

The Substance Abuse Services Division will provide continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services. SASD will partner with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has a position on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, and Southern Coast ATTC. These board positions allow SASD to participate in the planning and development of conferences to address the workforce needs of the treatment and prevention professionals across the state. The goal of SASD is to offer prevention and treatment courses at every conference.

Activity: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the annual Alabama School of Alcohol and Drug Studies, which will be held in Tuscaloosa, Alabama in March 23-26, 2010.

Prevention courses offered:

1.) Theoretical Basis for Prevention – Prevention is an approach to instituting, maintaining, modifying and/or changing the behavior(s) of individuals, groups and communities. It is rooted in the cognate areas of psychology and education and education. This course identifies and presents how specific behavioral theories are applied to substance abuse prevention strategies.
2.) Environmental Strategies – The goal of this course is for participants to obtain the knowledge and understanding how and why environmental strategies can be applied to a comprehensive continuum of services.
3.) Prevention Ethics – Prevention professionals need a model for ethical decision-making and practice. An ethical decision model will be taught and participants will be intensely involved in working through relevant case studies using the model. Participants will be prepared to address emerging issues using this model.
4.) Prevention Marketing Message – Prevention is an approach to instituting, maintaining, modifying and/or changing the behavior(s) of individuals, groups and communities. This course identifies and presents how specific marketing strategies can be applied to substance abuse prevention.
5.) Preparing for the Substance Abuse Prevention Certification Exam – This course provides learning and practice within the five prevention competency domains covered on the written test (i.e., the IC&RC exam) for certification. Many prevention professionals have limited knowledge and experience in certain competency domains. This course helps participants to gain an overview of the key elements, skills and knowledge areas of each of the five domains, and some practical application in each domain.
6.) Best Practices in Prevention – This course will analyze the components of best practices in prevention services and the "best practices" in prevention curricula identified by Center for Substance Abuse Prevention. The goal of this course is for participants to obtain knowledge and understanding of effectively conducting each of the original CSAP strategies.

Activity: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the Annual Alabama Alcohol and Drug Abuse Association annual treatment and prevention conferences. Dates to be determined.

Activity: The Substance Abuse Services Division will conduct training for substance abuse program staff in various locations throughout the State. Topics include, Understanding the ASAM Theory, Screening, Assessment, Placement and Beyond: Embracing Recovery Oriented System of Care Utilizing and Integrated Approach, and Case Management, Best Practices approaches, Adolescent treatment issues, and Client Center Treatment Planning, etc. Dates to be determined.

REVISION REQUEST:

Prevention courses offered:

7.) Theoretical Basis for Prevention – Prevention is an approach to instituting, maintaining, modifying and/or changing the behavior(s) of individuals, groups and communities. It is rooted in the cognate areas of psychology and education and education. This course identifies and presents how specific behavioral theories are applied to substance abuse prevention strategies.

8.) Environmental Strategies – The goal of this course is for participants to obtain the knowledge and understanding how and why environmental strategies can be applied to a comprehensive continuum of services.

9.) Prevention Ethics – Prevention professionals need a model for ethical decision-making and practice. An ethical decision model will be taught and participants will be intensely involved in working through relevant case studies using the model. Participants will be prepared to address emerging issues using this model.

10.) Prevention Marketing Message – Prevention is an approach to instituting, maintaining, modifying and/or changing the behavior(s) of individuals, groups and communities. This course identifies and presents how specific marketing strategies can be applied to substance abuse prevention.

11.) Preparing for the Substance Abuse Prevention Certification Exam – This course provides learning and practice within the five prevention competency domains covered on the written test (i.e., the IC&RC exam) for certification. Many prevention professionals have limited knowledge and experience in certain competency domains. This course helps participants to gain an overview of the key elements, skills and knowledge areas of each of the five domains, and some practical application in each domain.

12.) Best Practices in Prevention – This course will analyze the components of best practices in prevention services and the "best practices" in prevention curricula identified by Center for Substance Abuse Prevention. The goal of this course is for participants to obtain knowledge and understanding of effectively conducting each of the original CSAP strategies.

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FFY 2007 (Compliance)

The prevention planning system in Alabama is based on 22 catchment areas. Each catchment area has its own local board (referred to as 310 boards) that is responsible for planning mental health, mental retardation, and substance abuse services for the local catchment area. The funding for each catchment area is determined using a population-based formula. The results of the Alabama Pride Survey, the Alabama Social Indicators of Prevention Need, the Alabama Student Survey of Risk and Protective Factors, the Community Resource Assessment, and the Children's Policy Councils' Needs Assessments are disseminated to the local 310 boards for use in the development of their prevention planning efforts.

The needs assessment data for prevention planning in Alabama was identified from the following sources: the Alabama Pride Survey; the Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and Protective Factors; the Community Resource Assessment; and the Children's Policy Councils' Needs Assessments.

Each Children's Policy Council is responsible for identifying the most important issues affecting children in six categories: health; safety; education; economic security; early care and education; and parent involvement and skills. These issues are described in the annual needs assessment for each county and are used for policy recommendations and establishing priorities for each county's Children's Policy Council. The needs assessment serves several very important purposes. It fulfills a legal responsibility of both the county Children's Policy Councils and the Alabama Children's Policy Council. It serves as an avenue for the counties and state to identify the issues that are affecting children's lives and ability to grow into productive citizens. It also gives the members of the council a link to policy makers in Montgomery, Alabama and Washington, DC. Needs assessments are reviewed by agencies and legislators to learn what is needed and where priorities should be placed. Additionally, Children's Policy Councils consistently report that the most valuable benefit of the Needs Assessment is the local communication and planning that it fosters.

Alabama law requires that Children's Policy Councils submit their needs assessments by July 1st of each year and that the Alabama Children's Policy Council prepare this compiled report by October 1. The Department of Children's Affairs utilized a standardized list of descriptions to label and compare the county issues and priorities. Reports are prepared for several state agencies with the policy recommendations from the councils that are relevant to those agencies missions. The Department of Children's Affairs staff work with the counties and agencies on many of these recommendations to build better communication and facilitate positive outcomes.

The Substance Abuse Services Division (SASD) collaborated with the Department of Public Health to coordinate TB services for individuals receiving substance abuse prevention/treatment services.

SASD collaborated with contracted providers to coordinate HIV/AIDS services for individuals receiving prevention/treatment services.

SASD coordinated with community primary healthcare providers to deliver primary medical and pediatric care to pregnant women, including women with dependent children receiving substance abuse treatment.

FFY 2009 (Progress)

Activities:

The SASD will provide HIV prevention and educational services for the Alabama Correctional System in all pre-release settings.

Prevention workers will provide training to other health care providers on substance abuse signs, symptoms, etc.

Family-strengthening programs will be offered to families with a member in treatment.

High risk youth identification and education services will be provided to those individuals referred by the Department of Youth Services, school counselors, juvenile judges, the Department of Human Resources, etc.

Summer alternative programs will be provided to high-risk youth. Summer alternative programs are available within each of the four service regions of the state.

Results:

The SASD contracted with thirty-four community providers for the provision of prevention activities including; HIV prevention education, training for health care providers, family-strengthening, high risk youth identification and education programs, and summer alternative programs. These services were provided to individuals referred from the Alabama Correctional System, health care providers, Department of Youth Services, school counselors, juvenile judges, and the Department of Human Resources. Appropriate prevention activities are coordinated through cooperative agreement with the previously mentioned local agencies.

Objective I: Develop and implement a coordinated substance abuse services prevention and treatment system.

SASD is continuing to provide comprehensive health and social services to prevention substance abuse and/or support the sobriety of individuals receiving prevention and/or treatment services. The state continues to support the development and implementation of a coordinated substance abuse prevention and treatment system.

Objective II: Continue to work in partnership with other state agencies to coordinate the development and implementation of initiatives to expand access to treatment and services for the substance abusing population throughout the state.

SASD continues to play a major role as the single state authority with regulatory responsibilities and as an advocate for uninsured clients on interagency and intra-agency task forces.

SASD continues to successfully implement jointly funded acute treatment and outpatient services for the co-occurring. The division has helped providers to obtain specialized training for staff, and to maximize housing options for this population; continued negotiation on how to best serve this high risk population; and, is developing a universal screening tool instrument and protocol.

Ongoing prevention efforts are as follows:

Implement a common framework for all state substance abuse prevention funding sources that also aligns to the standard federal applications for similar programs.

Construct a substance abuse prevention system that is built on the foundation of a single state coalition, composed of a mix of state agencies and local prevention personnel that works in concert with all varieties of local coalitions representing substance abuse prevention stakeholders in the community.

Examine the issue of certification in the field of substance abuse prevention and the feasibility of developing a policy on certification and training that would apply across all agencies that distribute funds for substance abuse prevention.

Involve youth in state and local prevention coalitions.

Increase the effort in the area of cultural competency to bring training to all areas of the substance abuse prevention field.

Increase the amount of training offered to parents at the state and local level.

Ongoing treatment efforts are as follows:

Expand access to substance abuse services by requiring uniform rates, income eligibility, sliding fee scales and encouraging expanded coverage of substance abuse treatment services by health insurance companies (parity).

Develop certification standards for every level of substance abuse treatment and require all substance abuse treatment programs to comply.

Consistently educate judges regarding appropriate assessment and level of care determination for substance abuse treatment services.

Develop and adopt a statewide uniform substance abuse screening, assessment and level of care determination process.

Develop and adopt uniform priority populations to be served, i.e. women and dependent children.

Develop and implement uniform substance abuse treatment staff training, credentials and competency requirements.

Require the use of science/evidenced-based practices in every certified substance abuse treatment program.

Develop and implement a statewide outcome measurement process required for all certified substance abuse treatment programs.

Develop and implement a process to encourage increased local county and city financial support for substance abuse treatment services.

Analyze the appropriate process for serving citizens who are court ordered to substance abuse treatment when they have no desire to be treated.

Develop and implement substance abuse continuing education for professionals including: judges; legislators; nurses; doctors; ministers, etc.

Define and implement a continuum of care that is science/evidenced-based.

FFY 2010 (Intended)

Substance Abuse Services Division (SASD) will continue to provide comprehensive health education and social services to prevent substance abuse and/or support the sobriety of individuals receiving prevention and/or treatment services. The state will continue to support the development and implementation of a coordinated substance abuse prevention and treatment system.

REVISION REQUEST:

The implementation of the Systems Improvement Initiative, as described in Goal #1 (FY 2010 Intended Use) includes the implementation of greatly expanded levels of care. The implementation plan also includes a provider by provider assessment of the level(s) of care best suited to their skill level and client needs. The new expanded levels of care will be offered to the current providers and will identify new levels of care in their physical locations as identified in Goal #1. At this point the specific levels of care for each specific program location can not be determined.

Implementation of the Systems Improvement Initiative will continue throughout FY2010. Given this strategic plan was developed in collaboration with multiple state agencies, addresses concerns that are inter-agency and is being implemented in a collaborative manner. SASD will convene individuals to review the strategic plan and monitor progress on achieving goals and objectives articulated in the plan.

SASD will continue to collaborate with contracted providers on increasing both the mental health and substance abuse system's capacity to provide services to those with co-occurring disorders, continue to offer community based services, including residential support.

March 2010 REVISION REQUEST:

X. Prevention: As defined in the SASD Contract Billing Manual.

Program	County	Region
Agency for Substance Abuse Prevention	Calhoun	1
Alcohol and Drug Abuse Treatment	Jefferson	2
Aletheia House	Jefferson	2
Baldwin County MHC	Baldwin	4
Bibb, Pickens, Tuscaloosa MHC	Tuscaloosa	2
Cahaba MHC	Dallas	3
CED MHC	Cherokee/Etowah/DeKalb	1
Cheaha MHC	Talladega	2
Cherokee County SA Council	Cherokee	1
Chilton Shelby MHC	Shelby	2
Council on SA	Montgomery	3
Cullman MHC	Cullman	1
Drug Education Council	Mobile	4
East Alabama MHC	Lee	3
East Central MHC	Pike	3
Franklin Memorial	Mobile	4
Gateway	Jefferson	2
Huntsville Madison MHC	Madison	1
JCCEO	Jefferson	2
Family and Child Services	Jefferson	2
Lighthouse Counseling Center	Montgomery	3
Mountain Lakes MHC	Marshall	1
North Central MHC	Morgan	1
North Central SA Council	Cullman	1

Northwest MHC	Fayette/Lamar/Marion/Walker/Winston	1
Oakmont	Jefferson	2
Riverbend MHC	Colbert/Lauderdale	1
Sayno	Montgomery	3
South Central MHC	Coffee	4
Southwest MHC	Monroe/Escambia	4
UAB	Jefferson	2
West Alabama MHC	Marengo	4
Wiregrass MHC	Houston	4

The previously identified prevention activities will be operationalized by the SASD through contracts with community programs. The contracting process requires the following.

- Each community program must be certified in accordance with published standards (Goal 5 Attachment 1).
- Each community program must sign an annual contract (Goal 1 Attachment 2).
- The services/activities provided by the community program are described in the Contract Billing Manual (Goal 1 Attachment 1).
- Each community program is required to submit a plan for SASD approval which describes the selected priority populations, local needs assessment data that supports the selection of the priority populations, and measurable goals and objectives.
- Data regarding the individuals served and the activities provided are reported to the SASD monthly.
- On-site visits are conducted, technical assistance opportunities are provided, and attendance to national prevention training opportunities are supported by the SASD.

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the SAPT BG expenditure period.

The needs assessment data for prevention planning in Alabama was identified from the following sources: the Alabama Pride Survey; the Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and Protective Factors; the Community Resource Assessment; and the Children's Policy Councils' Needs Assessments.

The Alabama Pride Survey

The Alabama Pride Survey is the primary source for needs assessment data used for prevention planning in Alabama. The Pride Survey for grades 6-12 was first developed in 1980 with field testing and revisions occurring until 1982 when the questionnaire and associated survey procedures were introduced to Pride customers. The purpose of the Pride Survey and associated survey services was to provide schools and communities with a low cost means to obtain quality information about the prevalence and patterns of drug and alcohol use for their adolescents. Since 1982, more than seven million students have responded to the Pride Survey in communities throughout the United States and in eight foreign countries.

The SASD partners with the Alabama Department of Education and other social service agencies to financially support the conducting of the Alabama Pride Survey annually in Alabama. The Alabama Pride Survey was administered in public schools in all 67 counties in Alabama during the following school years: 2002-2003; 2003-2004; 2004-2005; 2005-2006; 2006-2007; 2007-2008 and 2008-2009. Results of the surveys were made available to prevention planers and programmers.

The Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and Protective Factors; the Community Resource Assessment

As part of the State of Alabama's efforts to conduct its first needs assessment, three projects were completed: 1.) the Alabama Social Indicators of Prevention Need; 2.) the Alabama Student Survey of Risk and Protective Factors; and 3.) the Community Resource Assessment.

The Alabama Social Indicators of Prevention Need was conducted in 2002 to provide measures of adult and youth substance abuse prevention needs in each county. This study identified indicators from a recommended list provided by the Center for Substance Abuse Prevention (CSAP) to assess community-related aspects of risk and prevention. Example indicators included rates of drug and alcohol arrests, adolescent pregnancies, alcohol sales permits, food stamp recipients, and church organizations. The purpose of the social indicator project was to provide planners and services providers with objective data to better determine the statewide and local prevention needs of Alabama's youth.

The Alabama Student Survey of Risk and Protective Factors was conducted in 2002 to provide self-reported data on substance use and other behaviors. The survey was administered to 96,000 adolescents across the state to assess factors such as community rewards, religiosity, transition and mobility, antisocial behavior, and depression. The survey used for this study was created by CSAP by a group of six states in collaboration with the Social Development Research Group at the University of Washington. No substantive modifications were made to this survey and it measures youth substance use, including alcohol, tobacco, marijuana, LSD/hallucinogens, cocaine/crack, and inhalants. The survey also measured risk and protective factors for substance use using four domains: peer/individual, family, school, and community. Results were made available to preventions planers and programmers.

The Community Resource Assessment was conducted to evaluate prevention services among programs funded by the Substance Abuse Services Division of the Alabama Department of Mental Health and Mental Retardation during fiscal year 2000. Programs evaluated received funding from the DARE Grant, the Governor's High Risk Youth Grant, and/or the Substance Abuse Prevention and Treatment Block Grant. This study inventoried and assessed prevention resources among providers throughout the state using the Core Constructs for Community Resource Assessment, a standard instrument used for all community resource assessments in the CSAP Prevention Needs Assessment program.

The central purpose of all three projects was to compare services provided with services needed. The Alabama Social Indicators of Prevention Need and the Alabama Student Survey of Risk and Protective Factors were used to provide data on need and the Community Resource Assessment was used to provide data on services provided.

The Children's Policy Councils' Needs Assessments

Children's Policy Councils were established in all 67 counties in Alabama in 2000 (Code of Alabama §12-15-133) to assess the needs of children and build relationships between community organizations and other interest groups that promote the well-being of children. The ultimate goal for the creation of the Children's Policy Council system was to mobilize providers of services for children and involve them working collaboratively to develop a community service plan which addresses the needs of children (ages 0 to 19). By empowering community decision makers with necessary knowledge and a coordinated plan, problematic issues regarding children can be resolved. The county Children's Policy Council is chaired by the local Juvenile Judge and has 15 mandated members plus seven members at-large. The legislative mandate of the Children's Policy Council is to meet at least quarterly, to set policy and procedures for children's services, to identify gaps in services, to encourage agency collaboration in order to avoid duplication of services, to conduct an annual needs assessment for the needs of children in the community and to maintain a list of local resources for children's services for their county. The membership of the CPC is a diverse cross section of public and private individuals interested in improving children's lives.

Each Children's Policy Council is responsible for identifying the most important issues affecting children in six categories: health; safety; education; economic security; early care and education; and parent involvement and skills. These issues are described in the annual needs assessment for each county and are used for policy recommendations and establishing priorities for each county's Children's Policy Council. The needs assessment serves several very important purposes. It fulfills a legal responsibility of both the county Children's Policy Councils and the Alabama Children's Policy Council. It serves as an avenue for the counties and state to identify the issues that are affecting children's lives and ability to grow into productive citizens. It also gives the members of the council a link to policy makers in Montgomery, Alabama and Washington, DC. Needs assessments are reviewed by agencies and legislators to learn what is needed and where priorities should be placed. Additionally, Children's Policy Councils consistently report that the most valuable benefit of the Needs Assessment is the local communication and planning that it fosters.

Alabama law requires that Children's Policy Councils submit their needs assessments by July 1st of each year and that the Alabama Children's Policy Council prepare this compiled report by October 1. The Department of Children's Affairs utilized a standardized list of descriptions to label and compare the county issues and priorities. Reports are prepared for several state agencies with the policy recommendations from the councils that are relevant to those agencies missions. The Department of Children's Affairs staff work with the counties and agencies on many of these recommendations to build better communication and facilitate positive outcomes

The format of the needs assessment was developed by a committee of county Children's Policy Councils representatives and child advocates. It is designed to promote discussion in a broad range of categories that affect children's lives, provide information to state agencies, and serve as a starting point for a strategic plan. The needs assessment has three parts. Part I asks councils to identify issues and action steps in six categories. This is often done though committees established by the council. Issues are the primary concerns or problems that put children at risk. Discussion in the committee will often identify several issues and the committee will narrow the list down to the two to three most important issues. Once a council has identified the issues facing the county, it lists concrete action steps that the Children's Policy Council can accomplish. These actions can be major or minor steps; they can be short or long term. This is the first initiative towards developing a strategic plan for the council. Part II provides an opportunity to make policy recommendations that are forwarded to state agencies and the Legislature. Policy Recommendations are listed that would help the county address the needs of children. This may include specific policy changes for state agencies or specific changes to legislation to: (1) improve the way services are provided, (2) eliminate road blocks or red tape that hinder quality services, or (3) provide for local flexibility in state programs. Part III requires the council to narrow the issues to the top three priority outcomes for children in the county. Once the issues, action steps, and recommendations have been developed for each category the council then identifies the three priorities for the county's children. This is when the council members must identify the most pressing issues. These outcomes should reflect the

council priorities for itself, its members, and the community for the next year. All 67 Children's Policy Councils listed the top priorities for their council and county in the coming year. These priorities were analyzed based upon the descriptions selected by the county. In analyzing the priorities, weight was given to the higher priorities. Top priorities were given three points, second priorities were given two points, and third priorities were given one point. This was totaled to get the weighted value. Counties were limited to their top three priorities. By limiting the responses to the top three and applying more value to the higher priorities, the most important priorities in the view of the Children's Policy Councils can be summarized.

In 2006, substance abuse prevention was the top issue and was clearly the top priority among the Children's Policy Councils. Family Resource Centers just cracked the top ten issues, but when it came down to the priorities it finished a strong second. Substance abuse prevention was the top priority for 11 counties and Family Resource Centers was the top priority for ten counties.

Prevention Planning Overview

The prevention planning system in Alabama is based on 22 catchment areas. Each catchment area has its own local board (referred to as 310 boards) that is responsible for planning mental health, mental retardation, and substance abuse services for the local catchment area. The funding for each catchment area is determined using a population-based formula. The results of the Alabama Pride Survey, the Alabama Social Indicators of Prevention Need, the Alabama Student Survey of Risk and Protective Factors, the Community Resource Assessment, and the Children's Policy Councils' Needs Assessments are disseminated to the local 310 boards for use in the development of their prevention planning efforts.

Each 310 Board is required to develop on annual prevention plan based on identified need including priority populations. Submission of the annual plans to the SASD is required.

Treatment:

The needs assessment data used for treatment planning and resource distribution in Alabama originate from the following sources: the original Needs Assessment Study; the National Survey on Drug Use and Health; Alabama waiting list data; and the Alabama resource shortages.

Original Needs Assessment Study

In 1999 Alabama completed a formal needs assessment study which indicated that approximately 273,000 Alabamian adults needed treatment and only 13,094 were served by public programs, leaving a huge gap in all areas of the state, in all races and both genders.

Regions	In Need of Tx.	Admitted	Gap
Region 1	70,120	2,843	67,277
Region 2	97,051	6,001	91,050
Region 3	49,647	1,927	47,720
Region 4	56,366	2,323	54,943
State Total	273,184	13,094	260,990

The National Survey on Drug Use and Health

The National Survey on Drug Use and Health annual report is used as a source to indicate trends, prevalence and unmet treatment needs. According to the 2004-2005 report, 114,307 Alabamians needed treatment for illicit drug use but did not get it and 282,298 Alabamians needed treatment for alcohol use but did not get it.

Alabama Waiting List Data

Alabama specific waiting list data indicate that approximately 600 Alabamians are determined to need residential treatment and are on waiting lists each day. Further analysis indicates that only one-half of those on waiting lists are admitted the same year they go on the lists.

Alabama Resource Shortages

Availability of resources has a direct impact on access to care and un-met need. The SASD has identified specific gaps in prevention and treatment services and is working to develop the resources to address the already identified un-met needs. Alabama includes sixty-seven counties. Twenty-two counties do not offer adult outpatient treatment services. Forty-seven counties do not offer adolescent outpatient services. Forty-four counties do not offer prevention services. Goals have been established an included in the State budget development process that would provide basic substance abuse prevention and treatment services for all the sixty-seven counties by 2012.

REVISION REQUEST:

No formalized needs assessment has been performed since 2002. However, PRIDE Surveys have been distributed to all Prevention Providers and are used to help develop Prevention Plans throughout the State of Alabama. The PRIDE Surveys are vital components to help assist in specific areas such as addressing Age of First Use, Perception of Risk, Prevalence of Drug Use, etc.

March 2010 REVISION REQUEST:
During 2007 the prevention needs in Alabama were determined by applying the following process.

- Each 310 Board, representing the twenty-two catchment areas that are divided into four planning regions, submitted a prevention plan for approval by the SASD.

- Each plan identified the priority population(s) addressed and the evidence-based strategy that was applied.

- Each plan included needs assessment data that supported the selection of the priority population(s). These local needs assessments were developed from a variety surveys/sources including.

o The Alabama Pride Survey: The primary source for prevention needs assessment data used for prevention planning in Alabama. The Pride Survey for grades 6-12 is conducted each year and the results are made available to prevention planners and programmers.

o The Children's Policy Council's Needs Assessment: Children's Policy Councils exist in all counties of Alabama. One of their primary responsibilities is to assess the local needs of children. An annual needs assessment is published which identifies the issues affecting children's lives. Substance abuse prevention continues to be a top issue in the annual Children's Policy Council's Needs Assessment.

o Other local data sources were used including juvenile arrests information, juvenile court data, fatality analysis, etc.

FY 2009 (PROGRESS)

Prevention

The needs assessment data for prevention planning in Alabama continues to be identified from the Alabama Pride Survey; the Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and Protective Factors; the Community Resource Assessment; and the Children's Policy Councils Needs Assessments. One additional resource has been added, the DMH Local Needs Assessment Process, which will be described in the Treatment section.

Once the data is received it will be analyzed, distributed to local prevention planners and programmers and will be utilized by the SASD to evaluate prevention plans developed by local 310 Boards.

Treatment

The SASD continued to utilize available data to estimate need for substance abuse treatment. Those sources included: the original Needs Assessment Study; the National Survey on Drug Use and Health; Alabama waiting list data and the Alabama resource shortages.

In addition the DMH implemented a local needs assessment process designed to develop service delivery and expansion plans. The plans include the development of budget request submitted to the Governor and the State Finance Director. Needs were identified for the three DMH service divisions, including the SASD. The Planning section of the 2010 SAPT BG application describes the process and includes the three primary goals established by the SASD. These goals are scheduled to be accomplished by 2012.

1. By 2012, a continuum of outcome supported prevention, treatment, and recovery support services for adults will be available in every county.

2. By 2012, a continuum of outcome supported prevention, treatment, and recovery support services for children and adolescents will be available in every county.

3. By 2012, prevention and treatment outcomes will be measured using the ten national outcome measures for substance.

The SASD is also using the following one page description of the status of substance use disorder in Alabama. The description is being used in presentations, discussions, media events, legislative opportunities, etc. to emphasize the needs in Alabama.

SUBSTANCE ABUSE/ADDICTION IN ALABAMA

- State funding for substance abuse prevention and treatment services in Alabama in inadequate:

- 300,000 Alabamians are estimated to need substance abuse treatment.
- Approximately 25,000 Alabamians are admitted for treatment in the public system per year.
- Approximately 600 Alabamians are on waiting lists for residential substance abuse treatment.
- Approximately ½ of those on the waiting lists will not be admitted the same year they go on the lists. 3
- Prevention activities are not available statewide.

- State agencies spend considerable portions of their budgets on citizens suffering from substance abuse or addiction:

- Adult Corrections 78% or $153,273,700
- Juvenile Justice 62% or 40,795,600
- Judiciary 79% or 75,949,500

- Education (Elementary/Secondary) 8% or 211,832,500
- Health 21% or 506,036,900
- Child Welfare 66% or 51,639,300
- Mental Health 46% or 65,392,400
- Developmental Disabilities 8% or 3,985,600
- Public Safety 20% or 5,725,100

Total $ 1.1 Billion

- Impact of the availability of effective services:

- Substance abuse is preventable.
- Addiction is treatable and recovery is possible.
- Re-arrest rates drop from 75% to 27% when inmates receive addiction treatment.
- Adolescent re-arrest rates decrease from 64% to 35% after one year of residential treatment.7
- Families receiving addiction treatment spent $363 less a month on regular medical care than untreated families.8
- Children whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care.9
- When mental health and drug and alcohol disorders are treated collaboratively patients have better outcomes.10
- Fetal Alcohol Syndrome affects an estimated 40,000 infants per year nationally and is totally preventable.11

- Summary:

- Effective substance abuse prevention and treatment services are good investments from financial, safety and quality of life perspectives.

- State financial investments in effective and efficient substance abuse prevention and treatment services must increase.

- References:

1. Department of Mental Health and Mental Retardation, Substance Abuse Services Division – Needs Assessment Study.
2. Department of Mental Health and Mental Retardation, Substance Abuse Services Division – FY 2004-2005 Client Services Profile.
3. Department of Mental Health and Mental Retardation, Substance Abuse Services Division – FY 2004-2005 Waiting List Profile.
4. Department of Mental Health and Mental Retardation, Substance Abuse Services Division.
5. National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: The impact of substance abuse on state budgets. Page #32. New York, NY.
6. National Association of State Alcohol and Drug Abuse Directors. (2005). Policy brief: Offender reentry. Washington, DC: National Association of State Alcohol and Drug Abuse Directors.
7. Grella, C.E., Hser, Y.I, Joshi, V. & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance disorders. Journal of Nervous and Mental Distress, 189(6): 382-92.
8. Belenko, S., Patapis, N., & French, M. (2005). Economic benefits of drug treatment: A critical review of the evidence for policy makers. Philadelphia, PA: Treatment Research Institute at the University of Pennsylvania.
9. Child Welfare League of America. (2001). Advocacy Fact Sheet. Retrieved May 8, 2006, from http://www.cwla.org/advocacy/aodfactsheet.htm.
10. U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2004). National treatment improvement evaluation study (NTIES), 1992-1997 [Computer file]. Conducted by National Opinion Research Center (NORC). 3rd ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research.
11. National Organization on Fetal Alcohol Syndrome. FASD: What everyone should know. Retrieved May 8, 2006, from http://www.nofas.org/MediaFiles/PDFs/factsheets/everyone.pdf.

REVISION REQUEST:

Prevention services have been sustained in multiple areas. For example, prevention goals include decreasing access and availability of alcohol to underage drinkers, and assistance in creating and implementing new ordinances relating to regulations and policies. Prevention objectives include collaboration with other agencies including law enforcement, city councils, and school personnel to educate about substance use and abuse among minors and adults. Prevention activities include media campaigns, and meetings with law enforcement officials to review and develop understanding of current practices.

During FFY 2009, over 37,000 individuals are receiving prevention services. See below.

Regions	Receiving Prevention Services
Region 1	6,621
Region 2	24,193
Region 3	1,440
Region 4	5,012
State Total	37,286

FY 2010 (INTENDED USE)

The SASD will continue to utilize the previously identified sources to document the need for both prevention and treatment services in Alabama. In addition, the SASD will pursue the completion of a formalized comprehensive prevention and treatment needs assessment study.

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the SAPT BG 2007 expenditure period.

The following statement was included in Exhibit SA-3 (Goal #1-Attachment #2) of each contract issued by the SASD during the SAPT BG 2007 expenditure period.

V. Restrictions on Expenditures (Applicable to all Contractors and their Subcontractors):

A. The Contractor and its Subcontractor(s) shall not expend SAPT Block Grant funds on the following activities:

1. To purchase inpatient hospital services;
2. To make cash payment to clients;
3. To purchase or improve land, purchase, construct, or permanently improve any building or facility;
4. To purchase medical equipment;
5. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
6. To provide individuals with hypodermic needles or syringes; or
7. To provide treatment services in a penal or correctional institution.

The SASD monitored compliance through the review of financial audits. Independent CPA audits are required for every contract provider. Audit reports must be submitted to the DMH Contracts Office. The audit reports are reviewed and follow-up is required for all findings identified in the audit report. During the SAPT BG 2007 expenditure period no audit reports indicated that the requirement related to hypodermic needles or syringes had been violated.

FY 2009 (PROGRESS)

The SASD continued the practice of including the probation statement regarding hypodermic needles or syringes in each contract. The audit reports will be collected when completed and corrective actions will be required for any violations.

FY 2010 (INTENDED USE)

The SASD plans to continue the practice of including the probation state regarding hypodermic needles or syringes in each contract. Audit reports will be required. In addition, the SASD is implementing a formalized on-site monitoring process which is described in Goal #5-Attachment #2 and will be implemented during SFY 2009-2010.

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the 2007 SAPT BG expenditure period.

The Independent Peer Review Plan, as described in Attachment H, was implemented. Selected peer reviewers contacted programs, scheduled and conducted the following visits during SFY 2008-2009.

Program	County	Region
Lighthouse of Cullman	Cullman	1
Calhoun Cleburne Mental Health Center	Calhoun	1
The Bridge	Cullman	1
Emma's Harvest Home	Mobile	4
Marwin Counseling Services	Marion	1
Freedom Rain Ministries	Jefferson	2
Shelby County Treatment Center	Shelby	2
Substance Abuse Council NW	Lauderdale	1

Reports were written for each visit and submitted to the SASD. The reports were compiled to produce the summary included in Attachment H, ALABAMA INDEPENDENT PEER REVIEW, 2008-2009. The primary purpose of the Independent Peer Review process is to improve the effectiveness of substance abuse services in the State of Alabama. This is evidenced in the ALABAMA INDEPENDENT PEER REVIEW, 2008-2009, specifically in the identified training needs listed on page ten.

TRAINING NEEDS

1. Training on new upcoming ASAM theory.
2. Training on new assessment/placement tool.
3. Continued support and TA as needed to use new assessment/placement tool.
4. Training and support around the Nurse Delegation Program.

These training needs will be addressed during SFY 2009-2010.

FY 2009 (PROGRESS)

The SASD is implementing the Independent Peer Review process and described in Attachment H.

Reviewers are being identified who possess expertise in the field of alcohol and drug abuse treatment and knowledgeable about the various disciplines utilized by the program being reviewed. Reviewers are knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction and are sensitive to the cultural and environmental issues that may influence the quality of the services provided.

Independent peer reviews will be conducted to exceed the 5% SAPT BG requirement. Written reports will be submitted for each review, the reports will be complied and a summary report will be generated which identifies training needs.

FY 2010 (INTENDED USE)

The SASD Independent Peer Review process as described in Attachment H will be implemented.

Reviewers will be selected based on their demonstrated expertise. Reviews will be scheduled and conducted in numbers that exceed the 5% SAPT BG requirement.

Written reports will be submitted for each review, the reports will be complied to develop a summary report used to generate training needs.

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2008 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

APPENDIX B

SUBSTANCE ABUSE SERVICES DIVISION
INDEPENDENT PEER REVIEW PLAN

PURPOSE:
The purpose of the Independent Peer Review is to improve the effectiveness of Alabama's substance abuse services. This will be accomplished by using professional peers to review the clinical and administrative practices of programs by identifying innovations and best clinical practices. As staff from different programs meet, observe, and review program practices, a natural sharing of information will take place. The opportunity for professionals from different programs to discuss best practices is the most advantageous part of the peer review process. This information will be summarized in a yearly report created by the Substance Abuse Services Division of the Department of Mental Health and Mental Retardation.

QUALIFICATIONS OF A PEER REVIEWER:
Peer reviewers shall be individuals with expertise in the field of alcohol and drugs abuse treatment and must be knowledgeable of the various disciplines utilized by the program being reviewed. Peer reviewers must be knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

BACKGROUND AND HISTORY OF INDEPENDENT PEER REVIEW:
The Federal Substance Abuse Prevention and Treatment Block Grant Regulations require the State to provide independent peer review. These regulations require that 5% of all programs receiving funding be reviewed annually by professional peers to assess the quality and appropriateness of their treatment services. "Quality" is defined as the provision of treatment services within the constraints of technology, resources, and patient/client circumstances that will meet accepted standards and practices which will improve patient/client health and safety status in the context of recovery. "Appropriateness" is defined as the provision of treatment services consistent with the patient/client identified clinical needs and level of functioning.

Independent peer reviewers are required to examine: admission criteria/intake process, assessment; treatment planning, including appropriate referral; documentation of treatment services provided; discharge and continuing care planning; and indications of treatment outcomes. The regulations state independent peer reviewers cannot review their own programs or programs which they have administrative oversight and the review must be separate from any funding decisions and not part of any licensing/certification process.

GENERAL OBSERVATIONS:
Independent Peer Reviewers will use a number of methods to gather information on programs and the services they provide. Methods used are:

- Tours of the facility.
- Interviews with agency staff performing various functions in the modality reviewing.
- Review of clinical forms used in the clinical records.
- Observation of admission/intake processes.
- Review of client satisfaction surveys or interview clients.
- Review of open and closed client records.

A clinical review of the program is required by the Federal regulations. The clinical review is broken into six sections:

SECTION 1. Determine if the admission/intake process respects the dignity of the clients.
SECTION 2. Determine if the assessment process identifies the need for care, the appropriate level of care and forms the basis for a treatment plan.
SECTION 3. Determine if the treatment plan provides a flexible guide for helping clients get better.
SECTION 4. Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs in a timely manner.
SECTION 5. Determine if the discharge plan supports the client's recovery.
SECTION 6. Determine the program's policies, procedures and practices regarding treatment outcome.
SECTION 7. Determine client satisfaction with the program.
SECTION 8. Administrative Review.
SECTION 9. Reviewer's Summary of Peer Review Process.
SECTION 10. Providers Assessment of the Independent Per Review Process

REVIEW PROTOCOL:
Each peer reviewer will complete the following:

1. Contact the program to be reviewed to:
a. Discuss the review agenda and arrange a mutually convenient date. Once the date has been set, the reviewer will inform the SASD and the program being reviewed in writing the date the review is scheduled.
b. Ask the program being reviewed if there are any specific areas they would like to focus on during the review.
c. Coordinate with the program being reviewed to have available documentation that will be needed for the review process. Some of this material may be provided to the reviewer prior to the review date. This material may include:
* Agency and or Program brochure,

* Sample case record format to facilitate chart review,
* Schedule of program activities,
* Program mission statement,
* Program objectives and philosophy,
* Criteria for client admission, movement through treatment phases and completion.

2. The review will begin with an introduction during which:
a. The reviewer explains the purpose of the review and how it will be conducted and asks, again, if there are any areas they would like to focus on during the review.
b. The program being reviewed provides the reviewer with a general overview of the program's operations including types of services, staffing and census.
c. If possible, the initial meeting should include any staff member who will participate in the review process.

3. A tour of the facility following the introductory session is recommended.
4. The reviewer begins the review process by following the guidelines set forth on the "IDEPENDENT PEER REVIEW FORM." The form provides methodologies on how to gather information, focus issues questions, and guidance in completing the final report.
5. Within one week after the site review, the reviewer will provide a draft of the report to the program reviewed.
6. The program may respond, verbally or in writing, to the reviewer to determine the information included in the final report.
7. Within 30 calendar days of the program review, the reviewer will be complete the final report and send it to the office listed below along with a contract/field voucher.

Charles Mitchell
Program Certification Office
DMH/MR Substance Abuse Division
100 North Union Street
P.O. Box 301410
Montgomery, Alabama 36130-1410

INDEPENDENT PEER REVIEW FORM

NAME OF PROGRAM REVIEWED:_____

DATE OF REVIEW:_____

MODALITY REVIEWED:_____

NAME AND TITLE OF REVIEWER:_____

NUMBER OF RECORDS REVIEWED: _____ OPEN _____ CLOSED

==========

Methodology section contains suggestions on how to gather information for each objective. The Focus Issues section contains questions that should be used. The reviewer is encouraged to be as detailed as possible in order to highlight the innovative and best practices activities of the program being reviewed.

==========

SECTION 1. DETERMINE IF THE ADMISSION/INTAKE PROCESS RESPECTS THE DIGNITY OF THE CLIENT.

Methodology: Interview intake personnel, observe the general admission area, review documentation of the process, and interview clients if available.

Focus Issues:

a. Does the staff present themselves to clients in a warm, informative, and non-threatening manner? YES NO

b. Are admissions timely? YES NO

c. What is the approximate length of time between contact and admission appointments?

d. How is the client made to feel comfortable?

e. How is the client informed of his/her rights and confidentiality regulations?

f. Reviewer's documentation:_____

_____

_____

_____

_____

_____

_____

Page 1.

SECTION 2. DETERMINE IF THE ASSESSMENT PROCESS IDENTIFIES THE NEED FOR CARE, THE APPROPRIATE LEVEL OF CARE, AND FORMS THE BASIS FOR A TREATMENT PLAN.

METHODOLOGY: Review charts and interview clinicians.

FOCUS ISSUES:

a. Does the assessment indicate the admission was appropriate to the admission criteria? YES NO

b. What is the approximate length on time between the assessment and admission in the program?

c. Does the assessment support the diagnostic impression? YES NO

d. Does the assessment identify and address areas of dysfunction? YES NO

e. Is the level of care appropriate? YES NO

f. Assessment was conducted within a reasonable time frame from the time of initial contact? YES NO

g. Reviewer's documentation:_____

_____

_____

_____

_____

_____

_____

SECTION 3. DETERMINE IF THE TREATMENT PLAN PROVIDES A FLEXIBLE GUIDE FOR HELPING CLIENTS GET BETTER.

METHODOLOGY: Review charts, interview clinicians and clients.

FOCUS ISSUES:

a. Does the treatment plan address problems noted in the psychosocial assessment? YES NO

b. Does documentation of treatment plan updates/revisions reflect a joint effort between the clinician and client? YES NO

c. Are the treatment goals achievable based on the client's abilities and program resources?

YES NO
d. How does the client participate in the treatment planning process?

e. Reviewer's documentation:_____

_____

_____

_____

_____
Page 2.

SECTION 4. DETERMINE IF THE DOCUMENTATION DEMONSTRATES THE DELIVERY OF APPROPRIATE TREATMENT SERVICES TO MEET THE CLIENT'S NEEDS IN A TIMELY MANNER.
METHODOLOGY: Review charts and interview clinicians.
FOCUS ISSUES:
a. Do progress notes tie in to the treatment plan? YES NO
b. Does the chart document the level of client functioning in response to the treatment and justify the level of services offered? YES NO
c. Is treatment rendered and documented on a timely basis? YES NO
d. Reviewer's documentation:_____

_____

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SECTION 5. DETERMINE IF THE DISCHARGE PLAN SUPPORTS THE CLIENT'S RECOVERY.
METHODOLOGY: Review charts and interview clinicians.
FOCUS ISSUES:
a. Is the discharge plan consistent with the documented history? YES NO
b. Is the plan consistent with the client's level of functioning and resources? YES NO
c. Did the client participate in the development of the plan? YES NO
d. Is the continued care of the client addressed in the plan and does it meet the client's needs? YES NO
e. Reviewer's documentation:_____

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Page 3.

SECTION 6. DETERMINE THE PROGRAM'S POLICIES, PROCEDURES AND PRACTICES REGARDING TREATMENT OUTCOME.
METHODOLOGY: Interview administrators and other staff, review documentation of process, and review sample discharge summaries/aftercare plans.
FOCUS ISSUES:
a. What if any, documentation is collected by the program regarding treatment outcomes at discharge?

b. How is the information utilized for program improvement?

c. Reviewer's documentation:_____

_____

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_____

SECTION 7. CLIENT SATIFICATION SURVEY.
METHODOLOGY: Interview clients and/or review client satisfaction surveys or others means used to measure client satisfaction if available.
FOCUS ISSUES:
a. How does the program assess client satisfaction? If the program does not use a survey, one is supplied for the reviewer to use to interview clients.

b. Does the client feel the program serves his/her needs? YES NO
c. Is the client informed of the procedures to be used for filing complaints, both internal and external? YES NO
e. Reviewer's documentation: :_____

_____

_____

Page 4.

_____

_____

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_____

SECTION 8. ADMINSTRATIVE REVIEW.
SUGGESTED AREAS OF DISCUSSION:
Quality Assurance Utilization Review Program Activity Scheduling
Staffing Patterns Internal Controls Customer Satisfaction
Program Development Outcome Measures Employment Environment
Computer Technology Marketing Data Flow Admin/Billing/Clinical

a. Is the administrative area system efficient and effective? YES NO
b. Does the selected system support the clinical goals? YES NO
c. Is the programs current practices based on research/evidence based practices? YES NO
If yes, please identify the practices._____

_____

_____

_____

d. What mechanism for information flow, in the areas of treatment and research information, exist in the program?
_____

_____

_____

e. Reviewer's Documentation: :_____

_____

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Page 5.
SECTION 9. REVIEWER'S SUMMARY OF THE PEER REVIEW PROCESS.

INNOVATIVE APPROACHES:_____

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SUGGESTIONS SHARED:_____

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SECTION 10. PROVIDERS ASSESSMENT OF THE INDEPENDENT PEER REVIEW PROCESS. Provider being reviewed needs to fill this out.

a. What part(s) of the Peer Review Process did you find most helpful/useful? _____

_____

_____

_____

_____

_____

b. What part(s) of the Peer Review Process did you find the least helpful/useful?_____

_____

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_____

c. What additional areas would you include as a part of the review? _____

_____

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_____

d. What changes to the review would you recommend? _____

_____

_____

_____

_____

_____

SECTION RATINGS

Rate the program in each section by circling the appropriate answer.

Section 1: Determine if the Admission/Intake process respects the dignity of the client.

Excellent Good Fair Poor

Section 2: Determine if the Assessment process identifies the need for care, the appropriate level of care, and forms the basis for a treatment plan.

Excellent Good Fair Poor

Section 3: Determine if the treatment plan provides a flexible guide for helping clients get better.

Excellent Good Fair Poor

Section 4: Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs on a timely manner.

Excellent Good Fair Poor

Section 5: Determine if the discharge plan supports the client's recovery.

Excellent Good Fair Poor

Section 6: Determine the program's policies, procedures and practices regarding treatment outcome.

Excellent Good Fair Poor

Section 7: Client satisfaction.

Excellent Good Fair Poor

_____
Signature of Peer Reviewer

Page 8.

CLIENT SATISFACTION SURVEY

Modality reviewed: Adult IOP Adult Crisis Residential Adult Residential Rehabilitation
Special Women's Program Adolescent IOP Adolescent Crisis Residential

Please circle your answers.

HOW SATISFIED ARE YOU:

1. with the staff who served you?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

2. with how staff keep things about you and your life confidential?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

3. that the agency staff respected your ethnic and cultural background?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

4. with the services you received?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

5. that services are provided in a timely manner.?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

6. that your treatment plan helped you get better?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

7. with how the staff treated you?
_____1_____ _____2_____ __3__ ___4___ _____5_____
Not at all satisfied Not Satisfied OK Satisfied Very Satisfied

8. What did you like best about the services you received?

9. How could the services you received be improved?

10. If you have any other comments, please write them on the back of this sheet.

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ALABAMA INDEPENDENT PEER REVIEW
2008-2009

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BACKGROUND

This report summarizes the coordination of the 2008-2009 Independent Peer Review (IPR). The U.S. Department of Health and Human Services mandates states receiving Substance Abuse Prevention and Treatment Block (SAPT) Grant funds conduct an IPR of 5% of SAPT supported treatment programs.

The purpose of the IPR is to improve the effectiveness of substance abuse services in the state of Alabama. Professional peers are recruited to review programs, identifying innovations and promising practices. As a part of the IPR process, programs review and share information, which may in turn, help to improve their services. The IPR process is designed to:

¿ Focus on "innovative approaches," giving programs an opportunity to identify and share information about activities they perceive to be innovative and successful.
¿ Be an educational process, for both the program being reviewed and the professional conducting the review, stimulating exchange of ideas and professional and programmatic growth.
¿ Reviews are conducted at the programs being reviewed; an environment where professional can identify quality improvement opportunities and provide feedback on how the program might improve practices and quality of services.
¿ Identify professional strengths and competency related to knowledge and skills, positive accomplishments, and innovative approaches.
¿ Facilitate sharing of important information with other substance abuse providers.

The participation of the provider's treatment personnel in IPR is a reflection of the commitment of the field to continually improve treatment services to individuals and families affected by the disease of substance abuse. Reviewers are individuals with expertise in the field of alcohol and drug abuse treatment and knowledgeable

of the various disciplines utilized by the program being reviewed. Reviewers are knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction and are sensitive to the cultural and environmental issues that may influence the quality of the services provided.

A clinical review of the program is required by the Federal regulations. The clinical review is broken into six sections which are rated by the reviewer. Each section has questions focusing on the section being reviewed. Reviewer's rate each section on the following scale is excellent, good, fair, and poor.

SECTION 1. Determine if the admission/intake process respects the dignity of the clients.

SECTION 2. Determine if the assessment process identifies the need for care, the appropriate level of care and forms the basis for a treatment plan.

SECTION 3. Determine if the treatment plan provides a flexible guide for helping clients get better.

SECTION 4. Determine if the documentation demonstrates the
delivery of appropriate treatment services to meet the client's needs in a timely manner.

SECTION 5. Determine if the discharge plan supports the client's recovery.

SECTION 6. Determine the program's policies, procedures and practices regarding treatment outcome.

SECTION 7. Determine client satisfaction with the program.

SECTION 8. Administrative Review.

SECTION 9. Reviewer's Summary of Peer Review Process.

Reviewers use a number of methods to gather information on programs and the services they provide. Methods used are:

¿ Tours of the facility.
¿ Interviews with agency staff performing various functions in the modality reviewing.
¿ Review of clinical forms used in the clinical records.
¿ Observation of admission/intake processes.
¿ Review of client satisfaction surveys or interview clients.
¿ Review of open and closed client records.

MODALITIES PARTICIPATING IN THE 08-09 IPR
Location Reviewer

Light house in Cullman Jim Counts
Lighthouse, Inc.
Executive Director: Billy Pepper www.ncaaa.tripod.com
925 Convent Road North East Services Offered Adult Male Residential Rehabilitation
Cullman, Alabama 35055
COUNTY: Cullman

Co occurring IOP of Calhoun Cleburne
MHC Jim Counts
Calhoun/Cleburne Mental Health Center
Executive Director: Mickey Turner
COUNTY: Calhoun
New Directions SA Director Robin Bridges
Anniston, Alabama 36207 Adult Co-Occurring Disorders (IOP)
COUNTY: Calhoun

The Bridge in Cullman Adolescent IOP Luciana Coleman

402 Arnold Street NE, Suite 104 Services Offered
Cullman, Alabama 35055 Adolescent Intensive Outpatient
Program Director;
COUNTY: Cullman

Emma's Harvest Home Phillip Drane
Executive Director: Emma Perryman
P.O. Box 6121 Services Offered
772 Sullivan Avenue Adult Female Residential Co-Occurring Rehabilitation
Mobile, AL 36606)
COUNTY: Mobile

Marwin Counseling Services, Inc. Travis Absher
Executive Director: Lavon Harris
P.O Box 1576 Services Offered
Winfield, Alabama 35594 Adult Intensive Outpatient
Telephone: (205) 487-0359
Fax: (205) 487-0002
COUNTY: Marion

TLC / Residential Rehabilitation Jackie Dean
Freedom Rain Ministries
Executive Director: Jimmy Hutchins
TLC/Residential Rehabilitation (formerly The Lovelady Center)
Services Offered Adult Residential Rehabilitation
7916 2nd Avenue South
Birmingham, Alabama 35206 (Female Only)
COUNTY: Jefferson

Shelby County Treatment Center Becky Clayton
Shelby County Treatment Center
Executive Director: Susan Sidwell www.shelbycountytreatmentcenter.com
750 Highway 31 South Services Offered Methadone Treatment
Saginaw, Alabama 35007
Director: Susan Sidwell
COUNTY: Shelby

Substance Abuse Council of Northwest Alabama
(Freedom House (Female Only) Adult Residential Rehabilitation) Adult IOP Jackie Dean
Executive Director: Peggy Perdue
15132 Highway 72 Services Offered
P.O. Box 1020
Rogersville, Alabama 35652
COUNTY: Lauderdale

2008-2009 FINDINGS

The following table outlines the percentage for each section reviewed.

SECTION	EXCELLENT	GOOD	FAIR	POOR
1	90%	10%		
2	80%	20%		
3	50%	50%		
4	90%	10%		
5	10%	80%	10%	
6	10%	90%		
7	80%	20%		

SECTION 1 Determine if the admission/intake process respects the dignity of the clients.

90 % scored excellent 10% scored good

Of the programs reviewed all of the programs indicated the staff presented themselves to the clients in warm, informative, and non-threatening manner. Comments

made by reviewers in this section are:

Reviewers noted Clients are made to feel welcome by the staff. The Staff begins establishing rapport the moment the client and or their families enter the facility.

Reviewers noted Staff provides a good video to watch explaining the program and the intake process Video was made by staff and has staff members in it.

Reviewers noted Reviewed Client files, had personal interviews with Clients and Staff, Observed dynamics between clients and staff.

Reviewers noted Warm accepting and supportive staff attitudes; approx 1-1/2 hours is dedicated to the admission process.

Reviewers noted Clients rights are clearly posted throughout the program.

SECTION 2 Determine if the assessment process identifies the need for care, the appropriate level of care and forms the basis for a treatment plan

80% scored excellent 20 % scored good

IPR reports indicated through interviews with clinicians, intake staff, and an examination of the client records that the assessment process identified the need for care, the appropriate level of care in most cases. Therapist appear to be passionate about wanting clients to feel they are in control of their treatment

Reviewer's noted From review of client records all treatment plans were individualized and goal oriented, utilizing obtainable objectives.

Reviewer's noted They individualize services until they can apply the assessed level of care.

Reviewer's noted There was a very strong recovery centered atmosphere where both staff and clients interact in a positive manner.

SECTION 3 Determine if the treatment plan provides a flexible guide for helping clients get better.

50% scored excellent 50%scored good

It was determined that the treatment plan provided measurable goals helping the client see the progress they are making. In all of the seven programs reviewed, the treatment plans addressed the problems identified in the psychosocial assessment.

Reviewer's noted Rehab plans seem to be a working plan that is individualized. The Client and staff review progress on an ongoing basis.
Reviewer's noted Staff seems to take personal interest in each client, appropriate changes in Treatment plan and goals done as needed.

SECTION 4 Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs in a timely manner.

Reviewer's noted Treatment plan issues and group individual notes coincide with each other in the Adolescent IOP.
Reviewer's noted Clients offered incentives for completion of assignments.

Reviewer's noted All clients must have family or significant others attending Family support groups.
Reviewer's noted All services reviewed appeared to be provided in a timely manner.

90 % scored excellent 10% scored good.

In the programs reviewed, IPR reports indicated that documentation demonstrated appropriate delivery of treatment services. Documentation of progress notes indicated they are a reflection of the treatment plan. Documentation indicated treatment was provided on a timely basis and reflected the client's functioning and are tied to the treatment plans.
.

SECTION 5 Determine if the discharge plan supports the client's recovery.

10% of programs reviewed scored excellent on this section 80 % scored good

10% programs reviewed scored Fair

Of the reports received, all indicated the following about discharge plans: they did support the client's recovery; were consistent with the documented history; clients did participate in the development of the plans; they addressed the continuing care needs, and plan did meet the client's needs. 30 programs reviewed received a fair rating on this section.

Reviewer's noted Clients discuss any fears they may have about staying clean.

Reviewer's noted Parents are a part of discharge planning with all adolescent clients.

Reviewer's noted Appropriate work on housing and employment.

In most cases discharge planning reflecting patient participation and aftercare needs was evident except in cases of unanticipated patient departure.

SECTION 6 Determine the program's policies, procedures and practices regarding treatment outcome.

10% scored Excellent 90% scored Good

Reviewer's noted This program uses Evidence based MET/CBT models utilized in Treatment.

Reviewer's noted Administrators review discharge records to see if there could have been treatment options available that could have been utilized.

SECTION 7 Determine client satisfaction with the program.

.

All programs use a client satisfaction survey with the exception of one. In addition to a client satisfaction survey, one program conducted a regular community meeting as a means to hear from clients.
Reviewer's noted

- Reports indicated clients felt the programs met their needs.
- Clients appear to be aware of how to file a compliant or grievance with the agency.
- The complaint/grievance procedures are posted through out the programs and in client's hand books.
- Reviewers also stated that documentation supported that clients are also informed of their right to file a grievance through advocates.

SECTION 8 Administrative Reviews

The administrative review selection offered useful suggestions from reviewers to help manage an agency. They are as follows.
Reviewer's noted

- Communication with Administration was present. The reason it is important to collect data and out comes needs to be explained on a routine basis.
- Programs are demonstrating evidence based practices by offering research based treatment models.
- Programs seem to be gearing up for ASAM based assessments and new Treatment standards.

SECTION 9 Reviewer's Summary of Peer Review Process

All programs reviewed were well organized and at are different levels of efficiency. Programs reviewed ranged from I year to more than 25 years in operation. Innovative approaches noted are listed below.
80% scored excellent 20% scored good

Innovative Approaches :
Reviewer's noted Women's residential rehab Wonderful continuum of care. Through the use of other Lovelady center programs, Clients at the residential Rehab program were able to receive child care medical care education and employment services.
Reviewer's noted Co-occurring services the electronic record system currently in use seems to encourage the client to take ownership in their treatment. If the client is not able to make the commitment the program continues to apply services with in the client's capability and motivation.

NEXT STEP

To continue the improvement of the IPR process the forms used by the reviewers will be updated in order to provide more precise information around the following areas:

Section 4: To monitor how implementation of the principals of ASAM and levels of care improved assessment and placement of clients.

Section 5: Does ASAMs placement criteria help the provider place the client at the accessed Level of care?
Are the clients followed throughout the process of treatment and moved through the levels of care based on progress or lack of progress instead of days completed.

Section 9: Workforce development and how the DMH can assist programs with working with area educational institutions to develop course work to provide better trained and prepared graduates for this field.

TRAINING NEEDS

The IPR indicated the following training is needed:

1. Training on new upcoming ASAM theory
2. Training on new assessment /placement tool
3. Continued support and T.A. as needed to use new assessment /placement tool
4. Training and support around Nurse delegation program.

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (COMPLIANCE)

This goal was met during the 2007 SAPT BG expenditure period.

Reported Activity: The Substance Abuse Services Division will promulgate standards to include a client rights section, which covers confidentiality.

Current Status: Goal #5-Attachment #1 includes the "Client Protection" section (standard #5203K) from the current promulgated certification standards that are applied to all certified substance abuse treatment programs in Alabama. The "Client Protection" section addresses; confidentiality of client records, external access to client records and conditions for client access.

Reported Activity: All substance abuse providers in Alabama will be reviewed in accordance with the certification standards.

Current Status: The following programs received certification on-site visits during the 2007 SAPT Block Grant expenditure period.

Program County Region Date
Birmingham Fellowship House Jefferson 2 10/2/06
Walker County Recovery Program Walker 1 10/5/06
Kaliedescope Montgomery 3 10/6/06
Mt View IOP Etowah 1 11/3/06
Riverbend MHC Lauderdale 1 11/3/06
Outpatient Recovery Group Etowah 1 11/7/06
New Choices Randolph 2 11/21/06
The Bridge Etowah 1 12/5/06
Mountain Lakes MHC Marshall 1 1/3/07
Mt View Hospital IOP Etowah 1 1/3/07
New Choices Tallapoosa 3 1/22/07
St Ann's Jefferson 2 2/15/07
Phoenix City Court Referral Wings Lee 3 3/14/07
Rapha Christian Home Etowah 1 3/14/07
Shelby County Treatment Shelby 2 3/29/07
Mobile Metro Treatment Center Mobile 4 4/4/07
Tuscaloosa Treatment Center Tuscaloosa 2 4/5/07
Shoals Treatment Center Colbert 1 4/24/07
Mobile MHC Mobile 4 5/8/07
Montgomery Metro Treatment Center Montgomery 3 6/5/07
Pathfinder Madison 1 6/12/07
Starting Over Autauga 3 6/14/07
Tri County treatment Jefferson 2 6/14/07
Oakmont Jefferson 2 6/18/07
Marion County Treatment Center Marion 1 6/26/07
UAB Methadone Jefferson 2 7/6/07
Northwest Treatment Center Jefferson 2 8/13/07
North Central Alabama MHC Morgan 1 8/15/07
Sandy's Place Etowah 1 9/10/07
Madison County Mental Health Center Madison 1 9/24/07

Reported Activity: Programs found non-compliant with any standard, including the client rights portion, will be given opportunity for correction. If corrective action is not taken the program will not be certified, therefore, cannot operate

in the State of Alabama.

Current Status: Based on application of the certification standards to all the programs listed above, the SASD has not de-certified any providers. Therefore, any programs cited for non-compliance with the "Client Protection" standards submitted satisfactory corrective action plans.

Reported Activity: Training will be provided regarding client rights as related to disclosure of patient records.

Current Status: During the 2007 SAPT BG expenditure period the SASD provided twenty-four training events described in Goal #11, FY 2007 (COMPLIANCE) section of the 2010 SAPT BG Application. Of those the following are relevant to confidentiality of patient records.

New Provider Orientations:
01/25/08

Technical Assistance Visits:
05/01/08 Love Lady Center, Jefferson County

Site Reviewer Training Session:
12/09/09

Alabama Methadone Treatment Association Conference
08/20/08

FY 2009 (PROGRESS)

The "Client Protection" section, included in the current certification standards, apply to all substance abuse treatment programs in Alabama.

The SASD conducted on-site certification visits and applied all certification standards, including the "Client Protection" section, to the following programs during the SFY 2008-2009.

Program County Region Date
Chemical Addictions Program Montgomery 3 10/08
New Life Counseling Services 3 10/08
Chilton Shelby Mental Health Center Chilton 2 11/08
Gulf Coast Counseling Services 4 11/08
East Central Alabama Mental Health Ctr. Pike 3 12/08
Freedom Rain Ministries 2 12/08
New Centurions Etowah 1 12/08
Rapha Christian Ministries Etowah 1 12/08
The Bridge Cullman 1 12/08
The Bridge Etowah 1 12/08
The Bridge St.Clair 2 12/08
The Bridge Tuscaloosa 2 12/08
The Bridge Mobile 4 12/08
Agency for Substance Abuse Prevention Calhoun 1 1/09
Anniston Fellowship House Calhoun 1 1/09
The Right Turn Montgomery 3 1/09
Riverbend Mental Health Center Lauderdale 1 1/09
Sumter County Treatment Center Sumter 2 1/09
CED Mental Health Center Etowah 1 2/09
COSA Prevention Montgomery 3 2/09
New Pathways St. Clair 2 2/09
Pneuma Christian Ministries 1 2/09
Alabama Abuse Counseling 2 3/09
Bradford Health Services Houston 4 3/09
Bradford Health Services Montgomery 3 3/09
Bradford Health Services Shelby 2 3/09
Bradford Health Services Tuscaloosa 2 3/09
Calhoun Cleburne Mental Health Center Calhoun 1 3/09
Pearson Hall Jefferson 2 3/09
St. Anne's Home Jefferson 2 3/09
Birmingham DUI Action Program Jefferson 2 4/09
Family Life Center 1 4/09
Birmingham Health Care for the Homeless Jefferson 2 5/09
Dothan-Houston Co. Houston 4 5/09
East Alabama Mental Health Center Lee 3 5/09
Gateway (Family & Child Services) Jefferson 2 5/09
JCCEO Jefferson 2 5/09
Phoenix House Tuscaloosa 2 5/09
SpectraCare Houston 4 5/09
T.E.A.R.S. 3 5/09
Aletheia House Jefferson 2 6/09
Lighthouse of Tallapoosa County Tallapoosa 3 6/09
AltaPointe Health Systems Mobile 4 7/09
Cahaba Mental Health Center Dallas 3 7/09

Gulf Coast Counseling Services Mobile 4 7/09
Indian Rivers Mental Health Center Tuscaloosa 2 7/09
Therapeutic Resources 4 7/09
UAB Jefferson 2 7/09
Cheaha Mental Health Center Talladega 2 8/09
Drug Education Council Mobile 4 8/09
Marwin Counseling 1 8/09
Oakmont Center Jefferson 2 8/09
The Pathfinder Madison 1 8/09
JCCEO (follow-up) Jefferson 2 9/09

The highlighted programs were found non-compliant with the "Client Protection" section (Standard # 5203K). All of the identified programs submitted acceptable corrective action plans and subsequently received full certification.

The following training sessions were conducted during SFY 2008-2009 and included "Client Protection".

New Provider Orientations:

10/28/08

01/29/09

Technical Assistance Visits:

01/23/09 Love Lady Center, Jefferson County

Site Review Team Training:

12/9/09

FY 2010 (INTENDED USE)

The SASD will continue to include the "Client Protection" section in the certification standards which will be applied through on-site visits to community treatment programs during the 2010 SAPT BG expenditure period. The following on-site visits are scheduled or will be scheduled.

Training efforts will be continued to include "Client Protection" or confidentiality through a variety of venues including: new provider orientations; technical assistance visits; and provider seminars.

Treatment Facility Cert Exp Date Review Date
Bibb, Pickens Tuscaloosa. MHC PREVENTION 09/30/09 9/15/09
JCCEO 10/04/09 9/15/09
Drug Education Council 10/30/09 9/9/09
Northwest Treatment Center. 10/30/09 9/15/09
Dothan/Houston Drug Treatment Center 11/30/09 10/15/09
Hamilton Economic Development 11/30/09 10/01/09
Lighthouse of Cullman 11/30/09 10/5/09
Mental Health Center of Madison County 11/30/09 10/15/09
Mt. Lakes Mental Health Center 11/30/09 10/22/09
Phoenix City Court Referral Program 11/30/09 10/15/09
Sandy's Place 11/30/09 10/15/09
AIDS Alabama 12/30/09 11/06/09
Alabama Recovery Center 12/30/09 11/19/09
Baldwin County Mental Health Center 12/30/09 11/16/09
Mental Health Center of North Central 12/30/09 11/05/09
The Bridge 12/30/09 11/23/09
Aletheia House 01/30/10 To Be Scheduled
Freedom Rain TLC 01/30/10 To Be Scheduled
New Choices Interventions 01/30/10 To Be Scheduled
Rapha Christian Ministries 01/30/10 To Be Scheduled
Southwest Mental Health Center 01/30/10 To Be Scheduled
Substance Abuse Council of Northwest Alabama 01/30/10 To Be Scheduled
Teen Empowerment Awareness with Resolutions 01/30/10 To Be Scheduled
The Bridge, Westwood Program 01/30/10 To Be Scheduled
Bradford Health Services Anniston 02/28/10 To Be Scheduled
Bradford Health Services Boaz 02/28/10 To Be Scheduled
Insight Treatment Program 02/28/10 To Be Scheduled
South Central Mental Health Center 02/28/10 To Be Scheduled
Infinity Counseling Services 02/28/10 To Be Scheduled
AL Abuse Counseling Center 03/30/10 To Be Scheduled
Bradford Health Services Shelby County 03/30/10 To Be Scheduled
Bradford Health Services Decatur 03/30/10 To Be Scheduled
Bradford Health Services Birmingham 03/30/10 To Be Scheduled
Bradford Health Services. Florence 03/30/10 To Be Scheduled
Bradford Health Services. Huntsville 03/30/10 To Be Scheduled
Bradford Health Services Madison 03/30/10 To Be Scheduled
Bradford Health Services Mobile 03/30/10 To Be Scheduled
Herring Houses of Dothan 03/30/10 To Be Scheduled
Cullman Treatment Center 4/30/10 To Be Scheduled
Second Choice 04/30/10 To Be Scheduled
Bradford Health Services. Warrior 05/30/10 To Be Scheduled
Huntsville Recovery Center 05/30/10 To Be Scheduled

Mobile Metro Treatment Center 05/30/10 To Be Scheduled
Shelby County Treatment 05/30/10 To Be Scheduled
Shoals Treatment Center 05/30/10 To Be Scheduled
Birmingham Health Care for the Homeless 06/30/10 To Be Scheduled
Birmingham Metro 06/30/10 To Be Scheduled
Calhoun County Treatment 06/30/10 To Be Scheduled
Cherokee County Substance Abuse Council 06/30/10 To Be Scheduled
Gulf Coast Treatment 06/30/10 To Be Scheduled
Huntsville Metro Treatment Center 06/30/10 To Be Scheduled
The Shoulder 06/30/10 To Be Scheduled
Tuscaloosa Treatment Center 06/30/10 To Be Scheduled
West Alabama Mental Health Center 06/30/10 To Be Scheduled
Bibb, Pickens Tuscaloosa Mental Health Center 07/30/10 To Be Scheduled
Cullman Area Mental Health Authority 07/30/10 To Be Scheduled
ECD Treatment Center 07/30/10 To Be Scheduled
Gulf Coast Counseling 07/30/10 To Be Scheduled
Marion County Treatment Center 07/30/10 To Be Scheduled
Montgomery Metro Treatment Center 07/30/10 To Be Scheduled
Outpatient Recovery Group 07/30/10 To Be Scheduled
Salivation Army 07/30/10 To Be Scheduled
Therapeutic Resources 07/30/10 To Be Scheduled
Marwin Counseling Services 08/30/10 To Be Scheduled
Franklin Primary Health 08/30/10 To Be Scheduled
Lighthouse Counsel Center 08/30/10 To Be Scheduled
Spectra Care 08/30/10 To Be Scheduled
Tri-Co. Treatment 08/30/10 To Be Scheduled
West Alabama Mental Health Center 08/30/10 To Be Scheduled
CED Fellowship House 09/30/10 To Be Scheduled
Gadsden Treatment Center 09/30/10 To Be Scheduled
Hope House 09/30/10 To Be Scheduled
SAYNO 09/30/10 To Be Scheduled
Walker Recovery 09/30/10 To Be Scheduled

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

Goal #17: Charitable Choice

FY 2007 (COMPLIANCE)

This goal was met during the 2007 SAPT BG expenditure period.

Reported Activity: The Substance Abuse Services Division (SASD) will assure that contracting religious organizations provide clients: (1) notice of their right to alternative services; (2) give clients options to choose alternative services; and (3) provide alternative services if requested by clients.

Result: Accomplished. During the 2007 SAPT BG expenditure period the SASD contracted with one Faith-based program – Rapha Ministries, Inc., Etowah County, Region 1. The notification of Charitable Choice requirements were provided in a letter (Attachment #10). The program's understanding and acceptance was acknowledged by a signed questionnaire (Attachment #10).

FY 2009 (PROGRESS)

Reported Activity: The SASD requires through a signed agreement with faith-based contracting organizations that "Participation is worship services group devotions and any other activities will be optional."

Current Status: The SASD currently contracts with three Faith-based organizations: Rapha Ministries, Inc., Etowah County (Region 1); The Shoulder, Baldwin County (Region 4); and New Centurions, Etowah County (Region 1). Although these services are purchased with State funds, the SASD distributed the documents in the Charitable Choice Package (Goal #17-Attachment #1) to each provider. The documents serve as notification of the Charitable Choice requirements and delineate reporting requirements for referrals.

FY 2010 (INTENDED USE)

The SASD will provide Alabama's Charitable Choice Package (Goal #17-Attachment #1) to all faith-based contract providers. The SASD will also annually report in the SAPT BG application the number of individuals objecting to the religious nature of each program and the number of individuals that requesting referrals to an alternative provider (beginning with the 2011 application).

FY 2009 (PROGRESS)

Reported Activity: The SASD requires through a signed agreement with faith-based contracting organizations that "Participation is worship services group devotions and any other activities will be optional."

Current Status: The SASD currently contracts with three Faith-based organizations: Rapha Ministries, Inc., Etowah County (Region 1); The Shoulder, Baldwin County (Region 4); and New Centurions, Etowah County (Region 1). Although these services are purchased with State funds, the SASD distributed the documents in the Charitable Choice Package (Goal #17-Attachment #1) to each provider. The documents serve as notification of the Charitable Choice requirements and delineate reporting requirements for referrals.

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The SASD will provide Alabama's Charitable Choice Package (Goal #17-Attachment #1) to all faith-based contract providers. The SASD will also annually report in the SAPT BG application the number of individuals objecting to the religious nature of each program and the number of individuals that requesting referrals to an alternative provider (beginning with the 2011 application).

Attachment I: Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2009) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- ☐ Used model notice provided in final regulations
- ☑ Used notice developed by State (Please attach a copy in Appendix A)
- ☑ State has disseminated notice to religious organizations that are providers
- ☑ State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- ☐ State has developed specific referral system for this requirement
- ☑ State has incorporated this requirement into existing referral system(s)
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers
- ☐ Other networks and information systems are used to help identify providers
- ☐ State maintains record of referrals made by religious organizations that are providers
- ☑ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Attachment J: Waivers

Attachment J: Waivers

If the State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

This narrative response not included because it does not exist or has not yet been submitted.

Form 4

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 10/1/2006 To: 9/30/2007

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2007 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 16,637,015	$ 2,734,461	$	$ 8,751,715	$	$
Primary Prevention	$ 4,753,434		$ 2,019,044	$	$	$
Tuberculosis Services	$	$	$	$	$	$
HIV Early Intervention Services	$ 1,188,359	$	$	$	$	$
Administration: Excluding Program/Provider	$ 1,188,358		$	$ 487,491	$	$
Column Total	**$23,767,166**	**$2,734,461**	**$2,019,044**	**$9,239,206**	**$0**	**$0**

***Prevention other than Primary Prevention**

Form 4ab

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$243,770	$	$	$	$
Education	$1,263,184	$	$	$	$
Alternatives	$807,609	$	$	$	$
Problem Identification & Referral	$0	$	$	$	$
Community Based Process	$863,982	$	$	$	$
Environmental	$1,574,889	$	$	$	$
Other	$0	$	$	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$4,753,434**	**$0**	**$0**	**$0**	**$0**

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Integration of Problem Identification & Referral Strategy

State of Alabama

Alabama currently offers Problem Identification & Referral Strategy (PIDR) as reimbursable activities through the SASD Contract Billing Manual (2010 SAPT BG Application, Goal #1, Attachment #1, pages 41-44) and the DMH Contract (2010 SAPT BG Application, Goal #1, Attachment #2). During SAPT BG 2007 expenditure period, no community contract providers reported or billed for any PIDR activities. However, some PIDR activities were provided, they were not reported through the SAPT BG Application since they were reimbursed with local funds and classified as "In Kind".

Alabama utilizes a historical funding mechanism to contract for direct Prevention services to twenty-two (22) designated Mental Health Boards. These areas cover all sixty-seven (67) counties in Alabama. The integration of the PIDR strategy will be accomplished by the following steps:

1) Technical Assistance and Training will be requested for Alabama.

2) Technical Assistance & Training will be available to all interested providers and reinforced by the Prevention Consultants to the local provider community (Transfer of Knowledge).

3) A Request for Proposals (RFP) will be published by July1, 2010 to integrate PIDR provision beginning October 1, 2010.

4) The Epidemiological Profiles from the State Epidemiological Outcomes Workgroup (AEOW) will be utilized to direct where the provision of service is needed.

The following activities will facilitate the accomplishment of the aforementioned four steps.

The SAPT BG gives annotated definition(s) to the various tenets of the strategy, however, specific components that will assist communities and individuals to move in this direction are not detailed. Therefore, a formal request to receive technical assistance in this area will be facilitated by April 16, 2010. This task could be accomplished via hard copy material and conference calls with designated state and community providers identified by the CSAP Project Officer and Johnson, Bassin & Shaw program staff.

Publications have been attained via on-line resources in the following areas:

- Alcohol, Tobacco and Other Drugs Resource Guide: Employee Assistance Programs;
- Benchmarking Employee Assistance Programs;
- Employee Assistance Programs Are Evolving to Meet Changing Employer Needs;
- Employee Assistance Programs Fact Sheet;
- Prevention Primer: Employee Assistance Programs; and
- Substance Abuse Prevention in the Workplace Fact Sheet.

In addition, technical assistance will be requested via the Center for the Application of Prevention Technologies in the area of Student Assistance Programs and how they interrelate to all of the existing federal programs under the Department of Education.

The technical assistance and training shall include the following information to assist the state and the community based providers with the skills and tools to facilitate community programs and needs. Successful programs in other states that have positive outcomes would also be beneficial for the state to effectively add this strategy on the provider/community level. The synthesis of the PIDR will primarily engage around the following areas for assistance:

- Driving While Intoxicated Education Programs;
- Employee Assistance Programs;
- Student Assistance Programs;
- Member Assistance Programs;
- Peer Assistance Programs;
- Coordination of In-House Programs;
- Coordination of Outside Programs;
- Coordination of Consortium Programs;
- Calculating Costs of Assistance Programs;
- Tips/Fact Sheet to Selecting an Employee Assistance Program Provider;
- An Overview of Online Resources;
- Successful EAP Models; and
- Guide to Employee Assistance.

Since PIDR programs recognize the relationship between substance use and other adolescent health problems such as mental health problems, family problems, early and unwanted pregnancies, sexually transmitted diseases, school failure and delinquency, it is imperative for Alabama to become familiar and align itself with other state programs which have shown success through proven outcomes in their respective communities. Lessons "already" learned will prove invaluable for Alabama to move forward in the process of integration.

The Prevention Consultants play an important role as a conduit to transfer knowledge and skill training to community providers. This area of building capacity in the state has been ongoing since March 2008. Relationships have been forged and new Prevention Specialists have

garnered support and expertise in the overall Prevention “Systems Improvement Initiative”. This step to provide ongoing support and technical assistance at the local level will be reinforced over time. Prevention Services recently hired a full time Epidemiologist to further the progress of the State Epidemiological profile deliverables. This new integration of the PIDR strategy will be addressed to answer the following questions in the future: 1) Where are the specific assistance programs needed in the state? 2) Where (location) does data support the need for this strategy? 3) How will this strategy enhance overall services that are already established within the state?

The RFP and the integration of the Epidemiological profile data will be synthesized together to provide the foundation for this change.

Form 4c

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2007 SAPT Block Grant?

○ Yes ◉ No

Expenditures on Resource Development Activities are:

○ Actual ○ Estimated

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$	$	$	$
Quality Assurance	$	$	$	$
Training (post-employment)	$	$	$	$
Education (pre-employment)	$	$	$	$
Program Development	$	$	$	$
Research and Evaluation	$	$	$	$
Information Systems	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**

Form 6

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2007			
1. Entity Number	**2. I-SATS ID** [X] if no I-SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services(other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
0001	AL750405	Statewide (optional)	$301,435	$2,305,669	$692,232	$203,953	$373,826
0002	AL300037	Statewide (optional)	$307,337	$1,370,058	$409,729	$199,235	$0
0004	AL750041	Statewide (optional)	$0	$198,039	$0	$0	$0
0005	AL900547	Region 2	$1,400	$0	$0	$289,370	$0
0006	AL750561	Region 4	$89,891	$162,707	$0	$165,297	$0
0006	AL302108	Region 3	$83,371	$364,239	$157,068	$60,227	$104,000
0007	AL900091	Region 2	$84,519	$512,961	$126,031	$168,207	
0009	AL900109	Region 2	$20,894	$203,708	$0	$0	$0
0010	AL900604	Region 3	$748,686	$1,086,859	$0		$80,055
0011	AL750157	Statewide (optional)	$1,000	$222,147	$0	$0	$0
0012	AL900570	Region 1	$17,644	$96,125	$0	$224,339	$0
0013	AL750272	Statewide (optional)	$0	$0	$0	$269,636	$0
0014	AL900620	Region 2	$140,741	$626,909	$0	$74,912	$44,749
0015	AL900554	Statewide (optional)	$1,000	$130,563	$0	$0	$0
0016	AL750090	Region 2	$79,532	$138,223	$0	$181,763	$0
0017	AL901362	Region 4	$48,000	$770,575	$0	$0	$0
0018	AL100551	Region 1	$1,400		$0	$528,340	$0
0020	AL302371	Region 3	$12,304	$58,700	$0	$41,045	$4,325
0020	AL900612	Region 3	$2,800	$436,366	$142,601	$246,355	$0
0021	AL100106	Region 2	$1,364	$0	$0	$126,551	$0
0022	AL750058	Region 2	$247,354	$1,003,374	$0	$0	$0
0023	AL100502	Region 4	$0	$0	$0	$64,900	$0
0024	AL750074	Region 2	$22,900	$189,522		$113,642	$0
0025	AL900737	Region 1	$118,105	$321,269	$0	$295,488	$3,910
0026	AL301407	Region 3	$59,573	$382,702	$140,346	$52,647	$62,999
0027	AL900588	Region 3	$18,855	$129,884	$0	$0	$0
0028	AL900786	Region 1	$175,522	$539,980	$0	$124,486	$0
0029	AL901206	Region 4	$181,521	$170,684	$136,320	$0	$271,996
0030	AL100429	Region 2	$98,005	$143,093	$0	$146,804	$0

0031	AL750512	Region 1	$0	$0	$0	$0	$0
0032	AL900117	Region 1	$22,639	$464,427	$224,025	$199,748	$0
0033	AL750199	Region 2	$398,732	$259,452	$0	$152,139	$0
0034	AL900653	Region 1	$21,189	$112,877	$0	$0	$0
0035	AL750371	Region 2	$91,738	$269,326	$0	$0	$0
0036	AL900778	Region 1	$18,166	$596,723	$187,996	$169,040	$0
0037	AL750140	Region 4	$49,680	$446,277	$0	$0	$0
0038	AL900513	Region 4	$58,835	$246,030	$99,145	$80,712	$0
0039	AL750082	Region 2	$0	$201,345	$0	$0	$0
0040	AL302330	Region 1	$1,823,219	$558,479	$0	$0	$0
0041	AL100049	Region 2	$317,264	$676,583	$137,166	$165,596	$242,498
0042	AL900687	Region 3	$16,240	$35,455		$78,481	$0
0043	AL750124	Region 4	$138,229	$810,195	$0	$203,543	$0
0044	AL100668	Region 1	$125,420	$232,618	$103,746	$0	$0
0051	X	Statewide (optional)	$30,057	$0	$0	$0	$0
0053	X	Statewide (optional)	$487,491	$0	$0	$0	$0
0056	X	Statewide (optional)	$48,625	$0	$0	$0	$0
0057	X	Region 3	$1,750,000	$0	$0	$0	$0
0058	X	Region 2	$85,298	$0	$0	$0	$0
0059	X	Region 2	$4,000	$6,176	$0	$0	$0
0064	X	Region 3	$0	$0	$0	$0	$0
0065	X	Region 3	$0	$0	$0	$0	$0
0066	X	Region 4	$295,753	$6,210			
0067	X	Region 3				$32,900	
0068	X	Region 1	$60,534				
0069	X	Region 3	$36,449				
0070	X	Region 1	$10,900				
0071	X	Region 1	$1,440				
0072	X	Statewide (optional)	$5,075				
0101	X	Region 1	$0	$28,257	$0	$0	$0
00SC	X	Region 4	$462,900	$23,966	$0	$0	$0
0ABC	X	Statewide (optional)	$0	$0	$0	$0	$0
cmha	X	Region 1	$14,182	$98,265	$0	$94,078	$0
Totals:			**$9,239,208**	**$16,637,017**	**$2,556,405**	**$4,753,434**	**$1,188,358**

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
0051	Department of Public Health	PO Box 303017 Montgomery, AL 36130-3017
0053	ADMINISTRATION	PO Box 301410 Montgomery, AL 36130 334-242-3961
0056	AL School	Alabama School of Alcohol and Other Drug Studies 300 Dexter Ave. Montgomery, AL 36104
0057	Human Resource Develpment Institute (HRDI)	411 Wall Street Suite B Montgomery, AL 36106
0058	Rapha Ministries	677 W. Covington Ave Attalla, AL 35954
0059	Hope House	1002 2nd Ave East Oneonta, AL 35121
0064	Alabama Department of Education	50 N Ripley Street Montgomery, AL 36104
0065	Family Guidance Center	2358 Fairlane Drive Montgomery, AL 36116
0066	Emma's Harvest Home	772 Sullivan Ave Mobile, AL 36606 251-478-8768
0067	SAYNO, Inc.	492 S Court St Ste 12nd Montgomery, AL 36104 334-265-1821
0068	New Centurions	933 3rd Avenue Gadsden, AL 35901 256-594-1164
0069	Montgomery County Commssion	101 S. Lawrence St Montgomery, AL 36104
0070	Appalachian School	307 Montgomery Building Jacksonville, AL 36265
0071	AL Alcohol & Druge Abuse	4473 Highway 55 E Eva, AL 35621 256-796-4490
0072	Southeastern School	1715 South Gadsden Street Tallahassee, FL 32301 850-222-6731
0101	Recovery Services	PO Box 680693 Fort Payne, AL 35968
00SC	Second Choice	552 Holcome Ave Mobile, AL 36606
0ABC	ALABAMA ABC BOARD	2715 Gunter Park Drive West Montgomery, AL 36109
cmha	Cullman Mental Health Authority	1909 Commerce Ave NW Cullman, AL 35055

Form 6a

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	2
	Resources directories [2]	2
	Brochures [4]	4
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	10
	Parenting and family management [11]	8
	Ongoing classroom and/or small group sessions [12]	51
	Peer leader/helper programs [13]	22
	Education programs for youth groups [14]	160
	Mentors [15]	9
	Preschool ATOD prevention programs [16]	4
	Drug free dances and parties [21]	15
	Youth/adult leadership activities [22]	15
	Community service activities [24]	28
	Recreation activities [26]	36
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	8
	Multi-agency coordination and collaboration/coalition [43]	16
	Community team-building [44]	14
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	4
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	24
	Modifying alcohol and tobacco advertising pratices [53]	9
	Product pricing strategies [54]	1
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	2
	Resources directories [2]	2
	Brochures [4]	6
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences,	6

	meetings, seminars [7]	
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	21
	Education programs for youth groups [14]	4
	Preschool ATOD prevention programs [16]	42
	Drug free dances and parties [21]	11
	Youth/adult leadership activities [22]	8
	Community service activities [24]	12
	Recreation activities [26]	42
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Multi-agency coordination and collaboration/coalition [43]	19
	Community team-building [44]	23
Drop-Outs [3]	Parenting and family management [11]	14
	Peer leader/helper programs [13]	3
	Youth/adult leadership activities [22]	3
	Multi-agency coordination and collaboration/coalition [43]	2
	Community team-building [44]	2
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	8
	Brochures [4]	15
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	4
	Parenting and family management [11]	15
	Ongoing classroom and/or small group sessions [12]	16
	Education programs for youth groups [14]	23
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	14
	Multi-agency coordination and collaboration/coalition [43]	21
	Community team-building [44]	29
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	2
	Resources directories [2]	2
	Brochures [4]	10

	Radio and TV public service announcements [5]	15
	Speaking engagements [6]	10
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	2
	Parenting and family management [11]	3
	Ongoing classroom and/or small group sessions [12]	14
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	81
	Preschool ATOD prevention programs [16]	42
	Drug free dances and parties [21]	13
	Youth/adult leadership activities [22]	11
	Community service activities [24]	15
	Recreation activities [26]	21
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	11
	Systematic planning [42]	4
	Multi-agency coordination and collaboration/coalition [43]	32
	Community team-building [44]	32
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	3
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	6
	Modifying alcohol and tobacco advertising pratices [53]	2
Abuse Victims [8]	Parenting and family management [11]	14
	Ongoing classroom and/or small group sessions [12]	19
	Education programs for youth groups [14]	2
	Preschool ATOD prevention programs [16]	71
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	4
	Multi-agency coordination and collaboration/coalition [43]	3
	Community team-building [44]	32
	Parenting and family management [	

Already Using Substances [9]	Parenting and family management [11]	4
	Peer leader/helper programs [13]	4
	Education programs for youth groups [14]	18
	Youth/adult leadership activities [22]	14

Form 7a

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 10/1/2006 To: 9/30/2007

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A.Number of Admissions**	**B.Number of Persons**	**C.Mean Cost of Services**	**D.Median Cost of Services**	**E.Standard Deviation of Cost**
Detoxification (24-Hour Care)					
Hospital Inpatient			$	$	$
Free-standing Residential	1023	846	$ 632.04	$ 516	$ **260.52**
Rehabilitation / Residential					
Hospital Inpatient			$	$	$
Short-term (up to 30 days)	3455	3199	$ 1234.29	$ 1088	$ **666.17**
Long-term (over 30 days)	1618	1560	$ 3069.54	$ 2205	$ **3256.07**
Ambulatory (Outpatient)					
Outpatient			$	$	$
Intensive Outpatient	17984	17984	$ 757.22	$ 253.50	$ **1061.40**
Detoxification			$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	310	310	$ 728.99	$ 578	$ **501.44**

Form 7b

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	1512	564	265	553	100	1	0	0	1	2	1	10	7	6	2	1117	368	19	8
2. 18-24	4074	1671	892	1197	256	1	2	3	3	10	9	10	6	13	1	2868	1159	37	10
3. 25-44	11313	4036	2745	3364	1049	1	0	15	6	22	12	23	6	24	10	7391	3798	95	30
4. 45-64	3978	1408	583	1533	414	0	1	5	1	10	7	2	1	9	4	2948	1007	18	4
5. 65 and over	88	46	6	31	4	0	0	0	0	0	1	0	0	0	0	77	11	0	0
6. Total	20965	7725	4491	6678	1823	3	3	23	11	44	30	45	20	52	17	14401	6343	169	52
7. Pregnant Women	216		144		66						3		3				213		3

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? Yes No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 4285

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

A) Pregnant Women and Women with Dependent Children

The base for services to pregnant women and women with dependent children was established in 1992 at $92,200. Aletheia House, Inc., NFR ID # AL 300037, had expensed $92,200.00. As per Section 1922 of the Block Grant five percent of the FFY 1993 grant was identified for services to pregnant women and women with dependent children. The FFY 1993 grant amount was $12,398,438 X .05 = $619,921.90. Adding $92,200 plus $619,921.90= $712,121.90 set-aside for FFY 1993. The FFY 1994 grant amount was $13,083,374.00 X .05 = $654,168.70. Adding $712,121.90 from FFY 1993 and $654,168.70 from FFY 1994 yielded a maintenance of effort of $1,366,290.60 for FFY 1994 and subsequent fiscal years.

Expenditures:

SFY 1994 1,366,290.60
SFY 1995 1,366,290.60
SFY 1996 1,366,290.60
SFY 1997 1,366,290.60
SFY 1998 1,366,290.60
SFY 1999 1,492,212.00
SFY 2000 1,366,290.60
SFY 2001 2,465,841.00
SFY 2002 2,302,085.00
SFY 2003 2,405,684.18
SFY 2004 2,843,124.00
SFY 2005 2,626,405.00
SFY 2006 2,556,405.00
SFY 2007 2,252,822.00
SFY 2008 2,556,405.00

B) Tuberculosis

The Alabama Department of Public Health is responsible for monitoring the trends in the tuberculosis rate and administering tuberculosis services in Alabama. When it became a necessity to establish a M.O.E. base for tuberculosis services provided to substance abuse clients, the SASD coordinated with the Alabama Department of Public Health as described in Appendix A. There were no funds spent for tuberculosis services at the contracting substance abuse programs. The Department of Public Health estimated that 6% of the citizens they provided tuberculosis services to were substance abusing. Therefore, a M.O.E. base was established by multiplying the Department of Public Health¿s budget (100% state funding) by the estimated 6% for SFY 1991 and SFY 1992, yielding a M.O.E. base of $148,200.

As the SASD and the Department of Public Health progressed through the process of testing every client entering substance abuse treatment, it was discovered (as described in Appendix A) that the complete testing was not cost effective. The process was modified to allow for testing of those clients that are observed at admission to be symptomatic for tuberculosis.

This summary (Appendix A) has been submitted as part of each block grant application since the change October 1, 1995.

C) HIV

Alabama became a HIV designated state in 1995. At that time there were no funds being spent for HIV services for substance abuse treatment clients. Therefore, the M.O.E. for HIV has always been reported as zero.

Alabama has, since 1995, set-aside 5% of each block grant award for HIV Early Intervention Services.

FFY 1995 $16,533,558 X.05 = $ 826.677.90
FFY 1996 17,021,620 X.05 = 851,081.00
FFY 1997 18,766,069 X.05 = 974,542.45*
FFY 1998 18,766,069 X.05 = 974,542.45*
FFY 1999 21,666,850 X.05 = 1,083,342.00
FFY 2000 22,197,312 X.05 = 1,109,865.60
FFY 2001 22,994,659 X.05 = 1,149,732.95
FFY 2002 23,828,000 X.05 = 1,191,400.00
FFY 2003 23,970,196 X.05 = 1,249,858.00
FFY 2004 24,056,022 X.05 = 1,039,630.00 **
FFY 2005 24,056,022 x.05 = 1,113,265.00 **
FFY 2006 24,007,464 x.05 = 1,200,373.20 **
FFY 2007 23,762,336 x.05 = 1,188,117.00 **
FFY 2008 x.05 = **

The SASD has assured that these funds are expended for HIV Early Intervention Services through the contracting system, data reporting system and monitoring.

* Included $36,239 from the SSI/SSDI supplemental appropriation.
** Alabama was not a designated state but continued to spend BG funds for HIV Early Intervention Services.

SSA (MOE TABLE I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) / 2 (C)
SFY 2007 (1)	**$9,147,589**	**$10,169,183**
SFY 2008 (2)	**$11,190,776**	
SFY 2009 (3)	$ 13,606,557	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2007 (•) Yes ( ) No

FY 2008 (•) Yes ( ) No

FY 2009 ( ) Yes (•) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2009 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

( ) Yes (•) No If yes, specify the amount and the State fiscal year: $, (SFY)

Did the State include these funds in previous year MOE calculations?

( ) Yes (•) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date)

TB (MOE TABLE II)

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	$ 2,470,000	6 %	$ 148,200	$ 148,200
SFY 1992 (2)	$ 2,470,000	6 %	$ 148,200	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2009 (3)	$ 1,978,243	14.427750 %	$ 285,416

HIV (MOE TABLE III)

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 --- 2 (B)
SFY 1992 (1)	$ 0	$ 0
SFY 1993 (2)	$ 0	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2009 (3)	$ 0

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$1,366,290**	
2007		**$2,556,405**
2008		**$2,252,822**
2009		$ 2,556,405

Enter the amount the State plans to expend in FY 2010 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 2,556,405

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of **up to three pages**, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected and how it is used in making these decisions. If there is a State, regional or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Describe the State's Epidemiological Outcomes Workgroup's composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.
Describe how your State evaluates activities related to ongoing substance abuse prevention efforts, such as programs, policies and practices, and how this data is used for planning. For the prevention assessment, States should focus on the SEOW process. Provide a summary of how data/data indicators were chosen, as well as, key date construct and indicators for understanding State-level substance use patterns and related consequences and mechanisms for tracking data and reporting significant changes should be outlined.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2010 application for SAPT Block Grant funds.

Alabama

Planning:

1. Provide a narrative description of how the State carried out sub-State area planning and determined which areas have the highest prevalence and greatest need.

Alabama is divided into twenty-two mental health catchment areas and four regions (Planning-Attachment #1). The catchment areas were designated in the late 1960's with the enactment of Act 310 by the Alabama Legislature. Act 310 created local 310 boards that were responsible for the planning and coordination of mental health, mental retardation, substance abuse and epilepsy services. Local city and county governments appoint these local 310 board members. The board members serve to represent the needs of the local communities regarding the services provided.

In 1991 the SASD divided Alabama into four regions (Planning-Attachment#2) for the purposes of planning services and allocating resources since it was not practical to expect that a full continuum of substance abuse services could be provided on a catchment area basis. Population, proximity of catchment areas, major metropolitan areas and the location of residential programs were all taken into consideration when making the divisions.

The SASD estimates incidence, prevalence and need by utilizing data collected through the Alabama Pride Survey, the Alabama Social Indicators of Prevention Need, the Alabama Student Prevention Need, the Alabama Student Survey of Risk and Protective Factors, the Community Resource Assessment, the Children's Policy Council's Needs Assessment, the original treatment Needs Assessment Study, the National Survey on Drug Use and Health, Alabama Waiting List data, identification of Alabama Counties without prevention and treatment services, and data from other State agencies, i.e. arrest data, AIDS cases, and Hepatitis B cases.

Data from these sources are compiled according to sub-State planning regions allowing regions to be ranked as described in the table below.

Example of Regional Rankings

	Region #1	**Region #2**	**Region #3**	**Region #4**
#s Served	4	1	3	2
#s Alcohol/Drg. Dependent	4	1	3	2
#s Needing Tx/not getting				
Alcohol	4	1	3	2
Drug	3	2	2	1
# of DUI Arrests	1	2	4	3
# of Other Drug Arrests	2	1	4	3
# of Hepatitis B Cases	3	1	2	4

# of AIDS Cases	4	3	1	2
# of TB Cases	1	3	2	3
Overall Score	26	15	24	22
Overall Ranking	4	1	3	2
SFY 08-09 Per Capita Funding (Ranking)	4	1	3	2

In summary, per capita funding for SFY 2008-2009 is aligned with estimated need rankings.

2. If there is a State, regional, or local advisory council, describe their composition and role.

The SASD must provide for a systematic long range and operational planning process that recognizes the statutory authority of both the Department, established under 22-50-1, et. seq. (Act 881), to set up state plans, and the Regional Mental Health Boards, established under 22-51-1, et. seq. (Act 310), to conduct local community planning.

Planning efforts for the Department include all services (treatment and prevention) to all populations.

In efforts to meet both obligations the Management Steering Committee was formed. This committee is charged with numerous responsibilities, one of which is the establishment of a coordinating subcommittee to facilitate development of a plan for substance abuse services through a collaborative effort between the Department, the 310 Boards, family members of consumers, and primary consumers. This coordinating subcommittee is responsible for integrating local and regional plans with statewide planning, consistent with strategic directions established by the Management Steering Committee.

The Substance Abuse Coordinating Subcommittee includes the following members:

- Mr. Ronald Hunt, Mental Health Consumer, Montgomery
- Ms. Gwen Thomas-LaBlanc, Advocate, Jasper
- Ms. Melissa Kirkland, Provider, Dothan
- Mr. Rannie Childress, Certification Board Representative, Gadsden
- Mr. Bill Layfield, NCADD, Mobile
- Ms. Joan Bowen, Family Member/Advocate, Springville
- Mr. Philip Drane, Consumer/Advocate, Mobile
- Ms. Marie Hood, 310 Board Representative, Decatur
- Mr. Fred Armstead, Prevention Provider, Birmingham
- Dr. Jim Dill, 310 Board Representatives, Birmingham
- Mr. Mike McLemore, Consumer Advocate, Eva
- Mr. J. Kent Hunt, Associate Commissioner for Substance Abuse, Montgomery

- Ms. Sarah Harkless, Director of Community Programs, Montgomery
- Ms. Joan Leary, National Alliance for the Mentally Ill, Birmingham
- Mr. Tom Murphy, Region #1 Family Representative, Decatur
- Mr. Buren Smith, Region #1 Consumer Representative, Eva
- Mr. Mike Adams, Region #2 Consumer Representative, Birmingham
- Mr. Tommy Chavis, Region #3 Consumer Representative, Montgomery
- Dr. Anne Penney, Region #3 Provider Representative, Opelika
- Ms. Angie Bradley, Region #4 Family Representative, Dothan
- Vacant, Region #4 Consumer Representative

The Management Steering Committee, Coordinating Subcommittee, the Council of Community Mental Health Boards, and the numerous substance abuse work groups made up of consumers, family members of consumers and providers of treatment and prevention services are involved with all aspects of planning and implementation of the services offered to the citizens of Alabama.

In addition to the Management Steering Committee process, the DMH/MR expanded local planning efforts during SFY 2007-2008 (Attachment # ____). The expanded local planning/needs assessment process requires pre-publicized, open meetings that are chaired by the local 310 Board Director. The meetings were designed to identify local mental health, intellectual disabilities and substance abuse needs. The identified needs were then rolled up to the regional planning level. These needs were considered and prioritized in regional meetings by consumer, family, advocate and provider representatives that were elected from the local meetings to represent the local groups at the regional meetings. The prioritized needs were then passed along the respective Coordinating Subcommittees for consideration, prioritization and inclusion in the DMH's budget request. The local planning/needs assessment process expanded the Substance Abuse Coordinating Subcommittee by adding seven members representing families, consumers, advocates and providers. The SA Coordinating Subcommittee now has twenty-one members; two DMH/MR staff members; three 310 Board representatives; two other SA provider representatives; and fourteen consumer, family advocates representing the local planning regions.

The prioritized needs identified through the first local process provided the basis for the FY 2009-2010 DMH/MR budget request that which was presented to the Governor in November 2008. As a result, the SASD requested $18 million new State funds to address the locally identified needs. The local planning/needs assessment process continues. Plans are already being implemented for the generation of the FY 2010-2011 budget request.

3. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevention and treatment needs.

Service data is submitted to the SASD by each contracting program. These data identify each unit of service provided and is accompanied with a client profile for each client served. Capacity and utilization levels are actual reported services from individual

providers that are then summed to represent regional totals. This is how Alabama reports that the numbers reported are ¿verifiable¿. Fiscal year admission, service and actuarial reports are prepared, analyzed and shared with planning entities to assist in making decisions. These publications are available for review on the SASD website.

The Office of Certification and Training of the SASD is responsible for constant, consistent and comprehensive monitoring of SASD-funded programs to insure service delivery is compatible and consistent with the community certification standards. These 'site-visits' consist of lengthy program visits where both data review and consultation with agency staff are assessed to insure adherence to approved program descriptions. In addition, the SASD conducts frequent review of the comprehensive data that is collected from funded providers. These data are extensively analyzed to further insure compliance with the planning process.

The SASD is also implementing an on-site monitoring process, as described in Goal#5-Attachment #2, designed to enhance the current contractual and data monitoring processes. This process will be implemented during SFY 2009-2010. Progress of the newly implemented monitoring process will be reported in the FY 2011 SAPT BG application.

4. Describe the composition of the State Epidemiological Outcomes Workgroup (SEOW).

A. OFFICIAL DESIGNATION

The name of this body shall be the Alabama Epidemiological Outcomes Workgroup (AEOW).

B. AUTHORITY

The AEOW shall operate under the authority of the Alabama Department of Mental Health and Mental Retardation (DMH/MR) as established by Alabama Acts 1965, No. 881, Section 22-50-2, and in conformance with Executive Order Number 23 signed by the Governor of Alabama on September 29, 2004 to establish the Alabama Commission for the Prevention and Treatment of Substance Abuse (ACPTSA). DMH/MR's Associate Commissioner for Substance Abuse Services serves as Chairperson of ACPTSA, as designated by the Executive Order, and is responsible for reports to the Governor's Office.

The AEOW was established on April 11, 2006 by authorization of ACPTSA and the DMH/MR Associate Commissioner for Substance Abuse Services and shall function as a permanent subcommittee of ACPTSA.

C. MISSION

The mission of the AEOW shall be to support state and community efforts to prevent substance abuse, dependency, and related problems by identifying, collecting, analyzing,

and disseminating data that describes the prevalence, consumption, and consequences of alcohol, tobacco, and other drug (ATOD) use in Alabama.

D. OBJECTIVES

The objectives of the AEOW shall be to:

1. Establish a process for collecting and reporting ATOD use and related data that is inclusive of all relevant data systems within and available to the State of Alabama.

2. Monitor state and community ATOD data needs and assist in the development of strategies to address those needs.

3. Collaborate with ACPTSA's Prevention Planning Committee to assist in planning efforts for unification of the ATOD prevention services system and implementation of the Strategic Prevention Framework.

4. Facilitate the utilization of ATOD consumption and consequence data by community organizations throughout the state for prevention planning efforts.

5. Provide ongoing surveillance, assessment, and analysis of the consumption and consequences of ATOD use throughout the State of Alabama.

	Member Affiliation	Member Name(s)
1.	Administrative Office of Courts	Vacant
2.	Alabama Council of CMH'c	Ms. Joan Leary
3.	Alcoholic Beverage Control Board	Cpl. Vance Patton
4.	Board of Pardons and Parole	Mr. Robert Oakes
5.	Department of Children's Affairs	Mr. Chris McInnish
6.	Department of Education	Dr. Marcus Vandiver
7.	Department of Human Resources	Ms. Kimberly Desmond
8.	Department of Mental Health	Vacant Mr. Brandon Folks Ms. Sarah Harkless Ms. Stephanie McCladdie Mr. Bob Wynn Mr. Kris Vilamaa
9.	Department of Public Health	Ms. Sondra Reese
10.	Department of Public Safety	Mr. Bill Shanks
11.	Department of Youth Services	Mr. Pat Pendergast
12.	Sentencing Commission	Mr. Bennet Wright

5. How does Alabama facilitate public comment?

In the past Alabama conducted regional meetings to elicit public comments on the Block Grant Application and the plans for substance abuse prevention and treatment services.

After three years of receiving practically no responses, the SASD decided that these meetings were not yielding the desired results so they were discontinued.

During FFY 2000 the SASD ran notices in the major metropolitan newspapers (cost of approximately $800.00) in the state inviting comments on the Block Grant Application. A total of six responses were received and incorporated into the planning process.

In light of the high cost and small response the SASD decided to rely on the input through the Management Steering Process, which includes consumer participation, and the annual budget presentations that the Commissioner is required to make before legislature. The Management Steering Process is ongoing and has already been described in this application. Commissioner John Houston presents the Department of Mental Health and Mental Retardation's budget request (which includes substance abuse) to the legislature each year. The Block Grant application is now available for review on the Alabama Department of Mental Health and Mental Retardation website at www.mh.alabama.gov.

Expanded Local Planning Process:

Alabama Department of Mental Health and Mental Retardation

Fiscal Year 2010 Planning Cycle
Substance Abuse Division - Outcome Report

Substance Abuse Planning in 2008

Local Level Assessment - Local level assessment meetings were held in communities for consumers and families to identify substance abuse needs. 24 meetings were conducted, 732needs statements were collected, and 93 people were recommended to represent their community at regional planning meetings.

Regional Level Planning - Regional level planning meetings allowed representatives to review substance abuse needs that were identified at the local assessments and recommend possible ways to resolve the needs. 7 regional level meetings were conducted with an average of 12representatives participating at each meeting. 17 goals and 47 strategies were recommended for the Department to consider. Representatives were selected at the regional level to serve on the Substance Abuse Coordinating Subcommittee to discuss the goals and strategies that were recommended from each region.

State Level Plan Development - A State Plan was developed with input from Regional Representatives that were selected to serve on Coordinating

Subcommittees. The Substance Abuse Division submitted their top three priorities to the Governor's Office.

Overview of the Department Planning Process

During 2008 the Department of Mental Health adopted a new planning process. Effort was made to involve more families and consumers than ever before. Participants identified needs, recommended potential solutions to the needs, and helped decide what priorities would be the focus during the coming years. This report is an overview of the Substance Abuse Division planning process that occurred during 2008 and the plan that was recommended for fiscal year 2010.

2008

Regional Level Planning Meeting: Goals recommended & Regional Representatives selected.

Local Level Assessment: Stakeholders involved – hosted by local 310 Planning Boards.

State Level Plan Development: Regional Representatives participate to review recommended goals & develop plan.

Develop Objective Measures: Outcome measures are developed to evaluate future progress of goals.

2009

Evaluate Planning Process:

Previous Year Planning and Resource Review: Review previous planning year outcomes with stakeholders.

Regional Level Plan Recommendations: Previous planning year outcomes are discussed & revisions recommended.

State Level Plan Development: Regional Representatives participate to review recommend revisions and establish a new plan.

Develop Objective Measures: Outcome measures are developed to evaluate future progress of new goals.

Substance Abuse:

Goal for Adult Continuum of Care- *Where We Want to Go...*

By 2012, a continuum of outcome supported prevention, treatment, and recovery support services for adults will be available in every county.

Fiscal Year 2010 Substance Abuse Division Plan

The Substance Abuse Division plan was developed through a planning process that included family and consumer input at the local, regional, and state levels. The top three goals for the Substance Abuse Division were included in a report to the Governor's Office to help monitor progress for: adult continuum of care, child and adolescent continuum of care, and measuring outcomes. (see goals on this and the following page)

Strategies for Adult Continuum of Care - *How We Want to Get There…*
Establish rate models for substance abuse services delivery system that sufficiently support recruitment, hiring, and retention of qualified prevention, treatment, and recovery support workforce.

Develop and implement written policies and procedures to guide and support the establishment of the American Society of Addiction Medicine continuum of care for adults throughout the State of Alabama.

Objectives for Adult Continuum of Care - *How We Know When We Get There…*
In each of DMHMR's four substance abuse service delivery regions, a residential detoxification and outpatient detoxification program will be available.

Residential treatment beds for females with substance related disorders will be increased by 100% above the FY 2008 level.

Service rates utilized to provide reimbursement for DMHMR funded substance related disorder programs will meet or exceed average rates for comparable services in the southeast United States.

Increase by 5 each year the number of counties offering adult treatment services.

Goal for Child and Adolescent Continuum of Care - *Where We Want to Go...*

By 2012, a continuum of outcome supported prevention, treatment, and recovery support services for children and adolescents will be available in every county.

Strategies for Child and Adolescent Continuum of Care - *How We Want to Get There…*
Increase the availability of evidence based prevention services that have been established to meet needs identified by local communities.

Develop non-detention adolescent residential treatment programs for substance related disorders.

Develop and implement written policies and procedures to guide and support the

establishment of the American Society of Addiction Medicine continuum of care for adolescents throughout the State of Alabama.

Objectives for Child and Adolescent Continuum of Care - *How We Know When We Get There…*
Increase the number of community need-based prevention programs by 9 each year.

Add one male and one female child and adolescent non-detention residential program with continuing care services.

Increase the number of counties that have DMHMR certified co-occurring outpatient services for children and adolescents by 10.

Current Substance Abuse Practices:

Alabama Substance Abuse Information System (ASAIS) is a web-based claims system designed to formalize client enrollment, improve the billing process, implement an outcome monitoring system, improve contract management, and provide a data warehouse allowing for easy access and data analysis for the substance abuse division. This system was implemented in 2008.

Substance Abuse Prevention and Treatment Standards are available to certify and monitor quality practices and define levels of care in the provision of evidence-based prevention and treatment services. Standards are being updated. Implementation of the newly revised standards is anticipated in 2009.

American Society of Addiction Medicine was used as a model for Alabama to work towards expanded treatment services and uniform screening, assessment and level of care determination during 2009.

State Incentive Grant is funding that Alabama received to coordinate substance abuse prevention dollars and develop a statewide strategy aimed at reducing drug use by youth. Funding was used to support twelve community coalitions as they developed a strategic plan that incorporates a range of effective community based prevention efforts. Counties include Barbour, Dallas, Elmore, Macon, Madison, Marshall, Mobile, Montgomery, Talladega, Tuscaloosa, Wilcox, and Winston.

The SYNAR Amendment requires States to have laws in place prohibiting the sale and distribution of tobacco products to persons under the age of 19 and to enforce those laws effectively. Compliance checks are facilitated collaboratively between the Department of Mental Health and Mental Retardation, the Alcoholic Beverage Control Board, and the Department of Public Health.

Alabama Commission for the Prevention and Treatment of Substance Abuse was established in 2004 under Executive Order #23 in order to make recommendations to foster collaboration, efficiency, and effectiveness among all state agencies regarding substance abuse activities.

Drug Courts were established in partnership with the Administrative Office of Courts to promote evidence-based, certified substance abuse treatment programs as an option for court
referral.

REVISION REQUEST:

Please identify how the State determined the resources for the State.

Resources available for substance abuse prevention and treatment are inadequate in all sub-state planning regions. SAMHSA sponsored surveys indicate thousands of Alabamians need treatment but do not get treatment in all sub-state planning regions. Alabama is attempting to address prevention and treatment needs by assuring that basic services – adult outpatient treatment services, adolescent outpatient treatment services and prevention activities are provided in all of Alabama's sixty-seven counties. Currently twenty counties do not offer adult outpatient, forty counties do not offer adolescent outpatient and thirty-five counties do not offer prevention activities. All new resources and any resources identified due to under-utilization are made available through the Request for Proposal (RFP) process for the development of basic services in counties without.

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2009 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

2 Population levels, Specify formula:

$1.07 Per Capita

1 Incidence and prevalence levels

Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

3 Problem levels as estimated by social indicator data

1 Problem levels as estimated by expert opinion

Resource levels as determined by (specify method)

Size of gaps between resources (as measured by)

and needs (as estimated by)

Other (specify method)

Form 8

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 1	1294062	81874	12281	1637	246	24563	3684	5119	4660	0	2.01	4.79	4.64

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 2	1503350	98410	14762	1968	295	25558	3834	4292	6572	0	3.39	6.05	3.19

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 3	830108	71165	10675	1423	234	21350	3202	2155	2565	0	2.17	11.08	4.34

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 4	1034380	71583	10737	1431	215	21475	3221	3685	4549	0	1.35	8.51	3.19

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	4627851	323032	48455	6459	969	92946	13941	13860	18930	0	2.80	8.50	3.80

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 0 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment	B. That would	A. Needing treatment	B. That would	A. Needing treatment	B. That would	A. Number of	B. Number of	C. Other:	A. Hepatitis B	B. AIDS/ 100,000	C. Tuberculosis /100,000

		services	seek treatment	services	seek treatment	services	seek treatment	DWI arrests	drug-related arrests	0	/100,000		
Statewide (optional)	4661900	323032	48455	6459	9901	92946	13941	15251	18346	0	2.34	7.21	3.80

Form 9

Substate Planning Area [95]: State Total

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	14,356	8,836	3,787	1,213	520											10,049	4,307	0	0
18 - 24 Years Old	0																		
25 - 44 Years Old	308,676	178,318	70,758	41,719	17,881											220,037	88,639		
45 - 64 Years Old	0																		
65 and Over	0																		
Total	323,032	187,154	74,545	42,932	18,401	0	0	0	0	0	0	0	0	0	0	230,086	92,946	0	0

Data is not available to complete columns D - J or rows 2, 4, & 5. The needs assessment which was funded by CSAT and completed in 1999 did not provide the level of race/ethnicity required in Form 9. Alabama is pursuing updated prevention and treatment needs assessment studies that will provide the required level of detail to be included in the 2011 SAPT Block Grant Application.

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

The data in Form 8 (columns 3, 4, and 5) and Form 9 indicating the numbers of individuals needing treatment were provided through the CSAT funded needs assessment study which was completed in 1999. Alabama is pursuing an updated treatment needs assessment study that will provide the required level of detail to be included in the 2011 Block Grant Application.

Alabama is also developing a State Epidemiological Outcomes Workgroup (SEOW) which will help to update prevention needs assessment and help to improve the volume, reliability, validity and usefulness of Alabama needs assessment data.

Data reported in Form 8 (columns 6 and 7) is collected from the relevant State agency maintained databases. The data included reflect calendar year 2008.

Form 11

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2010 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 17,949,156	$ 6,376,256	$ 268,821	$ 23,406,330	$	$ 10,356,700
Primary Prevention	$ 4,786,442		$	$	$	$
Tuberculosis Services	$	$	$	$	$	$
HIV Early Intervention Services	$ 0	$	$	$	$	$
Administration: (Excluding Program/Provider Lvl)	$ 1,196,610		$	$ 2,087,038	$	$
Column Total	**$23,932,208**	**$6,376,256**	**$268,821**	**$25,493,368**	**$0**	**$10,356,700**

Form 11ab

Form 11a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$382,915	$	$	$	$
Education	$2,929,303	$	$	$	$
Alternatives	$765,831	$	$	$	$
Problem Identification & Referral	$43,078	$	$	$	$
Community Based Process	$76,583	$	$	$	$
Environmental	$315,905	$	$	$	$
Other	$272,827	$	$	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$4,786,442**	**$0**	**$0**	**$0**	**$0**

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Form 11c

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2010 funds?

○ Yes ◉ No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$	$	$	$
Quality Assurance	$	$	$	$
Training (post-employment)	$	$	$	$
Education (pre-employment)	$	$	$	$
Program Development	$	$	$	$
Research and Evaluation	$	$	$	$
Information Systems	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**

Form 12

TREATMENT CAPACITY MATRIX

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2010 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)		
Free-standing Residential	1,900	1,885
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)		
Short-term (up to 30 days)	7,100	6,800
Long-term (over 30 days)	3,350	3,200
Ambulatory (Outpatient)		
Outpatient		
Intensive Outpatient	35,500	33,300
Detoxification		
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	250	230

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2010 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐ Competitive grants	Percent of Expense: %
☑ Competitive contracts	Percent of Expense: 10 %
☐ Non-competitive grants	Percent of Expense: %
☑ Non-competitive contracts	Percent of Expense: 90 %
☐ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☑ According to county or regional priorities	Percent of Expense: 20 %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Type of slot:
Rate: $	Type of slot:
Rate: $	Type of slot:

☑ Price per unit of service

Percent of Clients Served: 100 %
Percent of Expenditures: 100 %

Unit: Adult IOP	Rate: $ 15.34
Unit: CR	Rate: $ 70.72
Unit: RR	Rate: $ 46.80

☐ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:

Program Performance Monitoring

- [x] On-site inspections
  - Frequency for treatment: ANNUALLY
  - Frequency for prevention: ANNUALLY
- [x] Activity Reports
  - Frequency for treatment: MONTHLY
  - Frequency for prevention: MONTHLY
- [x] Management Information System
- [x] Patient/participant data reporting system
  - Frequency for treatment: MONTHLY
  - Frequency for prevention: MONTHLY
- [x] Performance Contracts
- [ ] Cost reports
- [x] Independent Peer Review
- [x] Licensure standards - programs and facilities
  - Frequency for treatment: ANNUALLY
  - Frequency for prevention: ANNUALLY
- [x] Licensure standards - personnel
  - Frequency for treatment: ANNUALLY
  - Frequency for prevention: ANNUALLY

Other:

- [ ] Specify:

Form T1

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Aggregates

Employment\Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients employed or student (full-time and part-time) [numerator]	1148	1459
Total number of clients with non-missing values on employment\student status [denominator]	4089	3956
Percent of clients employed (full-time and part-time)	28.08%	36.88%

State Description of Employment\Education Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T1? (Select all that apply)

- ☐ Client Self Report
  - Client self-report confirmed by another source:
    - ☐ Collateral source
    - ☐ Administrative data source
- ☐ Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T1? (Select one)

- ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ○ Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T1? (Select all that apply)

- ☐ Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
    - ○ In-Treatment data ____ days post admission
    - ○ Follow-up data ____ months post admission
    - ○ Other, Specify:
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T1? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
  - Select type of UCID:
    - ○ Master Client Index or Master Patient Index, centrally assigned
    - ○ Social Security Number (SSN)
    - ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
    - ○ Some other Statewide unique ID
    - ○ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge

	data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing employment\student status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T2

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Aggregates

Stability of Housing – Clients reporting being in a stable living condition (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients in a stable living situation [numerator]	3180	3681
Total number of clients with non-missing values on living arrangements [denominator]	3998	4233
Percent of clients in stable living situation	79.54%	86.96%

State Description of Stability of Housing (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T2? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [x] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T2? (Select one)

- ( ) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- (•) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T2? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
    - ( ) In-Treatment data ____ days post admission
    - ( ) Follow-up data ____ months post admission
    - ( ) Other, Specify:
- [ ] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [x] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T2? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
  - Select type of UCID:
    - ( ) Master Client Index or Master Patient Index, centrally assigned
    - ( ) Social Security Number (SSN)
    - ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
    - ( ) Some other Statewide unique ID
    - (•) Provider-entity-specific unique ID
- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge

	data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T3

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Aggregates

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]	3203	4242
Total number of clients with non-missing values on arrests [denominator]	4433	4433
Percent of clients without arrests	72.25%	95.69%

State Description of Criminal Involvement Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T3? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [x] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T3? (Select one)

- ( ) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- (•) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T3? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
    - ( ) In-Treatment data ____ days post admission
    - ( ) Follow-up data ____ months post admission
    - ( ) Other, Specify:
- [ ] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [x] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T3? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
  - Select type of UCID:
    - ( ) Master Client Index or Master Patient Index, centrally assigned
    - ( ) Social Security Number (SSN)
    - ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
    - ( ) Some other Statewide unique ID
    - (•) Provider-entity-specific unique ID
- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

	☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T4

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Aggregates

Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients abstinent from alcohol [numerator]	2879	3378
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	4508	4508
Percent of clients abstinent from alcohol	63.86%	74.93%

(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T4? (Select all that apply)

- [x] Client Self Report

Client self-report confirmed by another source:

- [ ] urinalysis,blood test or other biological assay
- [ ] Collateral source
- [x] Administrative data source

- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T4? (Select one)

- ( ) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- (•) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T4? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge

Specify:

- ( ) In-Treatment data ____ days post admission
- ( ) Follow-up data ____ months post admission
- ( ) Other, Specify:

- [ ] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [x] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T4? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

Select type of UCID:

- ( ) Master Client Index or Master Patient Index, centrally assigned
- ( ) Social Security Number (SSN)
- ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
- ( ) Some other Statewide unique ID

	◉ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing alcohol abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T5

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Aggregates

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients abstinent from illegal drugs [numerator]	1081	1451
Total number of clients with non-missing values on "used any drug" variable [denominator]	4508	4508
Percent of clients abstinent from drugs	23.98%	32.19%

(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)

State Description of Other Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T5? (Select all that apply)

- [x] Client Self Report

Client self-report confirmed by another source:

- [ ] urinalysis,blood test or other biological assay
- [ ] Collateral source
- [x] Administrative data source

- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T5? (Select one)

- ( ) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- (•) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T5? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge

  Specify:
  - ( ) In-Treatment data ____ days post admission
  - ( ) Follow-up data ____ months post admission
  - ( ) Other, Specify:

- [ ] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [x] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T5? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

  Select type of UCID:
  - ( ) Master Client Index or Master Patient Index, centrally assigned
  - ( ) Social Security Number (SSN)
  - ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
  - ( ) Some other Statewide unique ID

	Provider-entity-specific unique ID No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** Information is not collected at admission Information is not collected at discharge Information is not collected by the categories requested State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing drug abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T6

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	434	689
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	1409	1409
Percent of clients participating in social support activities	30.80%	48.90%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T6? (Select all that apply)

- [x] Client Self Report

Client self-report confirmed by another source:

- [ ] Collateral source
- [x] Administrative data source

- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T6? (Select one)

- ( ) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- (•) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T6? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge

Specify:

- ( ) In-Treatment data ____ days post admission
- ( ) Follow-up data ____ months post admission
- ( ) Other, Specify:

- [ ] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [x] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T6? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

Select type of UCID:

- ( ) Master Client Index or Master Patient Index, centrally assigned
- ( ) Social Security Number (SSN)
- ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
- ( ) Some other Statewide unique ID
- (•) Provider-entity-specific unique ID

- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission

	data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 10/1/2007 To: 9/30/2008

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential		5	6
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)		24	23
5. Long-term (over 30 days)		63	64
Ambulatory (Outpatient)			
6. Outpatient			
7. Intensive Outpatient		75	60
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy		193	193

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

This narrative response not included because it does not exist or has not yet been submitted.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–20 - FFY 2007	24.80	
		Ages 21+ - FFY 2007	40.90	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - FFY 2007	12.60	
		Ages 18+ - FFY 2007	31.70	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 12–17 - FFY 2007	9.70	
		Ages 18+ - FFY 2007	10.60	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2007	5	
		Ages 18+ - FFY 2007	4.50	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2007	5.80	
		Ages 18+ - FFY 2007	3.60	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2007	75.70	
		Ages 18+ - FFY 2007	80.90	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2007	87.10	
		Ages 18+ - FFY 2007	92.80	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2007	82.40	
		Ages 18+ - FFY 2007	80.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2007	12.90	
		Ages 18+ - FFY 2007	17.80	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2007	12.10	
		Ages 18+ - FFY 2007	15.50	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2007	12.80	
		Ages 18+ - FFY 2007	17.70	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish? " [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2007	13	
		Ages 18+ - FFY 2007	18.60	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2007	12.70	
		Ages 18+ - FFY 2007	21.10	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	88.90	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2007	82.30	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	84.40	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	84	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	84.60	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2007	((s))	
		Ages 18+ - FFY 2007	50.80	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2007	96.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2007	41.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2007	112.40	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2007	56.90	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2007	91.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2007	88.20	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Category	Description	Total Served
A. Age	1. 0-4	1033
	2. 5-11	7095
	3. 12-14	3661
	4. 15-17	777
	5. 18-20	67
	6. 21-24	21
	7.25-44	350
	8. 45-64	84
	9. 65 And Over	14
B. Gender	Male	6363
	Female	6531
C. Race	White	4351
	Black or African American	8523
	Asian	7
	American indian/Alaska Native	7
	Race Not Known or Other (not OMB required)	4
D. Ethnicity	Hispanic or Latino	322
	Not Hispanic or Latino	11760

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	61047
	2. 5-11	79639
	3. 12-14	33355
	4. 15-17	39120
	5. 18-20	37842
	6. 21-24	55227
	7.25-44	212800
	8. 45-64	200750
	9. 65 And Over	97874
	10. Age Not Known	364
B. Gender	Male	386845
	Female	429352
	Gender Unknown	
C. Race	White	372526
	Black or African American	419181
	Native Hawaiian/Other Pacific Islander	312
	Asian	10889
	American indian/Alaska Native	2296
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	3357
D. Ethnicity	Hispanic or Latino	13846
	Not Hispanic or Latino	802351

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	13266	N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	13266	816197

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	77	28	105	0	0	105
2. Total number of Programs and Strategies Funded	77	28	105	0	0	105
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	NaN	NaN	100.00%

Form P15 - FY 2007 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2007 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2007 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	77	$ 1855708.10
2. Universal Indirect	28	$ 2061231.50
3. Selective	0	$
4. Indicated	0	$
5. Totals	105	$3,916,939.60

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2007 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2007 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2007 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2007 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2007 Program/Strategy Name Universal Direct	**FFY 2007 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2007 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2007 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY 2007 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

Goal #1
Attachment #1

DEPARTMENT
OF
MENTAL HEALTH/MENTAL RETARDATION

SUBSTANCE ABUSE SERVICES DIVISION

CONTRACT BILLING MANUAL

EFFECTIVE
OCTOBER 1, 2002

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INTRODUCTION

This document is the Contract Billing Manual and is intended to function as a companion to the Substance Abuse Services Division's purchase of service contract. It serves to define billable services, eligible staff (where appropriate), reporting codes, units, unit rates, restrictions (if any), and any other condition of billing the service.

This manual provides for an assessment instead of a diagnosis for Substance Abuse Services Division DMH/MR services only (not Medicaid or other third party billed services). Admission for treatment services billed under the SASD DMH/MR services contract must be based on clinical criteria using the latest edition of The Diagnostic and Statistical Manual of Mental Disorders:

a) A diagnosis assigned by a licensed physician or a licensed psychologist based upon a face-to-face interview by the individual assigning the diagnosis; or

b) A diagnostic impression assigned based upon the DMH/MR approved assessment instrument completed by qualified staff.

Admission for treatment services billed under the SASD DMH/MR services contract must also be based on the clients ability to pay. A financial assessment must be used based on a sliding-fee scale.

These provision do not apply to Prevention Services as defined herein.

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PSYCHO-SOCIAL ASSESSMENT

Definition: Documentation of the problem areas assessed and description/summarization of the significant problems which are: (1) to be treated (2) impact upon problems which are to be treated or (3) which impact upon treatment and result in assignment of an assessment or diagnosis code for all five axes, using the current Diagnostic and Statistical Manual (DSM) criteria. Key service functions include:

1. A clinical interview with the client or a client and family members, legal guardian or significant other;
2. Screening for needed medical, psychiatric, or neurological assessment as well as other specialized evaluations;
3. Review of the client's presenting problem, symptoms, functional deficits, and history.
4. Initial diagnostic formulation;
5. Development of an initial recommendation for subsequent treatment and/or evaluation; and
6. Referral to other medical, professional, or community services as indicated.

Eligible Staff: See Standards

Psycho-social Assessment Instrument: The DMH/MR-SASD approved assessment instrument must be utilized. The information must be completed by qualified staff.

SAS Reporting Code: **5511**/Alcohol Assessment Adult
5512/Drug Assessment Adult
5521/Alcohol Assessment Adolescent
5522/Drug Assessment Adolescent

SAS Reporting Unit: 1 episode

SAS Contract Billing Rate: $105.00 per episode

Maximum Billable Unit (s): - 1 episode per year
- 2 updates per year at $25 each

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SASD Billing Combination Restrictions: May be billed with Intensive Outpatient services **only**.

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PSYCHO-SOCIAL ASSESSMENT UPDATE

Definition: Documentation and reassessment of problem areas previously assessed as needed when client has been in extended treatment or client is re-entering treatment in less than a year's time. Guidelines are outlined in the Psycho-Social Assessment requirements.

Eligible Staff: See Standards for Psycho-Social Assessment.

Psycho-social Assessment Instrument: Same as Psycho-Social Assessment. Use only the parts pertaining to updated information.

SAS Reporting Code:
5811/Alcohol Assessment Update Adult
5812/Drug Assessment Update Adult
5821/Alcohol Assessment Update Adolescent
5822/Drug Assessment Update Adolescent

SAS Reporting Unit: 1 episode

SAS Contract Billing Rate: $25.00 per episode

Maximum Billable Unit(s): 2 episodes per year

SAS Billing Combination Restrictions: May be billed with Intensive Outpatient services only.

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DIAGNOSTIC TESTING

Definition: Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the staff member and interpretation of the test results.

Eligible Staff:
(1) A licensed psychiatrist or licensed psychologist, or
(2) A psychometrist licensed or certified by an independent established for regulating the practice of diagnostic testing that has mutual reciprocity with surrounding states and is nationally recognized.

SAS Reporting Code:
5531/Alcohol Diagnostic Testing
5532/Drug Diagnostic Testing
5541/Adolescent Alcohol Diagnostic Testing
5542/Adolescent Drug Diagnostic Testing

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $80.00 per hour

Maximum Billable Unit(s): Five hours per fiscal year per client.

SAS Reporting Combination Restrictions: Cannot be billed with any residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

CASE MANAGEMENT

Definition: Case management is a service designed to assist individuals in accessing a broader array of services: physical and mental health, educational, vocational, financial, and legal, etc. Case management includes Human Service Needs Assessment (HSNA), case planning, crisis intervention, transportation, linkage, and advocacy.

Eligible Staff:	Staff members who have successfully completed a DMH/MR, SASD approved Case Manager Training program and who possess a valid Alabama driver's license.
SAS Reporting Codes:	**5711**/Case Management Alcohol **5712**/Case Management Drug **5721**/Adolescent Case Management Alcohol **5722**/Adolescent Case Management Drug
SAS Reporting Unit:	Five (5) minute increments
SAS Contract Billing Rate:	$3.00 per unit of five (5) minutes
Maximum Billable Unit(s):	None

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with Residential Rehabilitation or Crisis Residential.

Location: Outpatient and mobile; setting determined by client needs.

CRISIS RESIDENTIAL ADULT

Definition: A highly structured, short-term, intensive chemical dependency treatment service and intensive therapeutic activities, conducted in a 24-hour supervised living arrangement operated by the facility using employees around the clock, awake staff, provided to adult clients and designed to initiate and promote the client's "status" free of chemicals of abuse.

Eligible Staff: See Standards

SAS Reporting Code: **5211**/Crisis Residential Alcohol
5212/Crisis Residential Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $68.00 per day

Maximum Billable Unit(s): Stay is for 14 days with an allowable stay up to 30 days maximum with weekly justification documented by the Program Coordinator in the Client's record. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Crisis residential is an all inclusive service. However, family counseling provided for family members of clients who are in crisis residential programs outside the catchment area, can appropriately be billed as an intensive outpatient services. Intensive outpatient when performed before admission to a residential facility may be billed provided the service was conducted prior to entry into the residential facility.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

CRISIS RESIDENTIAL ADOLESCENT

Definition: A highly structured, intensive chemical dependency treatment service and intensive therapeutic activity, conducted in a 24-hour supervised living arrangement operated by the facility using employees around the clock, awake staff, provided to adolescent clients and designed to initiate and promote the client's "status" free of chemicals of abuse. An adolescent is a minor child, age 12 through 18 years, whose disabilities of minority **have not been** removed by judicial decree or by marriage. Programs specifically for adolescents must be designed to meet the special needs of adolescents, including academics.

Eligible Staff: See Standards

SAS Reporting Code: **5221**/Adolescent Crisis Residential Alcohol
5222/Adolescent Crisis Residential Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $82.00 per day

Maximum Billable Unit(s): Stay is for 14 days with an allowable stay up to 60 days maximum with weekly justification documented by the Program Coordinator in the Client's record. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Adolescent crisis residential is an all inclusive service. However, family counseling provided for family members of clients who are in crisis residential programs outside the catchment area can appropriately be billed as an intensive outpatient services. Intensive outpatient when performed before admission to a residential facility may be billed provided the service was conducted prior to entry into the residential facility.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

RESIDENTIAL REHABILITATION

Definition: A residential service that provides chemical dependency supportive services and therapeutic activities conducted in a residential setting designed to provide the environment conducive to recovery and to promote reintegration into the mainstream of society.

Eligible Staff: See Standards.

SAS Reporting Code: **5311**/Residential Rehab Alcohol
5312/Residential Rehab Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $45.00 per day

Maximum Billable Unit(s): Maximum stay is 90 days. Exceptions require monthly continued stay justification in the client record by the Program Coordinator. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Cannot be billed with assessment, testing, and/or crisis residential. A prerequisite to entry into residential rehabilitation is successful completion of a crisis stabilization, residential rehabilitation, or equivalent intensive outpatient program in the past six months, except where clinical documentation in the psycho-social assessment indicates otherwise. When more intensive treatment services are deemed appropriate, the client must be placed in a crisis stabilization or intensive outpatient program.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

May 1, 2002

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RESIDENTIAL BED, BOARD AND PROTECTION

ADOLESCENT

Definition: A highly structured, twenty-four hour, supervised living arrangement operated by the facility using employees around the clock, awake staff, provided to adult clients and disigned to initiate and promote the client's '"status" free of chemicals of abuse. Programs specifically for adolescents must be designed to meet the special needs of adolescents, including academics.

Eligible Staff: See Standards.

SAS Reporting Code: **5021**/Residential BB&PAlcohol
5022/Residential BB&P Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $35.00 per day

Maximum Billable Unit(s): Maximum stay is 14 days with an allowable stay up to 30 dayss maximum with weekly justification documented by the Proram Coordinator in the client's record. T**he maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Must be billed in conjunction with adult intensive outpatient. Cannot be billed with assessment, testing and/or adult crisis residential.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

10/01/01

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RESIDENTIAL BED, BOARD AND PROTECTION

ADULT

Definition: A highly structured, twenty-four hour, supervised living arrangement operated by the facility using employees around the clock, awake staff, provided to adult clients and designed to initiate and promote the client's '"status" free of chemicals of abuse.

Eligible Staff: See Standards.

SAS Reporting Code: **5011**/Residential BB&PAlcohol
5012/Residential BB&P Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $35.00 per day

Maximum Billable Unit(s): Maximum stay is 14 days with an allowable stay up to 30 dayss maximum with weekly justification documented by the Proram Coordinator in the client's record. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Must be billed in conjunction with adult intensive outpatient. Cannot be billed with assessment, testing and/or adult crisis residential.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

10/01/01

RESIDENTIAL DETOXIFICATION

Definition: An acute care residential service that provides medical intervention intended to rid the client of the presence of alcohol or drugs in his/her system, to promote recovery from the toxic effects of the drugs or alcohol, and to restore psychological, physiological, and behavioral function. The service is intended for clients who are suffering from severe or prolonged alcohol or drug intoxication, have symptoms of withdrawal, and who require the control afforded by a treatment service providing 24-hour monitoring by medical personnel.

Eligible Staff: See Standards

SAS Reporting Code: **5201**/Residential Detox Alcohol
5202/Residential Detox Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $129.00 per day

Maximum Billable Unit(s): Maximum of seven (7) units per admission, per client. Extended stay requires medical justification documented in clients chart daily. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: This is an all inclusive service and no other services may be billed in conjunction with this service.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

May 1, 2002

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RESIDENTIAL TREATMENT FOR - PREGNANT AND POST PARTUM WOMEN

Definition: A residential service for pregnant and post partum women and **their children** that provides around the clock awake staff, continuously available on-site emergency medical assistance, a structured and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day, seven day per week full time living arrangement which offers child care, linkages with educational opportunities, job placement and referral.

Eligible Staff: See standards.

SAS Reporting Code: **5991**/Pregnant Treatment Alcohol
5992/Pregnant Treatment Drug

SAS Reporting Unit: Day

SAS Contract Billing Rate: $82.60 per day

Maximum Billable Unit(s): Maximum stay is 90 days. Exceptions require monthly continued stay justification in the client record by the program coordinator. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).** The restrictions pertaining to Intensive Outpatient Services apply. These restrictions can be found under Intensive Outpatient Adult.

SAS Reporting Combination Restrictions: Cannot be billed with Crisis Residential.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

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RESIDENTIAL REHABILITATION - PREGNANT WOMEN

Definition: A residential service for pregnant and post partum women that provides around the clock awake staff, monitoring by an LPN or equivalent or higher credentialed individual, a structured and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social and vocational rehabilitation. It is a 24-hour a day, seven day a week full time living arrangement which offers child care, linkages with educational opportunities, job placement and referral.

Eligible Staff: See Standards

SAS Reporting Code: **5331**/Residential Rehab Alcohol Pregnant Women
5332/Residential Rehab Drug Pregnant Women

SAS Reporting Unit: Day

SAS Contract Billing Rate: $45.00 per day

Maximum Billable Unit(s):Continuous stay until seven days post-partum. **The maximum units billable in one day cannot exceed the number of certified beds (bill for day of admission only, will not reimburse for day of discharge).**

SAS Reporting Combination Restrictions: Cannot be billed with assessment, testing, and/or crisis residential. A prerequisite to entry into residential rehabilitation is successful completion of a crisis stabilization or equivalent intensive outpatient program in the past six months, except where clinical documentation in the psycho-social assessment indicates otherwise. Where more intensive treatment services are deemed appropriate, the client must be placed in a crisis stabilization or intensive outpatient program.

Location: In a residential structure that complies with all applicable federal, state, and local codes.

INPATIENT DETOXIFICATION

Definition: A safe and effective medical management process provided in an inpatient/hospital setting for the purpose of withdrawing an individual from an addictive substance; the process is designed to result in normal physiological functioning.

Eligible Staff:	To be determined by hospital requirements.
SAS Reporting Code:	**5101**/Inpatient Detox Alcohol **5102**/Inpatient Detox Drug
SAS Reporting Unit:	Day
SAS Contract Billing Rate:	$150.00 per day
Maximum Billable Unit (s):	None

SAS Reporting Combination Restriction: All Inclusive Service. Cannot be billed in conjunction with any other services.

Location: Hospital (non-profit community provider).

OUTPATIENT DETOXIFICATION

Definition: A safe and effective medical management process provided in a non-residential treatment setting for the purpose of withdrawing an individual from an addictive substance; the process is designed to result in normal physiological functioning.

Eligible Staff: Licensed M.D./properly credentialed nurse.

SAS Reporting Code: **5501**/OP Detox Alcohol
5502/OP Detox Drug

SAS Reporting Unit: Episode

SAS Contract Billing Rate: $420.00 Episode.

Maximum Billable Unit(s): 2 episodes per year per client.

SAS Reporting Combination Restrictions: All inclusive services. Cannot be billed in conjunction with any other services.

Location: Outpatient

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INTENSIVE OUTPATIENT
ADULT

Definition: Chemical dependency treatment services and intensive therapeutic activities provided to adults which are designed to initiate and promote a client's "status" free of chemicals of abuse.

Eligible Staff: See Standards.

SAS Reporting Code: **5411**/Intensive Outpatient Alcohol
5412/Intensive Outpatient Drug

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $14.75 per hour.

Maximum Billable Unit(s): None

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Maximum Group Size: Therapy Groups: 15 Adults.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

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INDIVIDUAL COUNSELING
COMPONENT OF INTENSIVE OUTPATIENT

Definition: A one-on-one interaction between an individual client and a counselor or therapist designed to assist in identifying and addressing those issues and problems specific to that person that prevent the initiation and maintenance of a lifestyle free of chemicals of abuse.

Eligible Staff: See Standards.

SAS Reporting Code: **5431**/Individual Counseling Alcohol
5432/Individual Counseling Drug

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $45.00 per hour.

Maximum Billable Unit(s): None.

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the clients rights to privacy and confidentiality.

Effective 10/01/98

OUTPATIENT GROUP COUNSELING COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of two or more clients with a counselor or therapist designed to assist the clients in understanding those issues and problems that prevent the initiation and maintenance of a lifestyle free of chemical of abuse. Group counseling is structured in the sense of processing client issues or problems as opposed to education.

Eligible Staff: See Standards

SAS Reporting Code: *__5451__/Group Counseling Alcohol
*__5452__/Group Counseling Drug

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $14.75 per hour

Maximum Billable Unit(s): NONE

Maximum Group Size: Limited to 15 clients per counselor.

SAS Reporting Combination Restrictions: Can only be billed in a residential rehabilitation program as part of the intensive outpatient treatment plan.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

* Inactive code, use 5411 and 5412 respectively.

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OUTPATIENT FAMILY COUNSELING
COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of the client and/or his/her family member(s) with a counselor or therapist designed to assist the family in identifying and addressing those issues and problems that prevent the initiation and maintenance of lifestyle free of chemicals of abuse.

Eligible Staff:	See Standards
SAS Reporting Code:	**5471**/Family Counseling Alcohol **5472**/Family Counseling Drug
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$14.75 per hour
Maximum Billable Unit(s):	NONE

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service. Can only be billed in a residential rehabilitation program as part of the intensive outpatient treatment plan.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

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DIDACTIC GROUP EDUCATION ADULT COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of two or more clients with a counselor or therapist designed to assist the clients in understanding those issues and problems that prevent the initiation and maintenance of a lifestyle free of chemicals of abuse.

Eligible Staff:	See Standards.
SAS Reporting Code:	**5911**/Alcohol Didactic Group **5912**/Drug Didactic Group
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$14.75 per hour
Maximum Group Size:	30 adults

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

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INTENSIVE OUTPATIENT/OUTPATIENT SERVICES SPECIALIZED WOMEN'S PROGRAMS ONLY

Definition: Chemical dependency treatment services and intensive therapeutic activities provided to pregnant women and women with dependent children which are designed to initiate and promote a client's status free of chemicals of abuse. The Program must provide a standard psycho-social assessment, **gender-specific substance abuse education, gender specific substance abuse therapy;** group, family and individual, supportive counseling/education and detoxification if needed.

Eligible Staff:	See Standards.
SAS Reporting Codes:	See components of Intensive Outpatient/Outpatient.
SAS Reporting Unit:	Hour.
SAS Contract Billing Rate:	See Components of Intensive Outpatient/Outpatient.
Maximum Billable Unit(s):	NONE
Maximum Group Size:	Therapy Group, 15 Adults.

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential services.

Location: Services can be delivered in any setting that is acceptable for both the client(s) and staff member(s).

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ANCILLARY SERVICES
SPECIALIZED WOMEN'S PROGRAMS ONLY

Definition: Other Services that must be provided or made available along with therapeutic activities for pregnant women and women with dependent children. These services **include a combination of**: 1. parenting, 2. child care and 3. transportation, if needed.

Eligible Staff:	Transportation staff must be a licensed driver in the State of Alabama. All other staff must meet federal, state and local laws as applicable to the specific service provided.
SAS Reporting Code:	**6001**/ Alcohol Ancillary Services **6002**/Drug Ancillary Services
SAS Reporting Unit:	Day
SAS Contract Billing Rate:	$50.00 per day
Maximum billable Unit(s):	One unit per day per client.

SAS Reporting Combination Restrictions: **If client is not present for IOP/Outpatient services ancillary services cannot be billed.**

Location: Service can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the clients rights to privacy and confidentiality.

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IN-HOME INTERVENTION
PREGNANT WOMEN AND WOMEN W/DEPENDENT CHILDREN

Definition: Time limited, home based services provided by a treatment team (two-person team, one master's level substance abuse professional and one person with a bachelor's level degree) to diffuse an immediate crisis situation, stabilize the family unit, and prevent out-of-home placement of the client. Key service function include as necessary:

a) individual/family counseling;
b) crisis management (24 hour availability);
c) parent/guardian significant other training;
d) linkage to other community resources;
e) education and reinforcement of recover skills; and
f) didactic substance abuse education.

Eligible Staff:
A two-person team composed of one with a master's level substance abuse related field and one year's post-master's experience in substance abuse treatment and one person with a bachelor's level degree. Additionally, each member must have successfully completed a DMH/MR approved Case Manager Training Program and a DMH/MR approved In-home Training Program.

SAS Reporting Code:	**5901**/Alcohol In-Home Intervention **5902**/Drug In-Home Intervention
SAS Reporting Unit:	Hour (0.25 hour increments)
SAS Contract Billing Rate:	$80.00 per hour
Maximum billable unit(s):	6 hours per day 16 weeks per case

SAS reporting combination restriction: May not be billed on the same day of Intensive Outpatient, Ancillary service or Crisis Residential. Only families who are enrolled in SAS certified Specialized Women's Program are eligible for this service.

Location: Service can be delivered in any in-home setting. Services may infrequently be provided in other location such as the clinic, jails, schools, etc. Such exceptions will not render the service ineligible for billing.

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INTENSIVE OUTPATIENT ADOLESCENT

Definition: Chemical dependency treatment services and intensive therapeutic activities provided to adolescents which are designed to initiate and promote a client's "status" free of chemicals of abuse in a non-residential treatment facility.

Eligible Staff: See Standards.

SAS Reporting Code: **5421**/Intensive Outpatient Alcohol
5422/Intensive Outpatient Drug

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $18.00 per hour

Maximum Billable Unit(s): NONE

Maximum Group Size: Therapy Groups, 12 Adolescents.

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

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INDIVIDUAL COUNSELING - ADOLESCENT COMPONENT OF INTENSIVE OUTPATIENT

Definition: A one-on-one interaction between an individual client and a counselor or therapist designed to assist in identifying and addressing those issues and problems specific to that person that prevent the initiation and maintenance of a lifestyle free of chemicals of abuse.

Eligible Staff: See Standards

SAS Reporting Code: **5441**/Individual Counseling Alcohol Adolescent
5442/Individual Counseling Drug Adolescent

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $45.00 per hour.

Maximum Billable Unit(s): None.

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Effective 10/01/99

OUTPATIENT GROUP COUNSELING - ADOLESCENT COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of two or more clients with a counselor or therapist designed to assist the clients in understanding those issues and problems that prevent the initiation and maintenance of a lifestyle free of chemicals of abuse. Group counseling is structured in the sense of processing client issues or problems as opposed to education.

Eligible Staff: See Standards.

SAS Reporting Code: *__5461__/Group Counseling Alcohol Adolescent
*__5462__/Group Counseling Drug Adolescent

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $18.00 per hour.

Maximum Billable Unit(s): NONE

Maximum Group Size: Limited to 12 clients per counselor.

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

* Inactive code, use 5421 and 5422 respectively.

OUTPATIENT FAMILY COUNSELING - ADOLESCENT COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of the client and/or his/her family member(s) with a counselor or therapist designed to assist the family in identifying and addressing those issues and problems that prevent the initiation and maintenance of lifestyle free of chemicals of abuse.

Eligible Staff: See Standards.

SAS Reporting Code: **5481**/Family Counseling Alcohol Adolescent
5482/Family Counseling Drug Adolescent

SAS Reporting Unit: Hour

SAS Contract Billing Rate: $18.00 per hour.

Maximum Billable Unit(s): NONE

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

DIDACTIC GROUP EDUCATION ADOLESCENT COMPONENT OF INTENSIVE OUTPATIENT

Definition: A structured interaction of two or more clients with a counselor or therapist designed to assist the clients in understanding those issues and problems that prevent the initiation and maintenance of a lifestyle free of chemicals of abuse.

Eligible Staff:	See Standards.
SAS Reporting Code:	**5921**/Alcohol Didactic Group **5922**/Drug Didactic Group
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$18.00 per hour.
Maximum Group Size:	24 adolescents

SAS Reporting Combination Restrictions: Cannot be billed in conjunction with any crisis residential service.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

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HIV GROUP COUNSELING

Definition: A structured interaction of two or more substance abuse treatment clients with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in preparing for HIV testing, dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

Eligible Staff:	See standards. In addition to the standards the counselor/therapist must have completed an HIV Training Course.
SAS Reporting Code:	**5931**/ HIV Group Counseling Alcohol **5932**/ HIV Group Counseling Drug
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$20.00 per hour
Maximum Billable Unit(s):	NONE

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services (HIV Individual Counseling, HIV Case Management, HIV Blood Test, or HIV Medical Assessment).

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

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HIV FAMILY COUNSELING

Definition: A structured interaction of the client and/or his family member(s) with a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients and their family members in dealing with positive test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

Eligible Staff:	See standards. In addition to the standards, the counselor/ therapist must have completed an HIV Training Course.
SAS Reporting Code:	**5941**/HIV Family Counseling Alcohol **5942**/HIV Family Counseling Drug
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$20.00 per hour
Maximum Billable Unit(s):	NONE

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services.

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

HIV INDIVIDUAL COUNSELING

Definition: A one-on-one interaction between an individual substance abuse treatment client and a qualified substance abuse counselor or other HIV specially trained therapist designed to assist clients in dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

Eligible Staff:	See standards. In addition to the standards the counselor/therapist must have completed an HIV Training Course.
SAS Reporting Codes:	**5951**/ HIV Individual Counseling Alcohol **5952**/ HIV Individual Counseling Drug
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$70.00 per hour
Maximum Billable Unit(s):	NONE

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services (HIV Group Counseling, HIV Case Management, HIV Blood Test, or HIV Medical Assessment).

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

HIV CASE MANAGEMENT

Definition: Case management is a service designed to assist substance abuse treatment clients, who have tested positive for HIV/AID's, in accessing a broader array of both physical and mental services, as appropriate, designed to prevent and treat the affects of HIV/AID's. Case management includes needs assessment, case planning, crisis intervention, transportation, linkage and advocacy, client and significant other education, and follow-up.

Eligible Staff:	Staff members who have successfully completed a state approved Case Management Course, an HIV Training Course and who possess a valid Alabama driver's license.
SAS Reporting Codes:	**5961**/ HIV Case Management Alcohol **5962**/ HIV Case Management Drug
SAS Reporting Unit:	Five (5) minute increments
SAS Contract Billing Rate:	$3.00 per unit of five (5) minutes
Maximum Billable Unit(s):	None

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services (HIV Group Counseling, HIV Individual Counseling, HIV Blood Test, or HIV Medical Assessment).

Location: Outpatient and mobile, setting determined by client needs.

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ORASURE HIV TEST
PRE-TEST COUNSELING

Definition: **An oral fluid (OraSure) test** given to consenting (in writing) substance abuse treatment clients designed to confirm the presence of HIV and AID's. OraSure draws antibodies out of the cheek and gum in oral mucosal transudate.

Pre-test counseling to prepare to client to take the HIV test and for the possible results of such a test.

Eligible Staff: Any appropriately trained personnel

SAS Reporting Code: **5971**/ HIV Test Alcohol & Pre-test counseling
5972/ HIV Test Drug & Pre-test counseling

SAS Reporting Unit: Test

SAS Contract Billing Rate: $56.75 per test and pre-test counseling

Maximum Billable Unit(s): As medically indicated.

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services (HIV Individual Counseling, HIV Case Management, HIV Group Counseling, or HIV Medical Assessment).

Location: Services can be delivered in any setting that is acceptable for both the client(s) and staff member(s), that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

HIV MEDICAL ASSESSMENT

Definition: Consultative services provided by a licensed physician regarding the test results or physical condition of a substance abuse treatment client participating in HIV Early Intervention Services.

Eligible Staff:	A licensed M.D.
SAS Reporting Codes:	**5981**/ Medical Assessment Alcohol **5982**/ Medical Assessment Drug
SAS Reporting Unit:	Hour
SAS Contract Billing Rate:	$100.00 per hour
Maximum Billable Unit(s):	As medically indicated.

SAS Reporting Combination Restrictions: Billed only for clients receiving HIV Early Intervention Services (HIV Individual Counseling, HIV Case Management, HIV Group Counseling, or HIV Blood Test).

Location: Services can be delivered in any setting that is acceptable for both the client(s) and staff member(s), that affords an adequate therapeutic environment, and that protects the client's right to privacy and confidentiality.

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METHADONE TREATMENT

Definition: Methadone treatment is a periodic service designed to offer the individual an opportunity to effect constructive changes in his/her lifestyle by using methadone in conjunction with the provision of rehabilitation and medical services. Methadone treatment is also a tool in the detoxification and rehabilitation process of narcotic dependent individuals. For the purpose of detoxification, methadone is used as a substitute narcotic drug; it is administered in decreasing doses for a period not to exceed 21 days. For individuals with history of Psychoactive Substance Dependence, severe narcotic dependency only prior to admission to the service, methadone may also be used in maintenance treatment. In these cases, it may be administered or dispensed in excess of 21 days at relatively stable dosage levels with treatment goal of an eventual drug-free state.

Eligible Staff: See Standards.

SAS Reporting Code: **5682**/Drug Methadone Treatment

SAS Reporting Unit: Day

SAS Contract Billing Rate: $4.00 per day.

SAS Reporting Combination Restrictions: NONE

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

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DEAF INTERPRETER

Definition: Services provided by a certified deaf interpreter to establish and maintain communication between an eligible deaf client and the treatment provider during the delivery of a therapeutic service.

Eligible Staff: Persons certified by the Sign Communication Proficiency Interview; listed on the Alabama State Screen Level 3 or higher; or a candidate for National Certification.

SAS Reporting Code: None

SAS Reporting Unit: Hour

SAS Contract Billing Rate: Rate established by Department of Education. Depending on credentials.

Maximum Billable Unit(s): None

SAS Reporting Combination Restrictions:

Location: Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

PHYSICIAN RETAINER

Definition: Funds to assure the services of a licensed physician as required for residential detoxification.

Eligible Staff: A state of Alabama licensed physician.

SAS Reporting Code: **5199**/Physician Retainer

SAS Reporting Unit: Month

SAS Contract Billing Rate: $1,000.00 per month.

Maximum Billable Unit(s): 12 per fiscal year.

SAS Reporting Combination Restrictions: Can be billed only in conjunction with residential detox.

Location: Residential Detox facility as required.

PREVENTION

Definition: Strategies developed to limit substance experimentation/use from beginning, or the identification and education in the earliest stages of alcohol, tobacco, or other drug use/abuse to preclude the onset of detrimental effects.

Eligible Staff: See Standards

PREVENTION DEFINITIONS

(1) **Education:**(616#) This strategy involves two-way communication where interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Examples of activities include (but are not limited to) the following:

(i) classroom and/or small group sessions (all ages)
(ii) family strengthening groups (all ages)
(iii) high-risk groups (all ages)

(2) **Alternatives:** (617#) This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. Examples of activities include (but are not limited to) the following:

(i) summer alternative programs
(ii) youth camping trips
(iii) community recreation activities

(3) **Problem Identification and Referral:** (618#) This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education.

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(Note: this strategy does not include any activity designed to determine if a person is in need of treatment). Examples of activities include (but are not limited to) the following:

(i) school counselor referrals
(ii) juvenile judge referrals
(iii) youth detention referrals

(4) **Community-based Process:** (619#) This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and other drug disorders. Examples of activities include (but are not limited to) the following:

(i) community and volunteer training
(ii) professional/teacher training
(iii) neighborhood action training

PREVENTION CODES & DOCUMENTATION

SAS Reporting Codes: **6161, 6162, 6163, 6164, 6165, 6166, 6167, 6168, 6169, 6170**/Education Objectives
6171, 6172, 6173, 6174/Alternative Objectives
6181, 6182, 6183/Problem Identification and Referral
6191, 6192, 6193/Community-based Process

SAS Reporting Unit (s): Hour

SAS Contract Billing Rate: $60.00 per hour.

Maximum Billable Unit(s): As approved through the RFP.

SAS Reporting Combination Restrictions: None

Location: A site appropriate to the facilitation of specific programs.

Documentation of services:

(1) Documentation of all prevention services shall be completed by the person who delivers the service and shall contain the date and location of each service delivery, the topic addressed, the length of the presentation, and the number of recipients by gender, age and race.

(2) Each prevention service provider organization shall develop and maintain a current prevention plan which outlines all prevention services provided by the organization.

(3) Each prevention objective shall have a separate individual folder(or notebook) containing the written objective, documentation of the service delivery, the outcome measurement instrument used, and the outcome evaluation results.

(4) At the end of each fiscal year each prevention organization shall submit to the SAS Division within sixty days a detailed evaluation report outlining the outcome results of each prevention objective. This report shall list the total number of recipients for each objective broken down by age range,

gender, and race; a copy of the type(s) of measurement used; what was being measured, size of the sample(s), and the outcome evaluation results.

(5) All prevention objectives shall conform to the guidelines as outlined within each annual Request For Proposal (RFP).

POPULATION CODES

POP-CODE	POP-NAME
I	IV DRUG DEPENDENT/ABUSE
V	WOMEN IV DRUG DEPENDENT/ABUSE
D	ADOLESCENT IV DRUG DEPENDENT/ABUSE
W	ALCOHOL OR DRUG ABUSE/ DEPENDENT WOMEN
A	ALCOHOL OR DRUG ABUSE/ DEPENDENT ADOLESCENTS
P	IV DRUG ABUSE/DEPENDENT PREGNANT WOMEN/WOMEN W/DEPENDENT CHILDREN
F	ALCOHOL OR DRUG ABUSE/ DEPENDENT PREGNANT WOMENT/WOMEN W/DEPENDENT CHILDREN
N	NOT APPLICABLE

FUND CODES

INSNO	FUND NAME
C	SPECIALIZED WOMEN
CAP	TRANSITIONAL REHAB
CHP	ALLKIDS
DMD	DUALLY DIAGNOSED
DRG	DRUG COURT
DMH	DMH/MR
G	INDIGENT OFFENDER
I	INDIVIDUAL
O	OTHER THIRD PARTY
P	PPO
TAB	ADOLESCENT JUVENILE JUSTICE
TAN	CORRRECTIONS DHR WOMEN/DEPENDENT CHILDREN
TXP	TRANSPORTATION
MCD	MEDICAID

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Goal #1
Attachment #2

EXHIBIT SA-2

FINANCIAL

A. This is a fee for service agreement with statewide fees established based upon prevailing usual, customary rates and rate models. Payment is for the provision of specific units of service to eligible individuals and U.S. citizens for which there is no other source of payment. Units of service will be reported based on individuals served and by service provided. Funding provided for Prevention Systems Improvement, Women's System Improvement and Treatment Improvement will be paid upon the submission of a contract field voucher requesting payment with documentation.

B. Service delivery and billing documentation must include **all** substance abuse services rendered to the client of the Contractor or its subcontractor for which DMH is paying in whole or in part and must specify the funding source for each service (DMH, Medicaid, other third party, and/or etc.). The billing documentation must also specify client number, social security number, service type, units of service, date of each service rendered and priority population codes (I,V,D,W,A,P,F,N). Each service claimed must be traceable from the billing, through the subcontractor's service documentation to the individual client record. All claims must be submitted for payment in one of two ways. Claims should be submitted via an electronic 837 file as described in the DMH SASD Contract Billing Guide or via direct entry of services into the Alabama Substance Abuse Information System (ASAIS).

C. Up to twice a month DMH shall pay the Contractor an amount equal to the monies received from the Alabama Medicaid Agency for approved claims processed by EDS. **The approved Medicaid rate (federal and state) will be used for this contract. The current Federal Matching Assistance Percentage (FMAP) is determined by the Federal Government and is subject to change. If the Federal Government changes the rate you will be notified immediately by DMH. In any event the total appropriation is not to exceed $1,000,000.00 allocated for statewide use. In the event $1,000,000.00 limit is exceeded the Provider is responsible for the required match.**

D. Up to twice a month DMH shall adjudicate claims received to date and pay the Contractor an amount equal to the approved claims from federal Block Grant and State dollars for services not eligible for Medicaid or services received by clients not eligible for Medicaid.

E. DMH will reimburse Alabama Department of Public Health approximately $5,000.00 for a statewide pool to be used for the State match for eligible ALLKIDS Plus services, consistent with the 2009 rate established by the Children's Health Insurance Program (currently at 22.39% state and 77.61% federal, but subject to change).

F. The Prevention contractor/organization and its Subcontractor(s) agrees to collect all supporting fiscal and programmatic documentation on approved forms on the

following data elements: age, gender, race, ethnicity and age of first use for each participant. All activities for each strategy, practice and policy initiative shall be collected and reported to DMH SASD. Programmatic outcomes and activities shall be designated to reflect a change in risk and protective factors with the targeted population. Any changes (amendments) to the overall plan of services shall be made in writing to the DMH SASD with appropriate justification for the stated amendment.

G. Coalition and Sustainability providers will work the overall goals of Unified Prevention System to promote the objectives of community Prevention Partners to develop, facilitate and promote the implementation of prevention strategies, practices and policies. Prevention services are intended to improve the health and social well being of youth and community. The coordination and collaboration of program strategies will lead to sustained community resources and efforts to prevent substance abuse.

H. Total payment shall not in any event exceed the total annual contract amount assigned to the Contractor or its subcontractor (see Exhibit SA-1) or the amount for each service category. For the purpose of this contract, the value of the above service categories shall be determined by summing the appropriate units of each service delivered to eligible clients and multiplying by rates for each service listed in the Contract Billing Manual (as amended).

~~I.~~ Service units in excess of maximum to be purchased under this agreement as shown in Exhibit SA-1 will not be paid. The Contractor also understands and agrees that payments by DMH under this contract are for the actual delivery of services as opposed to the services merely being made available to eligible individuals.

J. The Contractor agrees that for Line Item budgets (not fee for service) 25% of the total budget can be transferred between line items. The 25% total can be in part or one transfer. Under no circumstances can the total transfer equal more than the 25%.

~~K.~~ The Contractor agrees to forward to the Substance Abuse Services Division all signed subcontracts within 30 days of the beginning of this contract period.

L. Final billing for services rendered under this contract must be received within **45** days of the end of the contract period or as instructed by the Alabama Department of Finance's Comptrollers Office.

EXHIBIT SA-3

PROVISIONS SPECIFIC TO BLOCK GRANT AND OTHER REGULATORY REQUIREMENTS

I. Each Contractor and its Subcontractor(s) receiving any funds, as identified in Exhibit SA-1, agree to the following contract provisions specific to the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other regulatory requirements:

A. Tuberculosis

1. The Contractor and its Subcontractor(s) will have, directly or through arrangements with other public or nonprofit private entities, infection control procedures to prevent the transmission of tuberculosis. These procedures must include:

a. A screening process for identification of high risk individuals;
b. Referral for testing, if indicated by the screening process;
c. Case management, as indicated, and
d. A reporting process to appropriate state agencies as required by law.

B. Pregnant Women

1. The Contractor and its Subcontractor(s), exclusive of programs operating for males only, will give preference to pregnant women in admissions to substance abuse treatment.

2. If the Contractor and its Subcontractor(s) have insufficient capacity to provide treatment services for a pregnant woman, who seek services from the facility, the woman will be referred to the Substance Abuse Services Division (SASD) of DMH.

C. Continuing Education

1. The Contractor and its Subcontractor(s) will make continuing education services available to its employees who provide treatment and/or prevention activities.

D. The Contractor and its Subcontractor(s) will provide services in accordance with written program descriptions that have been approved by and filed at the SASD of DMH. Program descriptions are expressly made a part of this contract, and will be kept current with revisions made by the Contractor and its Subcontractor(s) as changes occur, including the location of service delivery.

E. The Corporation and its subcontractors agree that none of the services or programs identified in Exhibit SA-1 will be discontinued or substantially modified without the prior

written approval of the SAS Division of DMH, so long as funds are available under this contract.

F. Organizational control and policy functions of the Contractor and its Subcontractor(s) are and shall continue to be the responsibility of the respective Board of Directors of the organization(s).

G. The Contractor and its Subcontractor(s) will provide each client with HIV risk education, including prevention information.

H. The Contractor and its Subcontractor(s) will comply with all of the protocols of the statewide Waiting List Project, in order to insure compliance with provisions of the SAPT Block Grant pertaining to treatment access for special populations.

I. The Contractor and its Subcontractor will comply with all reporting requirements including but not limited to; screening of all presenting clients, referrals for services and wait list. After screening, each client will be assigned a unique, statewide identifier that will always be used for that individual. This number must be used to identify clients receiving services and presenting for claim reimbursement or any other client related data submission.

J. The Contractor and its Subcontractor(s) will participate in the Statewide Peer Review System.

K. The Contractor and its Subcontractor(s) will provide local planning information to the Regional Mental Health Authority and to the SAS Division of DMH in the form and format required by each agency.

II. The following provisions are applicable, only, to each Contractor and its Subcontractor(s) funded under this agreement to provide services for Pregnant Women and Women with Dependent Children under the SAPT Block Grant Set-Aside:

A. The Contractor and its Subcontractor(s) agree that funding from DMH will be expended for pregnant women and women with dependent children who have no other financial means of obtaining services for substance abuse treatment.

B. The Contractor and its Subcontractor(s) agree that treatment services will be provided or arranged for both women and their dependent children, if appropriate.

C. The Contractor and its Subcontractor(s) agree to provide or make available the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:

1. Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;

2. Primary pediatric care, including immunization, for their children;
3. Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting, and child care while the women are receiving these services;
4. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect; and
5. Sufficient case management and transportation to ensure that women and their children have access to services.

III. The following provisions are applicable, only, to each Contractor and its Subcontractor(s) funded under this agreement to provide services for Intravenous Drug use:

A. The Contractor and its Subcontractor(s) agree to notify the SASD of DMH any time 90% of the capacity to admit individuals to programs of treatment for intravenous drug use is reached;

B. The Contractor and its Subcontractor(s) will assist the SASD of DMH, as directed, in the process of ensuring that each individual, who requests and is in need of treatment for intravenous drug use, is admitted to a program of such treatment not later than:

1. Fourteen (14) days after making the request for admission to such a program; or
2. One hundred twenty (120) days after the date of such a request, if no such program has the capacity to admit the individual on the date of such request, and if interim services are made available to the individual not later than 48 hours after such request.

C. The Contractor and its Subcontractor(s) will carry out outreach activities to encourage intravenous drug users to seek treatment.

IV. The following provisions are applicable, only, to each Contractor and its Subcontractor(s) funded under this agreement to provide HIV Early Intervention Services:

A. The Contractor and its Subcontractor(s) agree to provide HIV early intervention services at substance abuse treatment programs which will, as a minimum, include:

1. Pretest counseling;
2. Testing for HIV disease;
3. Post-test counseling; and
4. Case management to provide linkages with related health and social services organizations.

V. Restrictions on Expenditures (Applicable to all Contractors and their Subcontractors):

A. The Contractor and its Subcontractor(s) shall not expend SAPT Block Grant funds on the following activities:

1. To purchase inpatient hospital services;
2. To make cash payments to clients;
3. To purchase or improve land, purchase, construct, or permanently improve any building or facility;
4. To purchase medical equipment;
5. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
6. To provide individuals with hypodermic needles or syringes; or
7. To provide treatment services in a penal or correctional institution.

EXHIBIT SA-4

CRITERIA FOR
PERSONS TO BE SERVED

It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons (and their family members when appropriate) who meet the following financial and clinical criteria:

A. Financial Criteria for treatment services:

1. Funds through this contract are expressly made available to support community treatment and rehabilitation services for persons in need of DMH financial assistance as determined by an individual financial assessment.

2. Contract funds will be used as **"payment of last resort."** The Contractor and its Subcontractor(s) are required to make every reasonable effort, including the establishment of systems for eligibility determination, billing, and collection to:

a. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under title XVIII,, any State compensation program. any other public assistance program for medical expenses, any grant program, any private insurance, or any other benefit program; and

b. Secure from clients payment for services in accordance with their ability to pay. However, the client's inability to pay cannot be a barrier to treatment.

B. Clinical Criteria for treatment services:

1. It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons (and their family members when appropriate) who, in addition to the financial criteria stated above, also meet the Diagnostic and Statistical Manual of Mental Disorders, latest edition, clinical criteria of psychoactive substance dependency or abuse, in the following order of priorities.

a. Pregnant women.
b. Women with dependent children.
c. Injectable drug users (6 month history of injectable drug use and use of injectable drugs within the last 30 days).
d. Psychoactive substance dependence, severe.
e. Psychoactive substance dependence, moderate.
f. Psychoactive substance dependence, mild.
g. Psychoactive substance abuse.

2. It is understood and agreed that dually-diagnosed clients that have appropriately

prescribed medications will be admitted and covered by this contract.

3. All potential clients presenting at The Contractor and its Subcontractor's facilities – in person or over the phone – shall be screened according to DMH/SASD criteria to determine eligibility for service. Screening information will be recorded and submitted to DMH as per SA-3, Section 1, Paragraph 1.

4. The Contractor and its Subcontractor(s) agree that client records for those clients served through this contract for the Drug Court Program will include a statement from a court verifying the client is prison bound if not for entering this treatment program.

5. The Contractor and its Subcontractor(s) agree that clients served though this contract will receive residential treatment (if appropriate) and referrals will be received on a state-wide basis (based on appropriateness and availability of space).

C. Criteria for indigent offenders:

It is understood and agreed that the Contractor and its Subcontractor(s) will serve persons determined indigent by the courts. If the offender becomes able to pay during treatment, or another future date, the waiver of fees may be revoked.

D. Criteria for prevention services:

Prevention services will be provided to target populations as defined in the DMH SASD planning guidelines. The target population are those individuals whereas data sources support the need for prevention programs, policies and/or practices. All prevention services must be approved by DMH SASD. The Contractor must identify goals and community objectives to be facilitated by all parties involved in service provision (subcontractors, fee for service and part/full time) staff members.

E. Other

It is understood and agreed that the Contractor and its Subcontractor(s) will provide vocational assistance (training, job placement, etc.) and housing support (assistance in locating long-term housing) to clients participating in the correctional program.

EXHIBIT SA-5

CONTRACT PERFORMANCE STANDARDS

A. The Contractor and its Subcontractor(s), if any, must operate in accord with the Standards for Community Mental Health Programs, promulgated by the DMH. Loss of DMH certification will result in withholding of contract funds until recertification is attained.

B. The Contractor and its Subcontractor(s), if any, agree to be governed by all applicable federal, state, or local laws and regulations. It is hereby acknowledged that funds paid to the Contractor under this agreement may include Federal Block Grant (SAPT Block Grant) funds and must be used in compliance with federal regulations and federal intended purposes.

C. The Contractor and its Subcontractor(s) understands that the federal funding in this agreement comes from the U.S. Department of Human Services Substance Abuse Prevention and Treatment Block Grant (Catalog of Federal Domestic Assistance Number 93.959, Grant Number B1 AL SAPT) and is subject to Subpart II & III, Part B, Title XIX, of the Public Health Services Act and the administrative regulations found in the Code of Federal Regulations, 45 CFR, Part 96.

D. The Contractor and its Subcontractor(s), if any, agree to deliver the specific service categories to eligible individuals as identified in Exhibit SA-1.

E. DMH shall perform cost determination audits and contract monitoring activities of such a nature as to assure that the Contractor is carrying out the terms of this contract.

F. Contractor and its Subcontractor(s) understands and agrees that the following will apply to ALL services:

1. Contractor will provide, within the limits of contract funds, services and supports that are most promotive of each client's safety, independence and recovery, not withstanding any description or restriction of services or supports set forth previously herein.

2. Contractor agrees to participate with all relevant stakeholders in the state-wide effort to develop: a) a mutually agreed upon client and family satisfaction assessment process, b) a community client advocacy program, c) a continuous quality improvement process, d) a client grievance process, and e) appropriate client outcome measures.

Contractor and its Subcontractor(s) agree to implement all aspects of F2, a through e above as soon as they may be approved by stakeholders and DMH.

EXHIBIT SA-6

ROBERT WOOD JOHNSON FOUNDATION (RWJF)

A. Robert Wood Johnson Foundation (RWJF) (ID 63728 – Advancing Recovery: State/Provider Partnerships for Quality Addiction Care) providers will establish a process for insuring that youth who complete residential substance abuse treatment through programs funded by the Substance Abuse Service Division of the Department of Youth Services are referred to and participate in continuing care services in their community. Providers will develop a process that integrates the use of case management and wrap around services for adolescents participating in Intensive Outpatient Service to increase their protective factors in their home and community. Funding provided for RWJF will be paid upon the submission of a voucher requesting payment with documentation.

SERVICES TO BE PROVIDED CONTRACTOR

Contractor agrees to send a person to two (2) conferences. Provider will be reimbursed by submitting a voucher requesting payment with documentation.

Goal #1

Attachment #3

SERVICE RATES
FY 08 -09 (INCLUDES 2.8% INCREASE)

ACTIVITY CODE/ HIPPA CODE	TRANSLATION/SERVICE	OLD RATE	NEW RATE
5000/A0120 HF	Transportation	$9.36	$9.62
5010/101 HF	Res BB& P - Adult	$36.40	$37.42
5020/101 HF HA	Res BB& P - Adol	$36.40	$37.42
5199/H0016	Detox - Physician Retain	$3,120.00	$3,207.36
5200/H0011	Detox - Residential	$134.16	$137.92
5210/H2036	Adult Crisis Residential	$70.72	$72.70
5220/H2036 HA	Adolescent Crisis Residential	$85.28	$87.67
5310/H2034	Residential Rehab - Reg	$46.80	$48.11
5330/H2034 HD	Residential Rehab - Pregnant	$46.80	$48.11
5340/H0047 HH	Dual Diag Residential Treat	$57.20	$58.80
5410/H0015	Adult IOP	$15.34	$15.77
5420/H0015 HA	Adolescent IOP	$18.72	$19.24
5430/90804 HF	Adult - Individual	$46.80	$48.11
5440/90804 HF HA	Adolescent - Individual	$46.80	$48.11
5470/90846 HF	Adult IOP- Family	$15.34	$15.77
5480/90846 HF HA	Adolescent - Family	$18.72	$19.24
5500/H0013	Detox - Outpatient	$436.80	$449.03
5510/90801 HF	Assessment - Adult	$109.20	$112.26
5520/90801 HF HA	Assessment - Adolescent	$109.20	$112.26
5530/96100 HF	Testing - Adult	$83.20	$85.53
5540/96100 HF HA	Testing - Adolescent	$83.20	$85.53
5680/H0033	Methadone Treatment	$11.00	$11.31
5710/H0006	Adult IOP - Case Mgt	$3.12	$3.21
5720/H0006 HA	Adolescent IOP - Case Mgt	$3.12	$3.21
5810/T1007	Assessment Update - Adult	$26.00	$26.73
5820/T1007 HA	Assessment Update - Adol	$26.00	$26.73
5900/H2011 HF	In-Home Intervention	$83.20	$85.53
5910/H0015 HQ	Didatic Group - Adult	$15.34	$15.77
5920/H0015 HA HQ	Didatic Group - Adol	$18.72	$19.24
5930/H0047 U6 HQ	HIV - Group Counseling	$20.80	$21.38
5940/H0047 U6	HIV - Family Counseling	$20.80	$21.38
5950/H0047 U6 HR	HIV - Individual Counseling	$72.80	$74.84
5960/H0006 U6	HIV - Case Mgt	$3.12	$3.21
5970/86689 U6	HIV - Orasure Test	$59.02	$60.67
5980/99205 U6	HIV - Medical Assessment	$104.00	$106.91
5990/H2036 HD	Pregnant Treatment	$85.90	$88.31
5991/H0047 HF HH	Co-occuring Residential	$85.90	$88.31
6000/T1009	Ancillary Services	$52.00	$53.46
6160/H0027	Prevention - Education	$31.20	$32.07
6161/H0027	Prevention - Education	$62.40	$64.15
6162/H0027	Prevention - Education	$83.20	$85.53
6170/H0029	Prevention - Alternatives	$31.20	$32.07
6171/H0029	Prevention - Alternatives	$62.40	$64.15
6172/H0029	Prevention - Alternatives	$83.20	$85.53
H0025	ENVIRONMENTAL		

PAYER CODE

DMH - DMH/MR
MCD - Medicaid
P - PPO
OTH - Other
TXP - Medicaid (MCD) Transportation
CHP - Children's Health

FUND SOURCE

000 -General (DMH)
601 -Special Women's Program
602 -Transitional Rehab
603 -Drug Court
604 -Indigent Drug Offender
605 -TANF Women
606 -Adolescent Juvenile Justice (TAB)
608 - Women's FAS
607 -MI/SA Dual Diagnosis
800 -MCD Transportation
900 -Individual
699 -Co-ocurring

PAYER CODE/FUND SOURCE EDITS

if PAYER CODE= then FUND SOURCE

DMH	CANNOT = 800 OR 900
MCD	CANNOT = 602
P	MUST = 900
OTH	MUST = 900
TXP	MUST = 800
CHP	MUST = 000

Goal #5
Attachment # 1

Standard	Measurement Criteria	YES	NO	N/A

1000 Introduction

These regulations establish reasonable certification rules for community programs which provide mental health services, mental retardation services, and substance abuse services.

1001 Statutory Authority

The Alabama Department of Mental Health and Mental Retardation (DMH/MR) was created by Alabama Acts 1965, Act 881, as codified in the Code of Alabama, 1975, Sections 22-50-1 through 22-50-90. Pursuant to these provisions, the DMH/MR has the authority to establish standards for all operations and activities of the State related to the provision of services to persons with mental illness, mental retardation, and/or substance abuse. Code of Alabama, 1975 defines mental health services as diagnosis of, prevention of, and research into the causes of all forms of mental or emotional illness, including, but not limited to, alcoholism, drug addiction, epilepsy or mental retardation. It is under this statutory authority that the Department of Mental Health and Mental Retardation requires compliance with these standards through these certification regulations by entities that hold themselves out as providers of services to persons with mental illness, mental retardation, and/or substance abuse in the State of Alabama.

1100 Compliance

I. No person, partnership, corporation or association of persons shall operate a facility or institution for the care or treatment of any kind of mental emotional illness or services to the mentally retarded or substance abuse services without first being certified for the physical facility by the Department of Mental Health and Mental Retardation or being licensed by the State Board of Health.

II. All programs after the effective date of the minimum standards contained herein shall comply with said standards. The Commissioner of the Department of Mental Health and Mental Retardation, and those persons designated by him/her, will monitor compliance with these minimum physical facility and programmatic standards.

1101 Applicability

I. The following entities which provide services to persons with mental illness, mental retardation, or substance abuse may be considered exempt from the certification requirements by the DMH/MR:

- **A.** General or psychiatric hospitals licensed as such by the Alabama Board of Health, unless the hospital requests to be a designated Mental Health Facility as certified by DMH/MR.
- **B.** Federal or state agencies.
- **C.** Public or private educational institutions.
- **D.** Qualified member of professions in their own private practice (such as licensed physicians, psychologists, psychiatrists, social workers, or Christian Science practitioners) as contemplated by the Code of Alabama, 1975, Section 22-50-17.

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Standard	Measurement Criteria	YES	NO	N/A

E. Voluntary self-help groups.

F. Groups, organizations or persons that provide only incidental or shelter-type services, but do not hold themselves out as providing treatment or services to persons who have mental illness, mental retardation, or substance abuse services needs.

G. Religious groups that operate non-treatment services solely for members of their church/organization, and do not hold themselves out as providing treatment services to persons who have mental illness, mental retardation, or substance abuse services needs.

H. Private homes or services that do not hold themselves out as providing services to persons with mental illness, mental retardation, or substance abuse.

I. Family member services, i.e. services provided by family members of the family related by blood or by marriage for which no remuneration is received.

J. A "private residence" that meets both of the following criteria:

1. The home/apartment was chosen by the individual who owns it or resides there (it was not chosen by DMH/MR staff, or a certified or contracted entity); and
2. There are no monies flowing through DMH/MR that go towards the rent/lease/purchase of the residence.

K. An entity that is funded and monitored under the Individuals with Disabilities Education Act (IDEA), Part C, Early Intervention Program.

L. A provider certified as an ICF/MR by the State Department of Public Health.

II. DMH/MR in its sole discretion may choose to accept wholly or partially a certificate/license/accreditation issued by any other state or national regulatory or other body for services and providers that would otherwise be reviewed through the DMH/MR certification process.

1200 Definitions of Types of Certifications/Certificates

I. Agency-specific.

A. Community Mental Health Center (CMHC) - The entity providing mental health services in a coordinated manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents with severe emotional disturbances. CMHC's will be certified by DMH/MR as defined in the Alabama Administrative Code §580-2-13.01. The entity must provide the following services directly through its employees:

1. Emergency services.
2. Outpatient services.
3. Consultation and education services.
4. Partial hospitalization/intensive day treatment/rehabilitative day services in order to be certified as a CMHC. The entity must also provide residential services either directly or through agreement with another certified provider.

Standard	Measurement Criteria	YES	NO	N/A

B. Mental Health services provider- An entity can be certified as a Mental Health Services Provider if it elects to provide one or more of the services required for Community Mental Health Center certification. The Mental Health Services Provider may seek certification for any (but not all) of the following services:

1. Emergency services.
2. Outpatient services.
3. Consultation and education.
4. Partial hospitalization/intensive day treatment/rehabilitative day services or;
5. Residential services.

C. 310 Boards - Code of Alabama, 1967, Act Number 310, as codified in Code of Alabama, 1975, Sections 22-51-1 through 14, provides for the formation of public corporations to contract with the DMH/MR in constructing facilities and operating programs for mental health services. Such entities are commonly referred to, and are referred to herein, as "310 Boards." 310 Boards will be certified by the DMH/MR as defined in the Alabama Administrative Code, Section 580-1-2-.02 and Section 580-1-2-.06.

II. Location-specific.

A. Community Residential Facility - A community-based living facility providing services to individuals with mental retardation, mental illness, or substance abuse in accordance with their assessed/identified needs.

1. Mental Illness Residential - A residential setting providing congregate living and dining to consumers. Residential services offered vary by type of program but all residential services must provide assistance with applying for benefits, social and communication skills, medication management, basic living skills, vocational skills, community orientation, recreational activities, transportation, education, and family support. Specific types of residential programs are defined in the Alabama Administrative Code, Section 580-2-13.

2. Mental Retardation Residential - A community-based living facility providing services to individuals with mental retardation in accordance with their assessed/identified needs, and the client's/guardian's choice of services and supports, and may address health, social, community living, personal, behavioral, basic living, work, and leisure skills, and other services/supports as needed and/or as desired by the individual to gain as much independence and self-direction as possible.

3. Substance Abuse Residential

a. Residential Detoxification - An acute care residential service that provides medical intervention intended to rid the client of the presence of alcohol or drugs in his/her system, to promote recovery from the toxic effects of the drugs or alcohol, and to restore psychological, physiological, and behavioral function. The service is intended for clients who are suffering from severe or prolonged alcohol or drug intoxication, have symptoms of withdrawal, and who require the control afforded by a treatment service providing twenty-four (24) hour monitoring by medical staff.

b. Crisis Residential Adult - A highly structured, short-term, intensive chemical dependency treatment services and intensive therapeutic activities, conducted in a twenty-four (24) hour supervised living arrangement operated by the facility staffed with awake employees around the clock, which is designed to initiate and promote the client's chemical free lifestyle.

Standard **Measurement Criteria** **YES NO N/A**

c. Crisis Residential Adolescent - A highly structured, short-term, intensive chemical dependency treatment service, and intensive therapeutic activities, conducted in a twenty- four (24) hour supervised living arrangement operated by the facility using awake staff, around the clock, which is designed to initiate and promote the client's chemical free lifestyle. An adolescent is a minor child, age twelve (12) through eighteen (18) years, whose disabilities of minority have not been removed by judicial decree or by marriage. Programs specifically for adolescents must be designed to meet the special needs of adolescents, including academics.

d. Residential Rehabilitation - A residential service that provides chemical dependency supportive services and therapeutic activities conducted in a residential setting designed to provide the environment conducive to recovery and to promote reintegration into the mainstream of society.

e. Residential Treatment for Pregnant and Postpartum Women - A residential service for pregnant women and their children that provides around the clock awake staff, continuously available onsite emergency medical assistance, a structured, and supervised peer group living arrangement emphasizing abstinence from alcohol/drugs, support group meetings, social, and vocational rehabilitation. It is a twenty-four (24) hour a day, seven (7) day per week, full time living arrangement, which offers childcare, linkages with education opportunities, job placement, and referral.

4. The following Community Residential Facilities occupied by four (4) or more consumers shall be classified as "new or existing Residential Board and Care Occupancies (NFPA).

a. Therapeutic group home.

b. Group foster home.

c. Partial hospitalization facility.

d. Residential substance abuse rehabilitation facility.

e. Crisis residential substance abuse facility.

5. The following Community Residential Facilities occupied by three (3) or less consumers shall be classified new or existing one and two (2) family dwellings (NFPA).

a. Foster Care Home (MI).

b. Semi-Independent Living Facility (MR).

6. The following Community Residential Facilities occupied by three (3) or less, shall be classified new or existing apartments

a. Semi-independent Living Apartment (MI-MR).

b. Independent Living Apartment (MI-MR).

Standard	Measurement Criteria	YES	NO	N/A

III. Day services.

A. Mental Illness Day Treatment.

1. Partial Hospitalization Program - An intensive, structured, active, clinical treatment program with the goal of acute symptom remission, hospital avoidance, and/or reduction of inpatient length of stay.
2. Adult Intensive Day Treatment — An identifiable and distinct program that provides highly structured services designed to bridge acute treatment and increased level of functioning and enhanced community integration.

3. Rehabilitative Day Program — An identifiable and distinct program that provides long-term recovery, achievement of personal life goals, recovery of self worth, illness management, and help to consumers to allow them to become productive participants in family and community life.

4. Child and Adolescent Day Treatment — A combination of goal oriented treatment services provided according to a multiple hour schedule over a week's time for clients under the age of 18. Key service functions will include initial screening, development of an individualized plan; individual group, and family psychiatric interventions; education for client's parents/guardians regarding emotional/cognitive development and needs, personal care skills, and services to enhance, family, social, community, and leisure skills.

B. Mental Retardation Day Habilitation Services - Services that focus on providing assistance with acquisition, retention, or improvement in self-help, socialization, work, and adaptive skills, occurring in a non-residential setting, separate from the home or facility in which the individual normally resides. Day habilitation services are based on identified needs and desires of the client, and may also serve to reinforce skills or lessons taught at school, in therapy, at home, or other setting.

IV. Outpatient/Case Management/Other Hourly Services.

A. Mental Illness.

1. General Outpatient — A program that includes a variety of treatment modalities and techniques and admission criteria inclusive of all ages, persons with serious mental illness/severe emotional disturbance, and persons discharged from inpatient psychiatric treatment. Services are planned and designed to assess and meet individual needs.

2. Emergency Services — The program must provide a twenty-four (24)-hour per seven (7) day week capability to respond to an emergency need for mental health services for enrolled consumers. Such capability shall include a telephone response by a clinician or a trained volunteer, face-to-face response by a clinician, and adequate provision for handling special and difficult cases.

3. Case Management — A client, focused strategy for engaging seriously mentally ill (SMI) adults and severely emotionally disturbed (SED) children/adolescents in necessary community support systems and services in order to improve their chances for recovery and successful community living. Key services include client specific assessment of need, development of a client coordinated written plan, assisting client through crisis situation, and/or arranging for the provision of assistance, services and ongoing reevaluation of needs and progress towards goals.

Standard	Measurement Criteria	YES	NO	N/A

B. Mental Retardation - Case Management services which will assist individuals in gaining access to needed services and supports, to include funding for services, as well as needed medical, social, educational and other services and supports, to include crisis and advocacy services; ongoing monitoring of the provision of services included in the individual's plan of care; assessment/re-assessment of level of care and review of plans of care.

C. Substance Abuse.

1. Opioid Treatment - Opioid treatment is the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services to an individual to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. Admission to maintenance treatment will be made by qualified personnel using accepted medical criteria such as the Diagnostic and Statistical Manual for Mental Disorders (DMS-IV), to determine that the person is currently addicted to an opioid drug, and that the person became addicted at least one year before admission to treatment. This service may also include short-term detoxification (less than thirty (30) days) or long-term detoxification (more than thirty (30) days, less than one hundred eighty (180) days).

2. Intensive Adult/Adolescent - Chemical dependency treatment services and intensive therapeutic activities provided to adult/adolescents which are designed to initiate and promote a client's chemical free lifestyle in a non-residential setting. At a minimum this service has to be offered 2.5 hours a day, three days a week.

3. Intensive Specialized Women's Programs - Chemical dependency treatment services and intensive therapeutic activities provided to pregnant women and women with dependent children which is designed to initiate and promote a client's chemical free lifestyle. The programs must provide a standard psychosocial assessment, gender-specific substance abuse education, gender specific substance abuse therapy; group, family, and individual counseling; supportive counseling/education and detoxification if needed.

4. Prevention Program - Strategies developed to limit substance experimentation/use from beginning, or the identification and education in the earliest stages of alcohol, tobacco, or other drug use/abuse to preclude the onset of detrimental effect.

5. Case Management - A service designed to assist individuals in accessing a broader array of services: physical and mental health,

educational, vocational, financial, and legal, etc. Case Management includes needs assessment, case planning, crisis intervention, transportation, linkage to other resources, and advocacy.

6. Detoxification - A safe and effective medical management process provided in a non-residential setting for the purpose of withdrawing an individual from an addictive substance; the process is designed to result in normal physiological functioning.

7. Individual Counseling - A one-on-one interaction between an individual client and a counselor or therapist designed to assist in identifying and addressing those issues and problems specific to that person which prevent the initiation and maintenance of a lifestyle free of chemicals of abuse.

8. In-Home Intervention (pregnant women and women with dependent children)-Time limited, home based services provided by a treatment team (two-person team, one master's level substance abuse professional and one person with a bachelor's level degree) to alleviate an immediate crisis situation, stabilize the family unit, and prevent out-of-home placement of the client.

9. Ancillary Services (specialized women's programs only)-These services include parenting, case management, childcare, and transportation (if needed).

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Standard **Measurement Criteria** **YES NO N/A**

10. Family Counseling-A structured interaction of the client and/or his/her family member(s) with a counselor or therapist designed to assist the family in identifying and addressing those issues and problems that prevent the initiation and maintenance of a lifestyle free of chemicals.

11. Diagnostic Testing - Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and staff member and interpretation of the test results.

12. HIV counseling (individual, group, family, case management) - A structured interaction between substance abuse treatment clients and a qualified SA counselor or HIV specially trained therapist designed to assist clients in preparing for HIV testing, dealing with test results, and/or modifying risky behavior designed to reduce the transmission of HIV.

D. The following outpatient services facilities shall be classified as "New or existing Business occupancies (NFPA).

1. Mental Health Services Provider.
2. Community Mental Health Center.
3. Community Mental Health Center Satellite Facilities.

E. The following Day Services Facilities shall be classified as "New or existing Educational occupancies (NFPA).

1. Intensive Day Treatment (MI).
2. Rehabilitation Day Treatment (MI).
3. Child and Adolescent Day Treatment (MI).
4. Day Habilitation Services (MIR).
5. Day Training Facilities (M
6. Work Activity Center (MR).
7. Outpatient Services (SA).
8. Intensive Outpatient Services (SA).
9. Specialized Women's (SA).
10. Methadone Clinic/Opiate Replacement (SA).

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Standard	Measurement Criteria	YES	NO	N/A

1300 Period of Certification

I. The provider is notified by the Commissioner of the status of certification.

II. Certificates may be issued for a period of up to two (2) years. If a program does not sufficiently meet all DMH/MR certification standards, it may be granted a provisional certification not to exceed sixty (60) days.

III. If the agency holds a provisional certification following a survey, there will be an automatic one (1) year restriction on the period for certification. In accordance with 580-3-23-.07 (4) hereunder, this period begins retroactively on the date of the expiration of the last certification that was not a provisional certification.

IV. If an agency is decertified under any division standards; the period of certification by the DMH/MR is automatically limited to one (1) year for all DMH/MR Divisions' certifications, and the certification will be retroactive to the expiration date of the last expiration date of the last certification that was not a provisional certification.

V. When DMH/MR issues a certificate, the certificate will be retroactive to the expiration date of the last certification and will be for the shortest period specified by any one division's review.

VI. A separate certificate is issued for each site, program, or service operated or provided by an entity.

VII. The certificate will reflect compliance with administrative standards, programmatic standards, and with Life Safety Code requirements as applicable.

VIII. The certificate must be maintained at the site of the service. If there is no physical plant for a specific service, the certificate will be maintained in the agency's main office.

IX. When a program is decertified, or the operation of a site or services ceases to exist or services are not provided for more than thirty (30) days, any current certificate must be returned to the DMH/MR Facilities Certification Office and, unless waived by the Commissioner of DMH/MR. The procedure for initial certification of the program or service must once again be completed before the program can resume the services.

1400 Application Process

I. A completed application for certification is sent by the provider/applicant to DMH/MR Facilities Certification Office sixty (60) days prior to projected date of service implementation. Any additional documentation must be submitted as required and specified by DMH/MR. For Methadone Clinic applications, an entity must also submit a Certificate of Need as approved by the Alabama State Health Planning and Development Agency.

II. DMH/MR may accept a certification/license/accreditation issued by other generally accepted recognized state or national organizations in lieu of an additional review through the DMH/MR certification process. However, DMH/MR reserves the right to apply DMH/MR certification standards to areas it determines are not adequately addressed in other state or national standards. Further, the DMH/MR reserves the right to conduct reviews, including onsite visits if appropriate, of programs that are certified/licensed/accredited by other entities where there is evidence of significant deficiencies.

III. The DMH/MR Facilities Certification Office submits the application to the respective DMH/MR Division(s) for approval according to the type(s) of services proposed by the provider.

Standard **Measurement Criteria** **YES NO N/A**

IV. Applications for MI Adult Foster Care are forwarded by the Facilities Certification Office to the respective Community Mental Health Center that contract with the provider. The CMHC approves the application and forwards it to the DMH/MR Facilities Certification Office. The DMH/MR Facilities Certification Office submits the application to the MI Division.

V. The applicable DMH/MR Division(s) review/approve the application and returns a copy of the approval to the DMH/MR Facilities Certification Office. An initial Life-Safety and Programmatic review is conducted, if applicable, by designated DMH/MR representatives. Applications remain valid for up to six (6) months after receipt by DMH/MR if the service has not been initiated by the provider or approved by DMH/MR.

VI. For new applicants/providers, the DMH/MR will conduct criminal background checks on the primary operator and/or subcontractor of the program.

VII. Once the provider completes the application process, and based upon its representations of compliance with applicable DMH/MR standards, the program is issued a letter of Temporary Operating Authority by the DMH/MR Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.

1401 New Services

I. When a certified entity develops new programs or services covered by DMH/MR standards, DMH/MR must be informed of the plan in writing and adequate documentation as specified by DMH/MR must be submitted to permit a determination that the plans are compliant with Life Safety/and/or programmatic standards established for that service/program.

II. Once necessary documents and information are received, a Life Safety and/or programmatic review is conducted as needed.

1500 Site Visits

I. A review of administrative requirements as set out in the Alabama Administrative Code, Sections 580-2-13, 580-1-2, and 580-5-30, shall be separate from program site visits.

II. A site visit is conducted prior to the expiration of the Letter of Temporary Operating Authority. The Provider may be required to submit additional documents prior to the certification site visit. If a program fails to demonstrate substantial compliance with minimum Department standards during this site visit, the Commissioner, in his/her sole discretion, may:

a) immediately withdraw the program's Temporary Operating Authority, taking into consideration the need for alternative placement of persons then being served by the program; or

b) extend the Temporary Operating Authority to allow the program time to achieve substantial compliance; or

c) place the program in provisional certification status.

III. The initial program site visit and/or administrative review will be scheduled with the agency. All subsequent program site visits will occur in accordance with the period of temporary operating authority or certification renewal date and may be unannounced. All subsequent administrative reviews will be conducted in accordance with the period of temporary operating authority or certification renewal date and with DMH/MR policies.

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Standard **Measurement Criteria** **YES NO N/A**

IV. At the end of each day of the site visit, a debriefing will be held with the agency's executive director or his designee and the surveyor to review any problems that may have been found that day.

V. At the conclusion of the program site visit, preliminary findings are given orally to the Agency Director and any selected staff, board members, and representatives of consumers and families available for the exit interview.

VI. An exit interview will be conducted upon the completion of the respective Division's/Office's certification site visit. An entity should have the opportunity to clarify or present evidence of compliance on issues being cited by the certification site visit team. At the exit meeting, the entity should provide documentation/information related to specific citations or the entity will be afforded the opportunity to provide documentation to demonstrate compliance to the respective division within one (1) working day of the exit meeting.

1501 Unannounced Visits

I. DMH/MR or its agents has the authority to periodically monitor entities' continuing compliance with standards, or contract requirements, as applicable, to conduct reviews and investigations at any time or to investigate a complaint or when other information is received regarding consumer rights, services, and/or program operations.

II. If there are findings of non-compliance, the procedures specified in 1601 through 1700 will be followed.

1600 Site Visit Reports

I. Within thirty (30) days of the site visit, the Certification Site Visit Report will be sent to the Agency's Director via certified mail. As applicable, a copy of the report will be sent to the agency's Board of Directors and, as applicable, a copy will be sent to the Executive Director of an agency holding the contract with DMH/MR (if the agency certified is a sub-contracting agency).

II. The Certification Site Visit Report lists each standard not met and specific findings, which constitute the basis for noncompliance, and may also, include recommendations for standards that need quality improvement. The report will specify timeframes for mandatory compliance with specific standards. Consistent failure to meet Department standards, as defined in this regulation (580-3-23-.16), may result in provider decertification without further certification site visits being conducted.

III. If a certification site visit determines that a provider is not in substantial compliance with a DMH/MR division's standards, the provider's Executive Director, and as applicable, the Board of Directors, the executive director of the provider's parent agency, and any other appropriate parties, will be notified by letter sent via certified mail that the provider is being placed in provisional certification status for a period of up to sixty (60) days.

Standard	Measurement Criteria	YES	NO	N/A

1601 Entity's Plan of Action

I. If the provider receives a provisional or a one-year certificate, or if it has its temporary operating authority extended pursuant to 580-3-23-.10 (2) (b), the provider is required to submit to the respective/applicable Division/Office a Plan of Action for issues cited, within thirty (30) days after the date of receipt of the Site Visit Report. The plan must project compliance within thirty (30) days for each deficit cited for Life-Safety issues identified by the survey team, and must project compliance with specified divisional standards within sixty (60) days after the completion of the site visit. A shorter timeframe may be required if findings indicate a risk to the health/safety of persons served and/or for non-compliance with specified standards.

II. In those cases in which the provider receives a provisional certification and has been found to have consistently failed to meet standards as defined herein (580-3-23-.16), or in those cases in which temporary operating authority is being revoked pursuant to 580-3-23-.10 (2) (a), the provider is required to submit to the respective Division/Office a Plan of Action that assures the health/safety of persons served during the pendency of any decertification/revocation action initiated against the provider.

1602 DMH/MR Response to Plan of Action

I. Actions taken by the respective DMH/MR Division/Office when the agency's Plan of Action is received may include one or more of the following:

A. Approve and recommend certification.

B. Request additional documentation or a supplemental plan of action.

C. Provide technical assistance in deficient area(s) if requested in writing to Service Division.

D. Conduct follow-up site visit prior to the end of the ninety (90) day period (following the site visit which discovered the deficiencies in question), or other period specified for compliance by DMH/MR.

II. Except in those cases in which the agency is found to have consistently failed to meet standards, if the agency does not comply with specified standards, a follow-up certification site visit must be conducted, or a recommendation for decertification of the agency must be made by the certification site visit team to its respective division.

III. If the agency is found to have consistently failed to meet standards, as defined herein (580-3-23-.16), a follow-up certification site visit may be conducted, or a recommendation for decertification of the agency may be made by the certification site visit team to its respective division.

1700 Appeal Procedures Within DMH/MR

I. A recommendation by any DMH/MIR Division for decertification may be appealed with fifteen (15) working days of the entity receiving the report/recommendation. The appeal by the entity must specify the precise reason(s) for the appeal and provide documentation to support modification of the site visit findings/recommendation for decertification.

II. Any final decision to order decertification of a program will be made by the DMH/MR Commissioner after the affected provider is afforded the opportunity for an administrative hearing on the matter. Such hearings will be conducted in accordance with the Alabama Administrative Procedures Act.

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Standard	Measurement Criteria	YES	NO	N/A

1800 Decertification

I. If the entity does not comply with required certification criteria within a specified timeframe, or if it is found to have consistently failed to meet standards, a recommendation for decertification is made to the DMH/MR Commissioner by the respective DMH/MR Division/Office. A copy of this recommendation is sent, via certified mail, to the Executive Director of the agency, and to its Board of Directors, and, as applicable, to the executive director of an agency holding the contract with DMH/MR. The term "consistently fails to meet standards" includes, but is not limited to, the receipt of provisional certification status by a program at least twice within one 12-month period.

II. If the Commissioner notifies an entity of the intent to decertify their program it may appeal the decision for decertification, or it may request a delay for up to sixty (60) days in the Commissioner's final decision due to extenuating circumstances which must be specified, in order to fully comply with applicable standards. It remains solely within the discretion of the DMH/MR Commissioner to approve such a delay, based upon the type(s) and/or numbers of deficits or standards not met. If approved, the Commissioner will notify the provider of the period of time within which the entity must comply with standards.

III. If the entity does not appeal the decision for decertification, or does not request a delay to comply with standards, the entity will be decertified on the date specified by the DMH/MR Commissioner.

IV. After notice and an opportunity to respond, the DMH/MR Commissioner may rescind or revoke any certification for any material neglect of, disregard of, or noncompliance with these standards and/or violation of federal, state or local law. The DMH/MIR Commissioner, may immediately, without notice suspend or revoke any Department Certificate under these standards if the Commissioner finds that a provider's deficiencies with a standard (or standards) poses a serious threat to the safety and welfare of any consumer served as determined by the Commissioner.

V. If the entity has complied with standards within the timeframe specified in the Certification Site Visit Report, or as specified by the Commissioner after having granted a delay to come into compliance, a recommendation is made by the respective Division(s) to the DMH/MR Commissioner to certify/re-certify the entity for a period of one year from the date of the expiration of the entity's previous certification.

VI. Failure to comply with one Division's/Office's standards will result in a recommendation for decertification of the entity for the provision of those services only. An entity may continue and be certified to provide services of another division(s) as long as the entity complies with those certification standards.

1900 Renewal of Certification

I. Site visits for the purpose of certification are scheduled and conducted within a sixty (60) day period prior to the expiration of the entity's current certification.

II. Updated information regarding services may be requested from an entity by an DMH/MR Division at any time.

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Standard		Measurement Criteria	YES	NO	N/A
2000	**Governing Body**				
2001	Each entity shall have written board approved operational policies.	The program has written board approved operational policies.	___	___	___
2002	Each entity shall have articles of incorporation (or charter) and bylaws.	The program has articles of incorporation and by-laws.	___	___	___
2003	Each entity shall have a current organization chart.	The program has a current organizational chart.	___	___	___
2004	Each entity shall have a written mission statement that is approved by the Board of Directors.	The Program has a mission statement approved by the Board of Directors.	___	___	___
2005	Each entity shall have in written form the responsibilities of the Board of Directors.	The program has written responsibilities of the Board of Directors.	___	___	___
2006	Records/minutes of Board meetings shall be maintained and available for review.	The program has records/minutes of Board meeting.	___	___	___
2007	Each employee shall have a personnel record which shall, at a minimum, include: a. A copy of the employee's valid drivers' license if the employee's job function entails or could entail the transportation of clients. b. Evidence of the employee's current tuberculosis skin test to include, at a minimum, those employees who have direct contract with consumers. c. Documentation of the employee's background check (hired after 3/11/05). d. A complete job application and/or resume. e. The required qualifications and credentials as identified in the respective DMH/MR program standards for the position.	Employee personnel records include the following: a. A copy of the employee's valid drivers' license if the employee's job function entails or could entail the transportation of clients. b. Evidence of the employee's current tuberculosis skin test to include, at a minimum, those employees who have direct contract with consumers. c. Documentation of the employee's background check (hired after 3/11/05). d. A complete job application and/or resume. e. The required qualifications and credentials as identified in the respective DMH/MR program standards for the posit	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___

Standard		Measurement Criteria	YES	NO	N/A
2008	As required by the Social Security Act and the Fair Labor Standards Act, the entity shall maintain a U.S. Department of Labor certification for all employees paid less than the current minimum wage.	The program has the required certification.	___	___	___
2009	Records of training for all employees shall be available for review.	Training records were available for review.	___	___	___
2010	Each entity shall have a written performance improvement/quality enhancement plan.	The program has a written performance improvement /quality enhancement plan.	___	___	___
2011	Each entity shall have a written plan that addresses the process of prevention and management of incidents.	The program has a written plan addressing the process of prevention and management of incidents.	___	___	___
2012	Each entity shall have a written plan/policy regarding the management of client's personal funds which require, at a minimum, the following. a. Clients shall manage their person funds accounts unless there is a payee, guardian or similar appointee who manages the account for them. b. The entity that manages a client's funds shall have on record the appropriate written consent to mange that client's personal funds. c. Clients/guardians shall be informed of the process whereby the client may access his/her personal funds. d. Each entity shall maintain documentation of all expenditures made from the client's personal fund account. Such expenditures shall be for the exclusive use and/or benefit of the client. e. Funds in excess of what are needed to maintain the client's personal fund account will be placed into an inter bearing saving account, with interest income accrued to the client's account. f. At least quarterly, an accounting of the client's personal fund account activity and saving account activity, if applicable, will be made to the client/guardian.	Each entity shall have a written plan/policy regarding the management of client's personal funds which require, at a minimum, the following. a. Clients shall manage their person funds accounts unless there is a payee, guardian or similar appointee who manages the account for them. b. The entity that manages a client's funds shall have on record the appropriate written consent to mange that client's personal funds. c. Clients/guardians shall be informed of the process whereby the client may access his/her personal funds. d. Each entity shall maintain documentation of all expenditures made from the client's personal fund account. Such expenditures shall be for the exclusive use and/or benefit of the client.			

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Standard	Measurement Criteria	YES	NO	N/A
	e. Funds in excess of what are needed to maintain the client's personal fund account will be placed into an interest bearing saving account, with interest income accrued to the client's account.	___	___	___
	f. At least quarterly, an accounting of the client's personal fund account activity and saving account activity, if applicable, will be made to the client/guardian.			
2100	**Organization**			
2101	The provider must be a public or private corporation.	The entity is a public or private corporation.		
[redacted] OUT	The organization must provide written documentation to SASD of its source of authority through its articles of incorporation (or charter) and bylaws.	The organization's source of authority is on file or available to SASD.	___	___ ___
2102	The Board of Directors of the corporation, as its governing body, has responsibility and authority for the overall conduct of operations including the treatment and/or prevention programs provided by the organization.	The Board of Directors exercises its responsibility and authority over treatment and/or prevention programs, in compliance with Alabama law.	___	___ ___
2103	A copy of the minutes from the scheduled Board of Directors meetings must be made available to the Substance Abuse Certification Review Team upon request.	The Board of Directors meetings minutes were available.	___	___ ___
2104	The latest financial audit shall be on record with the DMH/MR, Substance Abuse Division, if the State of Alabama contracts' with an agency or organization to provide treatment or prevention services.	The latest financial audit is on file.		

Standard		Measurement Criteria	YES	NO	N/A
3000	**PERSONNEL MANAGEMENT**				
3100	**General Staff**				
3101	The chief executive officer/agency director of a treatment provider organization shall be a full-time employee possessing a master's degree in an administrative or mental health related field with at least five years of progressive managerial experience of which three years were in a treatment setting.	The chief executive officer meets the required criteria.	___	___	___
3102	The chief executive officer/agency director of a program offering residential rehabilitation service only, and not operated as an organization unit of a larger service provider organization, shall be a qualified substance abuse professional, as defined in Standard 3202e or 3101 above.	The director meets the required qualification.	___	___	___
3103	The financial accounting operations of a service provider organization with a total annual budget exceeding $500,000 shall be supervised by a full time employee or contracted service provider who has the following qualifications:	The financial accounting manager meets the required qualification:	___	___	___
	a. At least a bachelor's degree in accounting or business, finance, management, public administration, with accounting courses;	a. Bachelor's degree.	___	___	___
	b. At least two years accounting experience.	b. Two years experience.	___	___	___
3104	The financial accounting operations of a service provider organization with a total annual budget less than $500,000 shall be supervised by an employee or contracted service who/which has the following qualifications:	Supervision of programs with a total annual budget less than $500,000 meets the required qualifications:	___	___	___
	a. Demonstrated familiarization with Generally Accepted Accounting Principles and;	a. Is familiar with Generally Accepted Accounting Principles.	___	___	___
	b. At least two (2) years accounting/bookkeeping experience.	b. Has 2 years experience.	___	___	___
3105	All medical aspects of client care shall be vested in a physician licensed to practice in Alabama.	The physician's job description or contract includes responsibility for all medical aspects of client care.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
3106	There shall be a full-time employee (in addition to the Executive Director) designated as responsible for the quality of clinical care and the appropriateness of clinical programs who shall have as a minimum either a master's degree in psychology, social work, counseling, or psychiatric nursing with a minimum of three years post master's relevant, clinical experience; or, who shall be a physician who has completed an approved three year residency in psychiatry. Small free-standing agencies that only offer one type of substance abuse service and whose total annual budget is less than $500,000 are not required to have a clinical director on staff but must arrange for clinical supervision from a qualified individual. (Does not apply to Residential Rehabilitation Programs that provide only residential rehabilitation services.)	A clinical director is assigned who meets the required qualifications.	___	___	___
3107	The provider must have an organizational chart depicting functional areas of responsibility and lines of supervision.	The organizational chart includes functional areas of responsibility and lines of supervision.	___	___	___
3108	Each direct treatment service functional area (A direct treatment service functional area is a group of people and resources brought together, under a single manager for a common purpose or objective, i.e. an intensive outpatient program.) of responsibility on the organizational chart shall be coordinated by a master's degree staff member in a mental health related field and two years post master's experience (except as defined in Standard 3102).	Supervision of a direct services functional area is vested in a staff member who meets the required qualifications.	___	___	___
3109	All direct service staff who perform counseling and/or therapy, but do not possess a master's degree in a mental health related discipline and has less than two (2) years experience in the field of substance abuse treatment, shall receive a minimum of 2 hours of face-to-face documented supervision per month, as well as receive 2 hours of ongoing case development documented supervision per month from an individual who holds at least a master's degree in a mental health discipline (psychology, social work, counseling, or psychiatric nursing). The two (2) years of face-to-face supervision will no longer be required once the employee has accrued 2 years of direct treatment experience.	Case development and ongoing supervision is provided by a qualified individual staff member.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
3110	Documentation of all required supervision must include the following information for each supervisory session: 1. Name & signature of supervisor; 2. Name & signature of employee; 3. Date of supervision; 4. Amount of time of supervisory session; and 5. Brief narrative describing the topics covered in the session.	There is written documentation of supervision for each staff member who requires supervision and the documentation contain all of the required elements.	___	___	___
3111	Staff members who hold a degree must have an official copy of their transcript on file with their employer.	Staff member transcript on file.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
3200	**Substance Abuse Staff**				
3201	Clinical assessments of substance abuse clients shall be performed by a person with at least two years of clinical experience and meeting any one or more of the following:	The person conducting assessments has at least two years clinical experience and:	___	___	___
	a. A person licensed as a psychiatrist, physician, psychologist, social worker, or counselor; or	a. Is licensed to practice, or	___	___	___
	b. A person with a master's degree in a clinical area.	b. Has a master's degree in a clinical area.	___	___	___
3202	Treatment planning and counseling of substance abuse clients shall be performed by a person meeting any one or more of the following:	The person conducting treatment planning and counseling meets one of the qualifications:	___	___	___
	a. A person who meets the qualifications stated in Standard 3201 above;	a. The person is licensed per Standard 3201, above;	___	___	___
	b. A person with a master's degree in a clinical area with a clinical practicum;	b. The person meets the required qualification;	___	___	___
	c. A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience or a person with a master's degree in a clinical area that did not require a practicum who receives at least two (2) hours of documented face-to-face clinical supervision monthly;	c. The person meets the required qualification and two hours of supervision is documented monthly;	___	___	___
	d. A person with a bachelor's degree and two (2) years supervised clinical experience: (reference 3109)	d. The person meets the required qualification;	___	___	___
	e. A person certified as a qualified substance abuse professional by an independent Board established for the purpose of providing an experienced based, voluntary credentialing process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.	e. The person is a qualified substance abuse professional.	___	___	___
	f. Services will be provided by practitioners as defined above consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama Law.	f. Services are provided consistent with established practices and Alabama Law.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
3203	Staffs that provide services primarily to specific sub-groups (such as children/adolescents, elderly) shall have specialized training/experience to work with such sub-groups or shall receive supervision by a staff member with specialized training/experience.	The person providing the service has the required specialized training/experience; or is supervised by one who does.	___	___	___
	a. Teachers must be certified.	a. Teachers hold a current Alabama teacher's certificate.	___	___	___
3204	Human Service Needs Assessment and Case Planning shall be performed by a person meeting the following:	The Case Manager supervisor meets the required qualifications:			
	a. A person who has successfully completed a Case Manager Training Program equivalent to that of the DMH/MR, Substance Abuse Division. A written request containing detailed accounts of the content of the training program and qualifications of trainer(s) should be submitted to SASD prior to the training.	a. Completed a DMH/MR approved Case Manager Training Program;	___	___	___
	b. Possesses a valid Alabama Drivers' License	b. Possesses a valid Alabama driver's license.	___	___	___
3205	Case Manager Supervision shall be performed by a person meeting the following:	Case Manager Supervisor meets the required qualifications:			
	a. A person who has a master degree in a mental health or related field and;	a. Master's degree in a mental health related field and	___	___	___
	b. Has completed a DMH/MR approved Case Manager Training Program and has: 1. two years post master's substance abuse clinical experience, or; 2. two years experience as a case manager regardless of whether it occurred at the bachelor or graduate level.	b. Completed a DMH/MR approved Case Manager Training Program, and has: 1. Two years post master's substance abuse clinical experience, or 2. Two years experience as a case manager at the bachelor or graduate level.	___ ___ ___	___ ___ ___	___ ___ ___
	c. Service providers that employ less than three full time equivalent Case Managers are not required to have on staff a Case Manager Supervisor who meets the above standards. The Clinical Director or Program Manager can act as the Case Manager's Supervisor.	c. Employs less than three Case Managers	___	___	___

Standard	Measurement Criteria		YES	NO	N/A
3206	Students who are completing a graduate degree in psychology, counseling, social work, or psychiatric nursing may conduct direct services under the following:				
	1. The student is in a clinical practicum that is part of an officially sanctioned academic curriculum.	1. The student(s) was/is in an officially sanctioned clinical practicum.	____	____	____
	2. The student receives a minimum of one hour per week direct clinical supervision (face-to-face) from a licensed/certified mental health professional having at least two years post master's experience in a direct service functional area.	2. The student received one hour per week of direct supervision from a qualified mental health professional.	____	____	____
	3. Any written clinical documentation generated by the student must be reviewed and signed by a qualified counselor.	3. Student's written documentation is signed by a qualified counselor.	____	____	____

4000 TREATMENT AND REHABILITATION PROGRAM OPERATION

4100 Program Descriptions

Standard		Measurement Criteria	YES	NO	N/A
4101	All service provider organizations will maintain current written program descriptions for each identifiable service program which must include as a minimum: a. Nature, scope and capacity of the program; b. Admission and re-admission criteria; and c. Termination and transfer criteria.	A current program description is on file for each service offered by the agency.	___	___	___
4102	Admission into a treatment or rehabilitation program must be based on: a. A psycho-social assessment conducted by a qualified substance abuse staff member as defined in Standard 3201; or b. A diagnosis substantiated by an adequate diagnostic data base and assigned by a person licensed to practice by the State of Alabama.	a. A psycho-social assessment is conducted by a qualified assessment specialist; b. A diagnosis is substantiated by a licensed individual.	___ ___	___ ___	___ ___
4103	A program must have a description of program rules and regulations which clients are expected to follow.	Program rules and regulations are available at the program for client and staff use.	___	___	___

Standard	Measurement Criteria	YES	NO	N/A
4200 Policies				
4201 The board must approve written operational policies. The following minimum procedures must be established:				
a. A description of each service functional area of responsibility as contained in the organizational chart that includes: 1. Admission/re-admission criteria; 2. Nature and scope of the program; and 3. Termination/transfer criteria and procedures.	a. Board approved descriptions of services are on file at the agency;	____	____	____
b. A description of the appeal policies and procedures for: 1. Persons denied admission/readmission; 2. Persons involuntarily dismissed from a program.	b. Board approved appeal policies and procedures are on file at the agency.	____	____	____
4202 There must be a written policy addressing circumstances under which drug screening of clients by body fluid (blood, urine, or salvia) may be utilized. If it is utilized at any point, the program must:	A written drug screening policy is on file that:			
a. Establish procedures that protect against the falsification and/or contamination of any urine specimen.	a. Protects against falsification or contamination of any urine specimen;	____	____	____
b. Demonstrate that the individual's privacy is protected each time a urine specimen is collected.	b. Provides individual privacy during collection;	____	____	____
c. Require that an observer will supervise urine collection.	c. Requires an observer be present during collection.	____	____	____

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Standard		Measurement Criteria	YES	NO	N/A
4300	**Client Protection**				
4301	There must be written policies and procedures that protect the client's welfare, the manner in which the client is informed of these protections, and the means by which these protections will be enforced.	Policies and procedures that protect the client's welfare are available and enforced.	___	___	___
4302	The written policies and procedures shall, at a minimum, address the following protections: a. To privacy;	Policies and procedures address and are documented in the client record: a. Client's right to privacy; 1. Procedures established for conducting searches of client or his/her living area and /or personal possessions;	___	___	___
	b. To confidentiality of and access to client records including: 1. requirement for the client's written authorization for release of information; 2. emergency authorization release; 3. internal access to client records; 4. external access to client records; and 5. conditions for client access to his/her records.	b. Adequate procedures are in effect that assure the client's right to confidentiality and access to client records;	___	___	___
	c. To complaint/grievance procedures, including appeal proceedings;	c. 1. Program provides every client an orientation and written statement of right, responsibilities, along with procedures to be followed to initiate, review, and resolve allegations of violations; 2. Program obtains written verification of receipt of right and grievance procedures;	___	___	___
	d. To be informed of the financial aspects of treatment;	d. Financial aspect; 1. Program provides every client an orientation and written statement of the financial aspect of treatment: 2. Information is presented to the client in language and terms appropriate to the client;	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
	e. To consent to treatment or to be informed of the need for parental or guardian consent for treatment, if appropriate;	e. Required procedures are in effect and are being followed;	___	___	___
	f. To be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services and types of providers of substance abuse services;	f. The client is informed of any treatment of an unusual or experimental nature;	___	___	___
	g. To give informed consent prior to being involved in research projects;	g. Required procedures are in effect and are being followed;	___	___	___
	h. To manage personal financial affairs, unless legally determined otherwise;	h. Required procedures are in effect and are being followed;	___	___	___
	i. To actively participate in treatment, including discharge planning, if appropriate;	i. Required procedures are in effect and are being followed;	___	___	___
	j. To be protected from harm including abuse, neglect or mistreatment;	j. 1. Procedures established to investigate any suspected abuse and/or neglect; 2. Acts or alleged acts applicable under state and local laws are reported; 3. Staff is provided upon employment a written policy statement and training regarding abuse and neglect;	___	___	___
	k. To receive treatment and care in a safe and humane environment;	k. Required procedures are in effect and are being followed;	___	___	___
	l. To receive the least restrictive treatment appropriate and available.	l. Assignment to the least restrictive available treatment is documented in the psycho-social assessment and treatment plan.	___	___	___
	m. To be informed of the means of accessing a DMH advocacy representative	m. Information regarding DMH advocacy services is displayed;	___	___	___
4303	Whenever special equipment, such as two-way mirrors, cameras, etc., is used, a written consent must be signed by the client.	Written client authorization is received prior to any use of special equipment.	___	___	___
4304	The program must report all cases of suspected abuse, neglect, exploitation of clients being served in the program where the alleged perpetrator is an employee, client, or other person in the program to the SASD Associate Commissioner's office in accordance with DMH/MR abuse reporting procedures.	Suspected cases of abuse, neglect, exploitation of clients are reported as required.	___	___	___
4305	Suspected cases of abuse and neglect will be reported to the local DHR office in accordance with applicable state law.	Suspected cases of abuse, neglect, and exploitation of clients are reported as required.	___	___	___

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Standard		Measurement Criteria	YES	NO	N/A
4400	**Physical Facilities.**				
4401	All grounds, space, equipment, and facilities, both those within the entity and those regularly used by clients as an integral part of their treatment program, must meet at all times applicable federal, state, and local requirements for safety, fire, health, and accessibility.	Physical facilities at all times meet applicable safety, fire, health and accessibility codes.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
5000	**CLIENT RECORDS**				
5100	**Case Files**				
5101	A case file must be established for each client admitted by the entity.	A case file is available for each client.	___	___	___
5102	The entity must maintain a system that provides for the control/location of all case files.	A policy/procedure is available that describes control/location of all case files.	___	___	___
5103	The entity must establish a system to secure client records from unauthorized access.	Client records are secured from unauthorized access.	___	___	___
5104	There shall be a staff member responsible for the storage and protection of client records in each location where records are stored.	Person responsible for storage/protection of records is identified.	___	___	___
5105	All entries and forms completed by the service provider in the client record shall be dated and signed, or appropriately authenticated in an electronic system. Written entries shall be made in ink and be legible.	a. All entries are dated, signed, and appropriately authenticated.	___	___	___
		b. All entries are in ink and legible.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
5200	**Control and Maintenance**				
5201	The client record shall include a Service Record which includes the date, service type, and service provider. The Service Record shall be filled out each time there is a contact with the client/collateral or correspondence and at case consultation and case review.	a. The required service record is included in the client record.	___	___	___
		b. An entry is made in the client record as required.	___	___	___
5202	Written clinical documentation shall be maintained to support each service, activity, or session for which services are rendered and the documentation must be filed in the client's clinical record within ten (10) working days from the delivery of the service, activity, or session. The following are required elements of this documentation:	Each service is supported with the following clinical documentation and filed in the client's clinical record within 10 working days:	___	___	___
	a. Specific type of service being rendered; b. Setting in which the service was rendered; c. Date and amount of time spent on delivering the service; d. Client's involvement in the activity; e. Relationship of the service to the client's treatment or rehabilitation plan.	a. Type of service rendered. b. Setting in which service was rendered. c. Date and time service was delivered. d. Client's involvement in the activity. e. Relationship of service to treatment or rehabilitation plan.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___
5203	Following the completion of the problem assessment and assignment for treatment, the following information, if available, shall be recorded in the client record:	The following information is included in the client record:	___	___	___
	a. **Problem Assessment**: Documentation of the Problem Assessment must include information as appropriate from among the following: 1. Family history; 2. Educational history; 3. Relevant medical background; 4. Employment/vocational history; 5. Psychological/psychiatric history; 6. Military history; 7. Legal history; 8. Alcohol/drug abuse history; 9. Mental status examination;	a. The Problem Assessment includes the following required elements: 1. Family history; 2. Educational history; 3. Relevant medical background; 4. Employment/vocational history; 5. Psychological/psychiatric history; 6. Military history; 7. Legal history; 8. Alcohol/drug abuse history; 9. Mental status examination.	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
	b. **Client identifying data including**: 1. Case number; 2. Client name; 3. Date of birth;	b. Required client identifying data is on file. 1. Case number; 2. Client name; 3. Date of birth;	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___

Standard	Measurement Criteria	YES	NO	N/A
4. Sex; 5. Race/ethnic background; 6. Home address; 7. Home telephone number; 8. Next of kin or person to be contacted in case of emergency; 9. Marital status; 10. Social security number; 11. Referral source; 12. Reason for referral; 13. Date of admission to the program; 14. Admission type (new, or re-admission).	4. Sex; 5. Race/ethnic background; 6. Home address; 7. Home telephone number; 8. Emergency contact; 9. Marital status; 10. Social security number; 11. Referral source; 12. Reason for referral; 13. Date of admission to program; 14. Admission type (new, or re-admission).	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
c. **Assessment**: There must either be: 1. A diagnosis substantiated by an adequate diagnostic data base and, when indicated, a report of medical examination. The diagnosis must be signed by a licensed physician, or a licensed psychologist, or; 2. Psycho-social assessment, conducted by and signed by an individual meeting Standard 3201.	c. An assessment or diagnosis is conducted. 1. A diagnosis is assigned by a licensed physician or psychologist, or; 2. A psycho-social assessment is assigned by an assessment specialist.	___ ___ ___	___ ___ ___	___ ___ ___
d. **Summary of Significant Problems**: A description/summarization of the significant problem(s) that the client is experiencing, including those that are to be treated and those that impact upon treatment.	d. A summary of significant problems, including those that are to be treated and those that impact upon treatment, is available.	___	___	___
e. **Treatment Plans**: Treatment programs must have a written treatment plan for each client that: 1. Are completed within 10 working days after admission; 2. Describe the focus of treatment based on clinical issues identified in the psych-social assessment; 3. Specify services necessary to meet the client needs; 4. Document referrals as appropriate for needed services not provided by the agency; 5. Identify measurable treatment objective toward which the client and therapist will be working to impact on the specific clinical issues.	e. The required treatment plan is completed: 1. Within 10 working days; 2. Clinical issues identified. 3. Specifies services to meet client needs; 4. Appropriate referrals are documented; 5. Measurable treatment objective identified.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___

Standard	Measurement Criteria	YES	NO	N/A
6. Be approved in writing by the program coordinator, clinical director, or medical director;	6. Is approved in writing;	___	___	___
7. The treatment planning process includes the consumer's signature/mark on the treatment plan/treatment plan update to document the consumer's participation in developing the plan/update.	7. Documents the client's participation in treatment planning.	___	___	___
f. **Rehabilitation Plans**: Residential rehabilitation programs must have a written rehabilitation plan that includes independent living issues and expected process/outcomes completed within 10 working days after admission in the residential program. The rehabilitation plan must address the following key elements:	f. The required residential rehabilitation plan is completed within 10 working days after admission and addresses the following key elements:	___	___	___
1. Identify the individual living issues that will be the focus of rehabilitation;	1. Identifies required individual living issues;	___	___	___
2. Specify services necessary to meet the client's needs and addressing the following:	2. Specifies services necessary to meet client needs.	___	___	___
(a) alcohol and illicit drug free resident living;	(a) a alcohol/drug free environment;	___	___	___
(b) supportive counseling;	(b) supportive counseling;	___	___	___
(c) rehabilitation support including linkages to Vocational Rehabilitation, job placement opportunities, educational opportunities, social rehabilitation opportunities, and motivational counseling.	(c) required support, including linkages to appropriate agencies is available.	___	___	___
3. Include referrals as appropriate for needed services not provided directly by the agency;	3. Referrals for needed services are made, as appropriate;	___	___	___
4. Identify expected outcomes and progress milestones toward which the client will be working to impact on the specific individual living issues;	4. Identifies expected outcomes and progress milestones;	___	___	___
5. Be approved in writing by the program coordinator or clinical consultant;	5. Is approved in writing;	___	___	___
6. The rehabilitation plan shall document the client's participation in developing the plan.	6. Documents client's participation in the plan.	___	___	___

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Standard		Measurement Criteria	YES	NO	N/A
5203g	g. Written assessments of the client's progress, or lack thereof, which are related to each of the goals and objectives, must be entered in the client record for:	g. Progress assessments are conducted as follows:	___	___	___
	1. Intensive outpatient: weekly;	1. Weekly in intensive outpatient;	___	___	___
	2. Residential stabilization: weekly;	2. Weekly in crisis stabilization;	___	___	___
	3. Residential rehabilitation: monthly;	3. Monthly in residential rehabilitation;	___	___	___
	4. Outpatient and Opiate Replacement Treatment: every 90 days.	4. Every 90 days in outpatient/ORT.	___	___	___
5203h	h. **Treatment and residential rehabilitation plans** shall be reviewed and updated at least:	h. Treatment and residential rehabilitation plans are reviewed according to schedule:	___	___	___
	1. Intensive outpatient: every 90 days;	1. Every 90 days in intensive outpatient;	___	___	___
	2. Residential stabilization: every 14 days.	2. Every 14 days in residential stabilization;	___	___	___
	3. Residential rehabilitation: every 90 days;	3. Every 90 days in residential rehab;	___	___	___
	4. Outpatient: every 20 visits or every 12 months, whichever comes first.	4. Every 20 visits or every 12 months, whichever comes first in outpatient.	___	___	___
	5. Opiate Replacement Treatment every 90 days for two years, annually thereafter.	5. Every 90 days or annually.	___	___	___
	i. **A medication chart** containing a profile of medication reported by the client (psycho-tropic, non-psycho-tropic, agency prescription, other physician prescription, and non-prescription) at intake and ongoing account of prescription medications taken by the client during the course of treatment:	i. A medication chart containing all drugs taken by the client is developed at intake and includes an ongoing account of all medications taken during the course of treatment.	___	___	___
	1. For medications prescribed by the agency, the date prescribed, the date refilled, and the number of refills permitted and the prescribing physician's name shall be included.	1. Agency prescribed medications are documented as required.	___	___	___
5203j	j. **Discharge Summary**: At discharge or 90 days after receipt of last service, documentation shall be completed within 15 days that shall specify the reason(s) for treatment termination or transfer to inactive status including discharge plan as appropriate.	j. A discharge summary is completed at discharge or within 15 days after 90 days of last service(s).	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
5203k	k. **Confidentiality**: The service provider organization will comply with the Federal Confidentiality Guideline, 42 CFR, Part II, as well as comply with HIPAA confidentiality guidelines.	k. There is compliance with 42 CFR Part II, as well as with HIPAA confidentiality guidelines.	___	___	___
	1. Consents for disclosure and other pertinent documentation shall be filed in the client record.	1. Documentation of confidentiality requirements are filed in the client record;	___	___	___
	2. A consent for follow-up must be completed prior to any follow-up contact.	2. Consents for follow-up are completed prior to follow-up contact.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
6000	**QUALITY ASSURANCE PROGRAM**				
6100	**Quality Assurance Plan**				
6101	The provider shall operate and maintain a Performance Improvement (PI) System designed to identify and assess important processes and outcomes, to correct and follow-up on problems, to improve the quality of services provided, and to improve client and family satisfaction with services provided. The PI system shall provide meaningful opportunities for input concerning the operation and improvement of services from clients, family members, consumer groups, advocacy organizations, and advocates. The PI system shall be described in a written plan which, at a minimum shall:	The current plan is written:			
	a. Identify and encompass all program service areas and functions, including subcontracted client services;	a. Covers all programs;	___	___	___
	b. Provide for review and approval by the Board of Directors/Governing Body at least every two years, and when revisions are made;	b. Approved initially by the Board/Governing Body;	___	___	___
	c. Outline the provider's mission related to PI;	c. Contains mission statement	___	___	___
	d. Contains the provider's goals and objectives related to PI;	d. Contains goals and objectives;	___	___	___
	e. Define the organization of PI activities and the person(s) responsible for coordinating the PI system;	e. Defines PI activities and person(s) responsible;	___	___	___
	f. Define the methodology for assessment, evaluation, and implementation of improvement strategies for important processes and outcomes;	f. Defines methodology for the assessment, evaluation, implementation of processes and outcomes;	___	___	___
	g. Provide for identification and monitoring of important processes and outcomes for the five components of Performance Improvement: Quality Improvement, Quality Assurance, Incident Prevention and Management, Consumer and Family Satisfaction, and Treatment Plan Reviews consistent with how they are defined in SASD Standards; and	g. Identifies and monitors outcomes in all five areas;	___	___	___
	h. Specify the manner in which communication of PI findings and recommendations, for all PI components, occurs at the governing body level, and the manner in which this process is documented.	h. Specifies manner of communication of PI findings;	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
6102	The Quality Improvement component of the PI System, at a minimum, shall include all SA System level performance measures as specified by the DMH/MR SASD, as well as, program specific, provider identified performance indicators.	The agency can produce data relative to monitoring the system level indicators.	___	___	___
6103	Quality Assurance Review: The review shall result in the determination as to whether: a. The application of each service began at the appropriate point during the client's course of service; b. The appropriate service were provided for an adequate duration; c. The appropriate goals were stated for each service in the client's program; d. The services produced the desired results I terms of the stated goals of the client's program; e. The client has been actively involved in planning and making informed choices regarding his/her program;	Quality Assurance Review: The review shall result in the determination as to whether: a. The application of each service began at the appropriate point during the client's course of service; b. The appropriate service were provided for an adequate duration; c. The appropriate goals were stated for each service in the client's program; d. The services produced the desired results I terms of the stated goals of the client's program; e. The client has been actively involved in planning and making informed choices regarding his/her program	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___
6104	A staff member shall not be the sole reviewer of the program of service for which he/she is responsible.	A staff member is not the sole reviewer of the program of service for which he/she is responsible.	___	___	___
6105	The review shall be conducted irrespective of source of funding for person served.	Reviews are conducted irrespective of source of funding for person served.	___	___	___
6106	The review shall involve at least a sampling of all clients served, including clients currently and formerly served.	Reviews include a sampling of all clients served, including clients currently and formerly served.	___	___	___
6107	As a result of the review, problem(s) identified, action taken, and follow-up shall be documented and communicated through organized discussion with all concerned staff.	Results of the review, problem(s) identified, action taken, and follow-up shall be documented and is communicated through organized discussion with all concerned staff.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
6108	Results of the review shall be documented and reviewed at least annually by the organization's administration and reported to the governing body.	Results of the review are documented and reviewed at least annually by the organization's administration and reported to the governing body.	___	___	___
6109	Findings and recommendations arising out of the internal, individual program review process shall be integrated into the program planning, evaluation, and management process.	Findings and recommendations arising out of the internal, individual program review process are integrated into the program planning, evaluation, and management process.	___	___	___
[redacted] OUT [redacted]	**Quality Assurance Review**				
	The Quality Assurance component of the PI system shall, at a minimum:				
	a. Include and describe a process for periodic and timely review of any deficiencies, requirements, and Quality Improvement recommendations received from DMH/MR certification site visits, advocacy visits, and/or from any other pertinent regulatory, accrediting, or licensing bodies. This process shall include a specific mechanism for the development, implementation, and evaluation of the effectiveness of action plans designed to correct deficiencies and prevent reoccurrence of deficiencies cited;	a. The process for review of regulatory findings and action plan is described;	___		___
	b. Include and describe a process for conducting an administrative and clinical review of a sample of active client records, and a sample of closed client records. This review shall function to assess the presence, accuracy and completeness of clinical documentation in relation to these standards and the agency's policies and procedures;	b. Administrative and clinical reviews are conducted on schedule;	___		___
	c. Describe procedures for annual review and documentation of aggregated findings from the administrative and clinical review of client records. These procedures shall include the protocol which will be used to address recommendations resulting from the review, and describe the process which will be utilized to resolve adverse findings;	c. Aggregate findings from the administrative/clinical reviews are review each year and evidence that appropriate actions were taken in response to findings;			
	d. Describe procedures for review, at least annually, of a representative sample of clinical records in each certified program to assess the appropriateness of admission to that program relative to published admission criteria.	d. Reviews were conducted on a representative sample in each program area			

Standard	Measurement Criteria	YES	NO	N/A
[redacted] Incident Prevention and Management System component of the PI system shall include, at a minimum, policies to address the following processes:	There are written policies and procedures that conform to the requirements;			
1. Identification and Reporting of Special Incidents: a. There shall be written policies and procedures that will ensure the identification of special incidents involving clients, and that specify the documentation and reporting requirements for these incidents.	a. Written policies and procedures identifying and reporting special incidents are in place;	___	___	___
b. Written policies and procedures shall specify that all special incidents involving clients, which occur in the contract provider's 24-hour care, in subcontracted care certified by DMH/MR, on the contract provider's premises, and/or while involved in an event supervised by the contract provider, shall be reported in accordance with written procedures published by DMH/MR SASD.	b. Written policies and procedures are in accordance with DMH/MR SASD procedures;	___	___	___
2. Investigation/Review of Special Incidents: a. There shall be written policies and procedures for investigating and correcting special incidents involving clients. The agency shall conduct, or cause to conducted, timely and adequate investigations of and response to Special Incidents involving clients.	a. The written policies and procedures conform to the requirements.	___	___	___
3. PI Review of Special Incidents Data: a. Written policies and procedures shall describe a process for the timely and appropriate review of special incident data, at least quarterly, via the PI System. Such review shall focus on the identification of trends and actions taken to reduce risk and to improve the safety of the environment for clients, families and staff members.	a. There are written procedures relative to quarterly reviews of special incidents data.	___	___	___

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Standard	Measurement Criteria	YES	NO	N/A
6203 The Client and Family Satisfactory component of the PI System shall include tools to assess the satisfaction of clients and families with services provided, and to obtain input from clients and their families regarding factors which impact their care and treatment.	Client and Family Satisfaction component is present.			
a. Written policies and procedures shall include and describe the mechanism for obtaining client and family input regarding satisfaction with service delivery and outcomes;	a. Mechanism for obtaining client and family input is present.	___	___	___
b. Where applicable, ensures that the manner of data collection assures client/family member confidentiality.	b. Mechanism for protecting client/family confidentiality is present	___	___	___
6204 The Treatment Plan Review component of the PI System shall include policies and procedures to ensure the timeliness, adequacy and appropriateness of services planned for each client. This component shall include, at a minimum, the following:	Treatment plan review components are present.	___	___	___
1. A written description of the process for conducting a treatment plan review;	1. A written description is present	___	___	___
2. A requirement that a sample of all direct service staff records be reviewed at least, annually, to assess proper case management, as evident by:	2. The review is conducted for all direct care staff at least every 12 months;	___	___	___
a. Timeliness of treatment plan development; b. Evidence of treatment plan reviews and updates as required by DMH/SASD standards; c. Appropriateness of the treatment plan in relation to assessed client needs; d. Documentation of service delivery in relation to the treatment plan; and e. Utilization of needed referral sources.	The review documents that assessment of each area listed;			
3. There shall be an aggregate review of clinical findings (from standard 6204.2) at least annually to assess trends and patterns and to determine actions for improvement based on findings.	There is an annual review of clinical findings and actions were taken based on the findings.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
[redacted]	As a result of the review, problem(s) identified, action taken, and follow-up shall be documented and communicated through organized discussion with all concerned staff.	The review is documented and communicated to all concerned staff.	___	___	___
[redacted]	Results of the review shall be documented and reviewed at least annually by the organization's administration and reported to the governing body.	Results are documented and reviewed annually and reported to the board.	___	___	___
[redacted]	Findings and recommendations arising out of the internal, individual program review process shall be integrated into the program planning, evaluation, and management process.	Findings and recommendations are integrated into program planning, evaluation, and management process.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
7000	**TREATMENT AND REHABILITATION SERVICES**				
7100	**All Treatment and Rehabilitation Services** (The standards specific to each service are listed under the heading for that service.) The following standards apply to all treatment services:				
7101	All service programs operated by the service provider organization must operate as described in the program description.	Programs are operated according to the program description.	___	___	___
7102	Programs serving adolescents must provide client education on key adolescent development issues.	Adolescent development issues are provided in all adolescent treatment programs.	___	___	___
7103	Each program must demonstrate that it maintains referral linkages with primary health care providers for the care of program's clients.	Linkages with primary health care providers are available for all clients.	___	___	___
7104	Each program must demonstrate that it provides each client HIV risk education including prevention information.	HIV risk education is provided to each client.	___	___	___
7105	Programs should demonstrate that the person(s) exposed to or appears to be affected by a contagious disease are to be treated by a competent medical staff person from that agency or referred to an outside agency for treatment.	Program demonstrates appropriate treatment and appropriate referral.	___	___	___
7106	The service provider organization must demonstrate that all medical care aspects of its programs are performed or supervised by a physician licensed to practice in the State of Alabama.	All medical care aspects of a program are performed by an Alabama licensed physician.	___	___	___
7107	The service provider organization must have written criteria to indicate when a medical examination is required for a client.	Written criteria indicate when a medical examination is required.	___	___	___
7108	The medical examination must be included in the client's diagnostic data base when indicated; however, programs are not required to provide uncompensated medical care.	The medical examination is included in the client's diagnostic data base; uncompensated medical care is not required.	___	___	___
[redacted] OUT	Each client admitted to a treatment service program must have a primary counselor assigned who is responsible for the management of the client's program of care.	A primary counselor is assigned to each client and manages the client's program of care.	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
7200	**Emergency Services**				
7201	All treatment service providers must provide or arrange for emergency services for enrolled clients.	Emergency services are available to enrolled clients.	___	___	___

Standard	Measurement Criteria	YES	NO	N/A
7300 Intensive Outpatient Program Services				
7301 Setting: Outpatient.	Setting is outpatient.	___	___	___
7302 Availability of services:				
The service provider organization must have the capacity to provide the following minimum continuum of care: a. Assessment services; b. Random or selective drug screening of clients in the program; c. Capacity to refer clients to other needed services including residential treatment; d. Initial intensive phase of treatment will include a minimum of 100 hours of treatment service activities conducted within six (6) months from date of admission. e. Capacity to serve the client for up to 12 months.	The minimum continuum of services were offered: a. Assessment services; b. Random or selective drug screening of clients in the program; c. Capacity to refer clients to other needed services including residential treatment; d. Initial intensive phase of treatment will include a minimum of 100 hours of treatment service activities conducted within six (6) months from date of admission. e. Capacity to serve the client for up to 12 months	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___
7303 **Attendance:** a. Attendance records for each client shall be maintained which documents the hours attended; b. Attendance shall be required on a regular basis for the scheduled series of treatment services; c. The minimum treatment service that a client may attend and remain an active client is one (1) hour of treatment per month; d. Actual frequency of attendance required will be determined by clinical judgment based upon client's progress and other client issues. Clients may advance or regress to more or less intensive requirements as deemed clinically necessary for client's recovery.	a. Required attendance records are maintained; b. Regular attendance at treatment is required; c. Each active client receives at least one hour of treatment services each month; d. Frequency of attendance is determined by clinical appropriateness.	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___

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Standard		Measurement Criteria	YES	NO	N/A
7304	**Core Functions:** Intensive outpatient program content shall consist of 2/3's (66.66%) service delivery time spent on providing direct treatment care services and 1/3 (33.34%) of the service delivery time spent providing support services.	The following core functions are available as part of the intensive outpatient program:			
	1. Direct treatment care services: a. Psychosocial assessment; b. Group therapy (process); c. Individual therapy; d. Family therapy; e. Therapeutic recreational activities for adolescents/adventure based therapy.	1. Direct treatment care services: a. Psychosocial assessment; b. Group therapy (process); c. Individual therapy; d. Family therapy; e. Therapeutic recreational activities for adolescents/adventure based therapy.	___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___
	2. Supportive care services a. Supportive counseling; b. Substance abuse education (didactic group); c. Family education.	2. Supportive care services a. Supportive counseling; b. Substance abuse education (didactic group); c. Family education.	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___

Standard		Measurement Criteria	YES	NO	N/A
7400	**General Outpatient Services and Opiate Replacement Treatment**				
7401	**Setting**: Outpatient.	The setting is outpatient.	___	___	___
7402	**Availability**: Service provider organization will make available as financial resources allow and depending upon client needs.	Services are available dependent upon financial resources and client needs.	___	___	___
7403	**Attendance**: Attendance records for each client will be maintained which documents the hours attended. Actual frequency of attendance required or needed will be determined by clinical judgment based upon client's progress and other client issues.	a. Attendance records reflect the hours attended; b. Actual frequency required of the client is based on clinical judgment.	___ ___	___ ___	___ ___
7404	**Core Functions**: The services for general outpatient treatment shall include: a. Psychosocial assessment; b. Individual, group, & family counseling/education; c. Supportive counseling.	Core functions include: a. Psychosocial assessment; b. Individual, group, & family counseling/education; and c. Supportive counseling.	___ ___ ___	___ ___ ___	___ ___ ___

Standard	Measurement Criteria	YES	NO	N/A
7500 Residential Stabilization:				
7501 **Setting**: Residential	The setting is residential.	___	___	___
7502 **Availability**: 24 hours, seven (7) days per week.	Program operated 24 hours, 7 days per week.	___	___	___
7503 **Staffing:** Awake staff 24 hours a day, seven days per week. On duty staff must provide supervision of client's health, welfare, and safety 24 hours a day.	a. Awake staff oversees the facility 24 hours a day, 7 days per week. b. On duty staff supervises client's health, welfare, and safety 24 hours a day.	___ ___	___ ___	___ ___
7504 Program must document all staff are current in: a. First aid b. CPR c. Crisis intervention d. Program policies and procedures	Documentation verifies staff are current in: a. First aid b. CPR c. Crisis intervention d. Program policies and procedures	 ___ ___ ___ ___	 ___ ___ ___ ___	 ___ ___ ___ ___
7505 **Core Functions**:				
a. <u>All residential programs</u> must provide:	a. Program provides:			
(1) Full-time residential environment in a clean, comfortable setting meeting federal, state, and local fire and life safety codes;	(1) Full-time residential environment which is a clean and comfortable setting meeting federal, state, and local fire and life safety codes;	___	___	___
(2) An alcohol and illicit drug-free environment;	(2) Environment is alcohol and illicit drug-free;	___	___	___
(3) Emergency medical response capability and procedures;	(3) Program has emergency medical response capability and procedures;	___	___	___
(4) Referral for other needed services.	(4) Program can document referrals are made as deemed appropriate.	___	___	___

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Standard	Measurement Criteria	YES	NO	N/A
b. Standard short term residential programs must also provide:	b. Program provide:			
(1) Three (3) balanced nutritional meals daily;	(1) Balanced nutritional meals are served three times a day;	___	___	___
(2) Case coordination;	(2) Case coordination is documented;	___	___	___
(3) Group, individual, and family education/counseling;	(3) Program provides group, individual, and family education/counseling;	___	___	___
(4) Supportive counseling;	(4) Program provides supportive counseling;	___	___	___
(5) Substance abuse education;	(5) Program provides substance abuse education;	___	___	___
(6) Case Coordination;	(6) Program provides case coordination;	___	___	___
(7) Continuing care planning;	(7) Program provides continuing care planning;	___	___	___
(8) Therapeutic recreational activities for adolescents clients;	(8) Therapeutic recreational activities are provided for adolescents clients;	___	___	___
(9) A minimum of 25 hours of treatment services must be provided each client each week. An appropriate mix of treatment services, including therapy and didactic/educational sessions will be offered. Use of support/self-help groups is encouraged but may not be considered as treatment.	(9) Program Provides: (a) A minimum of 25 hours of treatment services to each client each week.	___	___	___
	(b) An appropriate mix of treatment is offered.	___	___	___
	(c) Use of self-help groups is encouraged.	___	___	___
c. Residential Rehabilitation Programs must also provide:				
(1) Linkage with vocational rehabilitation;	(1) Linkage with vocational rehabilitation exists;	___	___	___
(2) Job Placement;	(2) Program can document efforts at job placement;	___	___	___
(3) Social rehabilitation opportunities;	(3) Social rehabilitation opportunities are provided;	___	___	___
(4) A written rehabilitation plan for each client (See Standard 5203f)	(4) Rehabilitation plans written in accordance with Standard 5203f is maintained on each client.	___	___	___

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Standard	Measurement Criteria	YES	NO	N/A
d. Short-term residential program that have unbundled their services must also provide:				
(1) The treatment component through an intensive outpatient program which consists of a minimum of 25 hours; (2) Linkage with vocational rehabilitation; (3) Supervised therapeutic recreational designed to provide leisure and promote a sprit of teamwork and cooperation.	(1) Treatment is provided through an intensive outpatient program with a minimum of 25 hours; (2) Linkage with vocational rehabilitation exists; (3) Therapeutic recreational activities are available, utilized, and supervised.	___ ___ ___	___ ___ ___	___ ___ ___

Standard		Measurement Criteria	YES	NO	N/A
7700	**Case Management**				
7701	**Setting**: Outpatient and Mobile.	The setting is outpatient and mobile.	___	___	___
7702	**Availability**: Scheduled to meet client population needs.	Meets client population needs.	___	___	___
7703	**Core Functions**: a. Human service needs assessment; b. Case planning; c. Linkage; d. Advocacy; and e. Monitoring.	Following core functions are provided: a. Human service needs assessment; b. Case planning; c. Linkage; d. Advocacy; and e. Monitoring.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___
7704	The Human Service Needs Assessment must include, but not be limited to: a. Key Elements: 1. Family Relationships; 2. Housing; 3. Vocational/Educational; 4. Recreational; 5. Transportation; 6. Mental Health; 7. Social Support; 8. Physical; 9. Financial; and 10. Spiritual. b. Summary of Significant Problems: A summary of significant problem(s) the client is experiencing, including those that are to be the focus of the case plan. c. Shall be approved by the Case Manager Supervisor	The Human Service Needs Assessment must include, but not be limited to: a. Key Elements: 1. Family Relationships; 2. Housing; 3. Vocational/Educational; 4. Recreational; 5. Transportation; 6. Mental Health; 7. Social Support; 8. Physical; 9. Financial; and 10. Spiritual. b. A summary of significant problem(s) is available. c. Approved by Case Management Supervisor	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
7705	The Human Service Needs Assessment must be: a. Updated whenever there are significant changes to the key elements. b. Reviewed with the client on the Anniversary date of the Human Service Needs Assessment and annually thereafter,	The Human Service Needs Assessment must be: a. Updated whenever there are significant the key elements b. Reviewed on anniversary date and annually thereafter	___ ___	___ ___	___ ___

Standard	Measurement Criteria	YES	NO	N/A
	if no breaks in the delivery of services occur.			
7706	Treatment programs must have a written case plan for each client that:	The required case plan is completed:	____	____	____
	1. Is completed within seven (7) days after completion of Human Service Needs Assessment;	1. Within (7) days;	____	____	____
	2. Defines each problem(s)/goal(s) to be addressed;	2. Defines problem(s)/goal(s);	____	____	____
	3. Identifies interventions towards which the client and Case Manager will be working to impact on the specific problem(s)/goal(s);	3. Identifies interventions;	____	____	____
	4. Includes referral as appropriate for needed services not provided by the agency;	4. Includes appropriate referral;	____	____	____
	5. Be approved in writing by Case Management Supervisor; and	5. Is approved in writing; and	____	____	____
	6. The case plan shall document the client's participation in developing the plan as appropriate.	6. Document s the client's participation in case planning.	____	____	____
7707	Case Plans shall be reviewed and updated every ninety (90) days with a written assessment of client's progress, or lack there of, which are related to each of the problem(s)/goal(s).	Case plans are:			
		1. Reviewed ninety (90) days;	____	____	____
		2. Written assessments of progress are conducted.	____	____	____

Standard		Measurement Criteria	YES	NO	N/A
7800	**Opiate Replacement Treatment**				
7801	Opiate replacement treatment programs must comply with all applicable federal regulations, particularly Federal Regulation 42 CFR Part 8, and all applicable portions of the Community Substance Abuse Services Program Standards.	a. The program is in compliance with all applicable federal regulations; b. The program is in compliance with Community SASD Program Standards.	___ ___	___ ___	___ ___
7802	Physicians in private practice must be certified by DMH/MR, SASD to dispense methadone and other opiate replacement drugs as required by law, and to operate a methadone treatment program.	Physician certified by SASD	___	___	___
7803	**Medical Director**: There shall be a medical director assigned who is physically present in the clinic two (2) hours per week per each fifty (50) clients and also:	A medical director is assigned who:			
	a. Assumes responsibility for the administration of all medical services;	a. Is responsible for medical services;	___	___	___
	b. Shall be a licensed physician in the State of Alabama.	b. Physician is licensed in Alabama.	___	___	___
	c. Assumes medical responsibility for more than one opiate replacement treatment program only with written approval of DMH/MR, SASD;	c. Assumes medical responsibility for only one program.	___	___	___
	d. Attends weekly staff meetings with counselors, or documents in the client record alternative and equivalent supervisory contact on a weekly basis;	d. Attends weekly staffing/documents supervisory contact.	___	___	___
	e. Works directly with other medical doctors in the area in cases where clients are on psychoactive and/or control medication prescribed by another doctor and documents in writing;	e. Contact with other physicians in cases where clients are on prescribed medication is documented by physician in client record.	___	___	___
	f. Performs client physical examinations prior to dosing, with thorough documentation of the client's opiate addiction.	f. 1. Performs physical prior to dosing: 2. Documents opiate addiction in record.	___ ___	___ ___	___ ___
	g. Performs annual client physical examination.	g. Annual physical performed.	___	___	___
	h. Approves all dose and phase changes.	h. All phase and dose changes approved.	___	___	___

Standard	Measurement Criteria	YES	NO	N/A
7804 **Program Sponsor**: The program sponsor shall:	The Program Sponsor:			
a. Be a licensed health care professional, licensed in the State of Alabama;	a. Is an Alabama licensed health care professional.	____	____	____
b. Have at least two years supervised experience in a substance abuse program;	b. Has two years substance abuse services supervised experience.	____	____	____
c. Meet the qualifications of a staff member and be included in the listing of personnel authorized access to the medication unit where he/she has access to the medication unit.	c. Meets qualifications of a staff member in order to have access to the medication unit.	____	____	____
7805 **Pharmacist:** There shall be a pharmacist assigned who:				
a. Shall be licensed as a pharmacist in the State of Alabama.	a. Pharmacist is licensed in Alabama.	____	____	____
b. Prepares all take-home medication.	b. Is present in the clinic to prepare take-home medication.	____	____	____
c. Conducts, at a minimum, an annual physical drug inventory.	c. Annual inventory performed.	____	____	____
7806 **Special Limitations:** Applicants who are under the age of eighteen (18) must document two (2) unsuccessful attempts at drug-free treatment prior to being considered for admission to opiate replacement treatment. A client under 18 years of age may not be administered LAAM.	Applicants under the age of 18 have documented two unsuccessful attempts at drug-free treatment before entering a maintenance program. No LAAM under 18.	____	____	____
7807 **Minimum Testing or Analysis for Drugs**: The person responsible for a program shall insure that:	The following minimum drug testing will be accomplished.			
a. At least twelve (12) drug tests per year. All drug tests will screen for drugs as outlined in 7807d.	a. At least twelve (12) drug tests per year, testing drugs as outlined in 7807d.	____	____	____
b. A positive urine drug screen for any drug other than the opiate replacement drug, or a urine drug screen that is negative for the opiate replacement drug, requires that the client with take-home privileges be placed on probation for 90 days, and receive twice-a-month urinalysis. A second positive urinalysis during that 90 days shall result in the client being placed back to Phase I, thus requiring compliance with Standard 7811a. Once the client has met Standard 7811a and 7811b, he/she may be considered for re-instatement of original phase.	b. Positive urine results in:			
	1. Probation for 90 days for first positive;	____	____	____
	2. Drop to Phase I for second positive during probation.	____	____	____

Standard	Measurement Criteria	YES	NO	N/A
c. The program must have a policy and procedure outlining protocols for the disposition of cases where clients have multiple positive urine screens for illicit drugs or negative for opiate replacement drugs. Ultimately the decision for each such client is a medical/clinical judgement, which must be adequately documented in the client record.	c. Specific policy and procedure is in place describing consequences for continued positive urine drug screens. 1. Exceptions to policy are documented.	____	____	____
d. Cut-off points for the immunoassay screening test must be: 1. Marijuana----------100 ng/ml 2. Cocaine ----------300 ng/ml 3. Opiate ----------300 ng/ml 4. Amphetamine/methamphetamine----------1000 ng/ml 5. Benzodiazepine----------200 ng/ml 6. Propoxyphene----------300 ng/ml 7. Methadone----------300 ng/ml 8. Barbiturates----------200 ng/ml 9. Alcohol---------- .03 gm/dl	d. Assays reflect required cut-offs for each substance tested. 1. Other ORT drugs used with State Methadone Authority approval.	____	____	____
In cases where opiate replacement drugs other than methadone are being used, the clinic should contact the State Methadone Authority to determine the cut-off point on the immunoassay test.				
e. Immunoassay screening tests must be conducted by a laboratory certified by an independent, federally approved accreditation entity.	e. Appropriately certified lab used for drug testing.	____	____	____
7808 **Drug Testing Employees' Policy**: Each program will have a drug screening test or analysis policy for all employees working in the opiate replacement treatment program. As a minimum, the policy will stipulate that:	Program has a drug-testing employee policy:			
a. Prior to employment, new employees will be drug tested to assure they are drug free;	a. All new employees are drug tested to assure they are drug-free;	____	____	____
b. All employees are subject to drug testing any time there is evidence to suspect that the employee is no longer drug-free.	b. All employees are subject to drug testing when there is evidence to suspect drug use.	____	____	____

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Standard		Measurement Criteria	YES	NO	N/A
7809	All direct service staff must be trained in:				
	a. CPR b. Program policies and procedures.	a. Staff trained in CPR b. Staff trained in policies and procedures	____ ____	____ ____	____ ____
7810	**Staffing:** The person responsible for the program shall ensure that: a. No more than thirty (30) clients under one year in treatment will be assigned to a counselor. The ratio may be increased to1:50 by adding twenty (20) clients to the case load for clients that have been in treatment in excess of one year. Clients who receive take-home doses under hardship waivers shall be considered as per the earned phase for purposes of the counselor caseload.	a. Counselor/client ratio 1:30, not to exceed 1:50	____	____	____
7811	**Take-Home Medication:**		____	____	____
	Clients in Phase I will not receive any take-home doses, including Sundays. Clients on LAAM will follow the federal guidelines regarding take-home doses. In order to be approved for take-home medication, the following must be accomplished and documented in the client record:	Clients in Phase 1 attend clinic each day.			
	a. Twice-a-month urine tests showing the client is free of all narcotic and non-narcotic drugs and positive for methadone for at least 90 consecutive days prior to being considered for take-home doses.	a. Twice-a-month urine drug screens on file for 90 consecutive days before client is considered for take-home doses.	____	____	____
	b. Medical director's determination of: 1. Absence of recent abuse of drugs (narcotic or non-narcotic), including alcohol; 2. Regularity of clinic attendance; 3. Absence of serious behavioral problems at the clinic; 4. Absence of known recent criminal activity, e.g., drug dealing;	b. Medical director's determination of: 1. Absence of recent abuse of drugs/alcohol. 2. Regular clinic attendance. 3. Absence of behavioral problems at clinic. 4. Absence of criminal activity.	____ ____ ____ ____	____ ____ ____ ____	____ ____ ____ ____

Standard	Measurement Criteria	YES	NO	N/A
5. Stability of the client's home environment and social relationships;	5. Stability of home/relationships.	____	____	____
6. Length of time in treatment;	6. Time in treatment.	____	____	____
7. Assurance that take-home medication can be safely stored within the patient's home; and	7. Assurance that take-home can be stored safely.	____	____	____
8. Whether the rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.	8. Benefit outweighs risk of diversion.	____	____	____
c. The maximum number of take-home doses is six (6).	c. Maximum take-home dose is six (6).	____	____	____
d. Requests for hardship waivers and exception of take-home dose limits must be approved in writing by the State Methadone Authority and when applicable by the appropriate federal agency. All conditions outlined in the approval shall be documented in the client file.	d. Hardship waivers: 1. Hardship waivers approved in writing by State Methadone Authority are on file. 2. Conditions are documented.	____ ____	____ ____	____ ____
7812 **Client Transfer:** Upon proper notification and authorization of release of information, the transferring clinic must provide the following minimum information:				
a. Admission date.	a. Admission date.	____	____	____
b. Original date of admission for current treatment episode (i.e., take-home eligibility time in treatment.)	b. Date of original admission for current treatment episode.	____	____	____
c. Current phase and date in phase.	c. Current phase and date in phase.	____	____	____
d. Urinalysis results for past year.	d. Urinalysis results for past year.	____	____	____
e. Dose level, to be confirmed by nursing staff at transferring clinic and documented in client record.	e. Dose level.	____	____	____
f. Most recent TB test results and date of test.	f. Most recent TB test results and date of test.	____	____	____
g. Reason for transfer.	g. Reason for transfer.	____	____	____
h. Other information as specified on release of information.	h. Other information as specified on release of information.	____	____	____
7813 **Guest Dosing**	**Guest Dosing**			
a. Guest dosing must be arranged in advance by the sending clinic.	a. Arranged in advance.	____	____	____
b. Medical personnel shall verify dose prior to dosing.	b. Verification by medical personnel of dose.	____	____	____
c. If guest dosing is more than 14 days, a drug screen shall be obtained.	c. Drug screen obtained after 14 days.	____	____	____
d. Guest dosing shall not exceed 28 days.	d. Guest dosing shall not exceed 28 days.			

Standard	Measurement Criteria	YES	NO	N/A
7814 **Therapeutic Services**	**Therapeutic Services:**			
a. As part of the rehabilitative services provided by the program, each client must be provided with individual, group and family counseling and drug education appropriate to his/her needs and consistent with the treatment plan.	a. Individual, group, family counseling, and drug education provided and consistent with: 1. Client needs. 2. Client treatment plan.	___ ___	___ ___	___ ___
b. The frequency and duration of counseling provided to clients must be determined by appropriate program staff and be consistent with the treatment plan, and also must include as a minimum the following: 1. Documented face-to-face contact with client at least two (2) times per week for a minimum of 5 minutes each time during the first three (3) months; 2. Individual counseling as indicated for the first three (3) months, but not less than one (1) hour per month for the first 18 months; 3. Group counseling for every client as indicated, but not less than one (1) continuous hour per month for two (2) years. 4. Group education for every client as indicated, but not less than one (1) hour per month for at least 18 months; and 5. When indicated and properly authorized by client, family should be contacted and offered counseling/education. Family group counseling and education shall be made available at a minimum of one (1) hour per week. Individual family counseling shall be provided as indicated. All contact with family members must be documented in the client record.	b. Frequency and duration of services determined by appropriate staff and consistent with treatment plan. Services include: 1. Face-to-face contact 2. Individual therapy 3. Group therapy 4. Group education 5. Family therapy/education: a. Client record documents release to contact family. b. Client record documents efforts to get family involved.	___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___
c Treatment plans must indicate a specific level of counseling services needed by the client as part of the rehabilitative process.	c. Treatment plans indicate a specific level of counseling services needed by the client.	___	___	___
d. The treatment plan of a client in treatment for a short period of time (up to three months) must show that consideration was given to that client's need for more intensive counseling services.	d. The treatment plan of a client in treatment up to three (3) months reflects the client's need for more intensive counseling services.	___	___	___

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Standard	Measurement Criteria	YES	NO	N/A
e. When appropriate, each client shall be enrolled in an education program, or be engaged in a vocational activity (vocational evaluation, education, or skill training) or make documented efforts to seek gainful employment. Deviations from compliance with these requirements shall be explained in the client's record.	e. 1. Each client is enrolled in an education program, engaged in a vocational activity, or making documented efforts to seek gainful employment; 2. Deviations from 1 above are explained in the client's record.	____ ____	____ ____	____ ____
f. Each program shall take steps to ensure that a comprehensive range of rehabilitative services, including vocational, educational, legal, mental health, alcoholism and social services are made available to the clients who demonstrate a need for such services. The program can fulfill this responsibility by providing support services directly or by appropriate referral.	f. A comprehensive range of rehabilitative services is made available to clients who demonstrate a need for such services, either directly by the program or indirectly through referral.	____	____	____
g. Support services recommended and utilized shall be documented in the client record.	g. All support services recommended and utilized are documented in the client record.	____	____	____
h. The client record shall document that clients have been questioned about being pregnant, and informed about pregnancy and physiological implications with opiate replacement drugs. Pregnant clients shall not be dosed with LAAM.	h. Client record documents pregnancy questions.	____	____	____

Standard	Measurement Criteria	YES	NO	N/A
7815 **Registry System**: To prevent simultaneous enrollment of a client in more than one opiate replacement treatment program, each program shall:				
a. Obtain written consent and photograph the applicant at the time of admission.	a. Written consent and photograph of client on file.	___	___	___
b. Cooperate with the State Methadone Authority in maintaining a Central Registry by routinely providing client identifying information as determined by the State Methadone Authority;	b. Program cooperating with State Methadone Authority regarding the central registry.	___	___	___
c. Require that within thirty (30) days of admission all clients show proof of identification in the form of an official state driver's license or a non-driver's license issued by the state's Department of Public Safety;	Proof of identification on file within thirty (30) days of admission.	___	___	___
d. Insure that the methadone program does not admit anyone who is reported by another program to be participating in another such program.	d. The program insures that they do not enroll a person who is currently participating in another such program.	___	___	___

Standard	Measurement Criteria	YES	NO	N/A
7816	The state authority for governing the treatment of narcotic addition with a narcotic drug in Alabama is the Department of Mental Health /Mental Retardation, Substance Abuse Services Division.	____	____	____

Standard	Measurement Criteria	YES	NO	N/A

7817 **Application to Operate an Opiate Replacement Treatment Program**

The program shall submit to the Substance Abuse Services Division the following information:

a.	A Certificate of Need issued by the State Health Planning and Development Agency.	____	____	____
b.	Application for certification.	____	____	____
c.	Articles of Incorporation and Board By-laws.	____	____	____
d.	Organizational chart.	____	____	____
e.	Policy and Procedure manual.	____	____	____
f.	Program description.	____	____	____
g.	Description of the facility.	____	____	____
h.	Dispensing hours and program hours.	____	____	____
i.	Copy of the client rights.	____	____	____
j.	Copy of the program rules.	____	____	____
k.	Description of the primary geographic area to be served; the number of clients to be served; the daily charge to the client.	____	____	____
l.	Quality assurance plan.	____	____	____
m.	Job description for all personnel to include a copy of employment contract for the medical director and pharmacist. A resume with degree transcripts and/or copies of licenses for all personnel.	____	____	____
n.	A blank client record.	____	____	____
o.	Lab to be used for drug screens.	____	____	____
p.	Copy of any other forms to be used by the program.	____	____	____
q.	Copy of the U. S. Department of Justice, Drug Enforcement Administration license.	____	____	____
r.	Copy of application to center for Substance Abuse Treatment for certificate.	____	____	____
s.	Copy of license issued by the Alabama State Board of Pharmacy.	____	____	____
t.	Copy of business license.	____	____	____
		____	____	____

Standard		Measurement Criteria	YES	NO	N/A
8000	**MEDICAL, PHARMACY, AND DETOXIFICATION**				
8100	**General Medical and Pharmacy**				
8101	The agency must demonstrate that all medical care aspects of the program are performed or supervised by a physician licensed to practice in the State of Alabama.	All medical care aspects are performed or supervised by an Alabama licensed physician.	___	___	___
8102	The agency must have written medical procedures which describe the steps for the management of medical emergencies.	Written procedures are available that describe management of medical emergencies.	___	___	___
8103	All residential programs must demonstrate their client's accessibility to a local licensed hospital for the purpose of providing emergency hospital care.	All residential clients have access to emergency hospital care.	___	___	___
8104	All substance abuse treatment programs must provide for, or be able to refer, clients for physical and/or laboratory examinations when clinically appropriate in accordance with the supervising physician's written medical procedures. However, programs are not required to provide uncompensated medical care.	Physical and/or laboratory examinations are available to clients in accordance with the supervising physician's written medical procedures.	___	___	___
8105	For those situations where drug screening by urinalysis is deemed appropriate and necessary by the program director, or supervising physician, the program must:	Where drug screening by urinalysis is deemed appropriate:			
	a. Establish procedures which protect against the falsification and/or contamination of any urine sample;	a. Urine collection procedures protect against falsification/contamination of any urine sample;	___	___	___
	b. Provide assurance that no client will be discharged from treatment solely on the basis of a single positive urine analysis (not applicable to substance abuse residential programs).	b. Except for residential programs, no client shall be discharged solely on the basis of a single positive urine analysis.	___	___	___
8106	The agency must, at all times, meet applicable federal and state requirements regarding the storing and/or dispensing of "prescription legend" and/or "controlled substance" drugs (including, but not limited to Code of Alabama 1975, Section 34-23-94; Code of Alabama 1975, Section 20-2-1 through 20-2-93; Federal Controlled Substance Act of 1970; Indigent Drug Program Manual for Mental Health Centers, where applicable).	The agency meets at all times applicable federal and state requirements regarding the storing and/or dispensing of "prescription legend' and/or "controlled substance" drugs.	___	___	___
8107	Any agency storing bulk quantities of "controlled substance" or "prescription legend" drugs must document that one of the following Drug Enforcement Administration (DEA) registration procedures has been met:	Storage of bulk quantities of "controlled substance" or "controlled legend drugs" complies with one of the following:			

Standard		Measurement Criteria	YES	NO	N/A
	a. The supervising or consulting physician for the program has registered the facility as one of his offices with the DEA Registration Branch, or;	a. The physician has the facility registered as one of his offices with DEA; or	___	___	___
	b. The program itself has been registered with the DEA Registration ranch when there is more than one physician involved with the program.	b. The program itself has been registered with the DEA Registration Branch.	___	___	___
8108	The agency must demonstrate accurate accounting/tracking procedures for all "controlled substance" and/or "prescription legend" drugs purchased/dispensed by the program. These procedures must additionally account for any client owned medication that is present in the facility. The following records must be kept on all such drugs received, and administered, or self-administered:	Accurate accounting/tracking procedures for all "controlled substance'" and/or "prescription legend" drugs purchased /dispensed by the agency and those client owned medications in the facility are maintained as follows:	___	___	___
	a. A medication log/running inventory on which the following information is recorded:	a. A medication log/running inventory is maintained that includes:	___	___	___
	1. Date on which drug(s) were placed in inventory;	1. Date drug(s) were placed on inventory;	___	___	___
	2. Brand name/generic name;	2. Brand name/generic name;	___	___	___
	3. Quantity/dosage of drug(s);	3. Quantity/dosage of drug(s);	___	___	___
	4. Date drug(s) were administered;	4. Date drug(s) were administered;	___	___	___
	5. Initials/signature of nurse administering drug(s).	5. Initials/signature of nurse administering drug(s).	___	___	___
	b. A medication sheet for each individual client on which the following information is recorded each time drugs are administered:	b. A medication sheet is completed each time drugs are administered:	___	___	___
	1. Brand name/generic name;	1. Brand name/generic name;	___	___	___
	2. Date/time drugs were administered;	2. Date/time drugs were administered;	___	___	___
	3. Quantity/dosage;	3. Quantity/dosage;	___	___	___
	4. Initials/signature of nurse administering drugs, or initials/signature of client when self medicating;	4. Initials/signature of nurse administering medication or initials/signature of client when self medicating;	___	___	___
	5. Client's name.	5. Client's name.	___	___	___
	c. Non-prescription medication allowed to be self-administered by a client in a residential treatment program shall be recorded on the medication sheet.	c. Residential client self-administered, non-prescription medication is recorded on the medication sheet.	___	___	___

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Standard		Measurement Criteria	YES	NO	N/A
	d. The agency must document that a reconciliation of the drug inventory, performed under the supervision of the program director or supervising physician, is performed according to the following: 1. At least semiannually; 2. Each time there is a change in the responsibilities among those individuals with designated access to the drug supplies.	d. Reconciliation of the drug inventory is performed: 1. At least semiannually; 2. Each time there is a change among those with access to the drug supplies.	___ ___	___ ___	___ ___
8109	All "controlled substance" and/or "prescription legend" drugs kept in the facility must be stored in a locked cabinet or other substantially constructed storage that precludes surreptitious entry.	All "controlled substance" and/or "prescription legend" drugs are stored in such a manner that precludes surreptitious entry.	___	___	___
8110	All such storage units must be locked when not in use.	Drug storage units are locked when not in use.	___	___	___
8111	Access to all "controlled substance" and/or "prescription legend" drugs must be restricted to the absolute minimum number of employees needed to handle daily transactions of such drugs.	Access to all drugs is restricted to the absolute minimum number of employees needed to handle daily transactions of such drugs.	___	___	___
8112	A listing of those employees permitted access to the drugs will be on file at the agency. This listing should be displayed in the drug storage area.	A listing of employees permitted access to drugs is on file at the agency.	___	___	___
8113	In the event of loss or the theft of controlled substances, the agency must perform the following: a. Notify local law enforcement personnel immediately upon the detection of the loss; b. Notify the supervising physician immediately upon the loss if the supervising or consulting physician has registered the program as one of his offices with the DEA Registration Branch; c. Notify the DEA Registration Branch directly if the program itself has been registered with the DEA; d. Notify the Director, Substance Abuse Services Division, DMH/MR within 24 hours of the detection of the loss; e. Provide a subsequent written description of the events and extent of the loss to the Director, Substance Abuse Services Division, DMH/MR. This written description must be mailed within 72 hours from loss detection.	The following is accomplished in the event of loss or theft of controlled substances: a. Local law enforcement personnel are immediately notified of the loss; b. If the supervising/consulting physician has registered the program with DEA, notify him immediately of the loss; c. If the program itself is registered with DEA, notify them directly; d. Notify the Director SASD, DMH/MR within 24 hours of detection of the loss: e. Within 72 hours from loss detection provide DMH/MR, SASD a written description of the events and extent of loss.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___

Standard	Measurement Criteria	YES	NO	N/A
8114 For residential services, there shall be a registered nurse or licensed practical nurse as a full time or part-time employee or a consultant to the provider who is responsible for supervision of delegation of medication assistance to the unlicensed personnel. Access to an on call nurse must be available 24 hours/day, 7 days/week. Providers will implement policies and procedures approved by their Boards of Directors requiring full compliance with the Alabama Board of Nursing's regulation 610X6.15 Alabama Department of Mental Health Residential Community Programs.	a. The program has a registered nurse or licensed practical nurse as a full time or part-time employee or a consultant to the provider who is responsible for supervision of delegation of medication assistance to the unlicensed personnel.	___	___	___
	b. The program can demonstrate access to a on call nurse 24hours 7 days a week	___	___	___
	c. The program has policies and procedures indicating compliance with the Alabama Nursing Regulation 610-X-6-.15 that include but are not limited to the following:	___	___	___
	1. Policy outlining the task of the supervising nurse that can not be delegated according to the nursing regulation 610-X-6-.15	___	___	
	2. Documentation indicating the nurse is MAS trained.	___	___	
	3. Documentation indicating the unlicensed worker received the minimum 24 hours training approved outlined by the broad of nursing.	___	___	
	4. Documentation indicating the registered nurse or licensed practical nurse performs periodic and regular evaluations and monitoring of the unlicensed worker.	___	___	
	5. Documentation indicating the registered nurse or licensed practical nurse routinely and periodically conducts quality monitoring of the unlicensed worker in the following areas: training, competency, documentation, error reporting and methods of identifying the right patient, tasks, method, quantity and time.	___	___	

Standard		Measurement Criteria	YES	NO	N/A
8200	**Outpatient Detoxification.**				
8201	Supervised withdrawal from alcohol and drug intoxication in non-residential setting (client remains in usual living situation) using medication after medical evaluation and following physician approved guidelines.	Outpatient detoxification is the supervised withdrawal from alcohol and drug intoxication using approved physician guidelines on an outpatient basis.	___	___	___
8202	Any agency providing outpatient detoxification services must have written procedures that describe the protocols taken by the program to ensure the safe detoxification of any client assigned to this method of treatment.	Written procedures that describe protocols to ensure the safe detoxification of the client are available.	___	___	___
8203	All outpatient detoxification programs must have 24-hour emergency services available, either on site or through an affiliated agreement.	All outpatient detoxification programs have 24-hour emergency services available.	___	___	___
8204	All detoxification programs must demonstrate by written agreement their client's accessibility to a local licensed hospital for the purpose of providing emergency hospital care.	A written agreement for the provision of emergency hospital care for those being detoxified is available.	___	___	___
8205	Detoxification programs will have psychosocial assessment and/or supportive services available and accessible to the client and family as soon as deemed clinically appropriate.	Psychosocial assessment and/or supportive services are available as soon as clinically appropriate.	___	___	___

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Standard		Measurement Criteria	YES	NO	N/A
8300	**Residential Detoxification.**				
8301	Supervised withdrawal from alcohol and drug intoxication for an individual who can safely be treated outside an acute general hospital setting, using medication after medical evaluation and following physician approved guidelines, but who requires 24-hour a day supervision.	Residential detoxification is the medically supervised withdrawal from alcohol and drug intoxication in a residential setting.	___	___	___
8302	Programs providing detoxification services must have coverage by a licensed physician trained in detoxification protocols and/or addiction medicine.	Residential detoxification services have coverage by a licensed physician trained in detox protocols and/or addiction medicine.	___	___	___
8303	Medical supervision of detoxification must be available 24 hours a day, seven days a week.	Medical supervision is available 24 hours a day, seven days a week.	___	___	___
8304	Criteria for determining the need for detoxification with medication must be described in a written procedure approved by the physician. The procedures must include: a. Description of symptoms requiring medical detoxification; d. Continuous nursing assessment following admission to the program to determine if there are any changes in detoxification needs.	Criteria for determining the need for detoxification with medication is written/approved by the physician and include: a. Description of symptoms requiring detox; b. Continuous nursing assessment following admission.	___ ___ ___	___ ___ ___	___ ___ ___
8305	All clients will be screened by a registered nurse upon admission and will be administered a physical examination by a physician, physician's assistant or certified nurse practitioner within 24 hours of admission.	All clients are screened by a registered nurse on admission and administered a physical exam within 24 hours of admission.	___	___	___
8306	The program must provide for physical and/or laboratory examination in accordance with the supervising physician's written medical procedures.	Physical and/or laboratory exams are provided in accordance with written medical procedures.	___	___	___
8307	There must be written protocols approved by the physician that describe care given during medical detoxification, including administration of medication, monitoring of vital signs, and emergency procedures.	There are written physician approved protocols for detoxification.	___	___	___
8308	The licensed physician must be consulted prior to the initiation of medical detoxification.	The physician is consulted prior to initiation of detoxification.	___	___	___
8309	The program must provide and document clinical staff training in all detoxification protocols and emergency procedures.	Documented clinical staff training is provided in all detox protocols and emergency procedures.	___	___	___
8310	When detoxification procedures are initiated by phone order with the physician, these must be reviewed and signed by the physician within 24 hours of the initiation of detoxification.	Phone orders of the physician must be reviewed and signed by the physician within 24 hours of the initiation of detoxification.	___	___	___
8311	All programs providing detoxification must demonstrate by written document the client's accessibility to a local licensed hospital for the purpose of providing emergency hospital services.	Written agreements demonstrate emergency hospital services are accessible to all clients being detoxified	___	___	___

Standard		Measurement Criteria	YES	NO	N/A
8312	The program shall have transportation available on a 24 hour-a-day basis for emergency purposes.	Transportation is available 24 hours a day for emergency purposes.	___	___	___
8313	The program shall have a full time registered nurse on staff and on-call registered nurse accessibility at all times. Any time the registered nurse is not on site, an L.P.N. will be on site.	a. A full time registered nurse is assigned. b. There is on-call registered nurse accessibility at all times. c. An L.P.N. is on site any time the registered nurse is not on site.	___ ___ ___	___ ___ ___	___ ___ ___
8314	The program shall have staff on duty and awake 24 hours a day.	Awake staff is on duty 24 hours a day.	___	___	___
8315	Detoxification programs will provide psycho-social assessment and/or support services to the client and family, when deemed clinically appropriate.	Psycho-social assessment and/or supportive services are available when clinically appropriate.	___	___	___
8316	All direct care staff employed in programs providing detoxification shall be provided basic education in methodology of detoxification treatment, the signs and symptoms of withdrawal, and approved intervention techniques.	All direct care staff have been trained in: a. Detox treatment methodology; b. Signs and symptoms of withdrawal; and c. Approved intervention techniques.	___ ___ ___	___ ___ ___	___ ___ ___

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Standard		Measurement Criteria	YES	NO	N/A
9000	**PREVENTION SERVICES CERTIFICATION PROCEDURES**				
9000	**Applicability**				
	All agencies/organizations that receive Federal Block Grant funds for primary prevention services must receive programmatic certification by the Department of Mental Health/Mental Retardation (DMH/MR), Substance Abuse Services Division (SASD).	Agency programs are operated according to the programmatic certification.	____	____	____
	The following standards apply to all agencies/organizations under contract to the SASD for the provision of primary prevention services.	A contractual agreement exists between provider and SASD.	____	____	____
9001	The Code of Alabama, 1975 § 22-50-1 defines mental health services as the "Diagnosis of, treatment of, rehabilitation for, follow-up care of, prevention of and research into the causes of all forms of mental or emotional illnesses . . ."				____
9002	**Program Approval**				
	(a) A site visit shall be conducted on each agency/organization providing primary prevention services, under a contract with DMH/MR, at intervals not to exceed two years between site visits.	A site visit shall be conducted at least every two years.	____	____	____
	(b) A site visit report, or certificate, as appropriate, shall be mailed to each contracted prevention program within thirty (30) calendar days following an onsite visit by representatives of the DMH/MR to determine program compliance.	Findings are documented to define program compliance.	____	____	____
9003	***Appeal Procedure***				

Standard	Measurement Criteria	YES	NO	N/A

(c) If no deficiencies are found, a certificate of compliance shall be issued within thirty calendar days following the site visit. If deficiencies are found, a site visit report will be sent within thirty calendar days following the site visit stating the deficiencies that were identified. ____

(d) Upon receipt of the site visit report, programs are given thirty calendar days to respond with a written action plan stating how and when the deficiencies noted with the report shall be corrected. ____

9003 Appeal Procedure

(1) Notice of certification action or any specific findings contained in the Site Visit report may be appealed in writing to the Director, Substance Abuse Services Division, *(Associate Commissioner) within 15 working days after the notice of certification action or the Site Visit Report. The written appeal must specify the precise reason(s) for the modification of the Department certification decision or the site visit findings. ____

(2) The Director of the Substance Abuse Division *(Associate Commissioner) must respond in writing to the appeal within 15 working days after receipt, either upholding or revising the initial findings of the certification decision. ____

(3) If the Division Director *(Associate Commissioner) does not find that there is adequate basis to modify the site visit findings of the Department Certification decision, a second appeal may be made in writing to the Commissioner of Mental Health/Mental Retardation within 15 working days after receipt of the written notice of the Director of Substance Abuse Services Division's (Associate Commissioner's) decision. The Commissioner will have 15 working days after receipt of the second level appeal in which to render a decision in writing.

Standard	Measurement Criteria	YES	NO	N/A
(4) Final appeal of the Associate Commissioner's decision must be made in writing to the Commissioner within 15 working days after receipt of the decision. The Commissioner will have 30 working days after receipt of the final appeal in which to schedule a hearing from both parties and render a final decision in writing.				
9004 Duration of Approval				
(1) Upon satisfactorily meeting all regulations, a program shall be issued a certification of compliance. Each certificate of compliance shall remain in effect until:	All standards must be satisfactorily met to meet program compliance.			
(a) A subsequent site visit is conducted; or				
(b) The contract expires and is not renewed. In this event, the program shall return the certificate to DMH/MR.				
9005 Governing Body Authority				
(a) The provider must be a public or private nonprofit corporation.	The entity is a public or private corporation.			
(b) The organization must provide written documentation to the DMH/MR of its source of authority through its articles of incorporation (or charter) and bylaws.	The organization's source of authority is on file or available to DMH/MR.			
(c) The Board of Directors of the corporation, as its governing body, has responsibility and authority for the overall conduct of operations including the treatment and/or prevention programs provided by the organization.	The Board of Directors exercises its responsibility and authority over treatment and/or prevention programs, in compliance with Alabama law.			

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Standard		Measurement Criteria	YES	NO	N/A
9100	**PERSONNEL MANAGEMENT**				
9101	**General Staff**				
9102	The chief executive officer/director of a prevention provider organization shall be a full-time employee possessing: 1. At least a baccalaureate in an administrative or mental health related field with at least three years of progressive managerial experience in either substance abuse treatment or prevention; or 2. Be certified as a Prevention Manager by an independent certification board offering a credential approved by the Substance Abuse Services Division of the State Department of Mental Health/Mental Retardation.	The chief executive officer meets the required criteria.	____	____	____
9103	The financial accounting operations of a service provider organization with a total annual budget exceeding $500,000 shall be supervised by a full time employee or contracted service provider who has the following qualifications: a. At least a bachelor's degree in accounting or business, finance, management, public administration, with accounting courses; b. At least two years accounting experience.	The financial accounting manager meets the required qualification: a. Bachelor's degree. b. Two years experience.	____ ____ ____	____ ____ ____	____ ____ ____
9104	The financial accounting operations of a service provider organization with a total annual budget less than $500,000 shall be supervised by an employee or contracted service who/which has the following qualifications: a. Demonstrated familiarization with Generally Accepted Accounting Principles and; b. At least two (2) years accounting/bookkeeping experience.	Supervision of programs with a total annual budget less than $500,000 meets the required qualifications: a. Is familiar with Generally Accepted Accounting Principles. b. Has 2 years experience.	____ ____ ____	____ ____ ____	____ ____ ____

Standard		Measurement Criteria	YES	NO	N/A
9105	Prevention Staff				
9106	The Prevention Director/Coordinator shall meet any one or more of the following: 1. Have a master's degree in a human services related field and one year experience in the field of substance abuse prevention (may complete one prevention course at a State Alcohol and Drug Studies School within one year of employment in lieu of one years experience); or 2. Be certified as either a Prevention Manager or a Prevention Specialist by an independent certification board offering a credential approved by the Substance Abuse Services Division of the State Department of Mental Health/Mental Retardation; or 3. Have a baccalaureate degree in a human services or related field and two years experience in the field of substance abuse, one of which shall be in prevention.	The Prevention Director/Coordinator meets the required qualifications.	____	____	____
9107	All Prevention Services Providers shall meet any one or more of the following: 1. The same requirements aforementioned; or	The person meets the required qualifications	____	____	____
9108	Be certified as an Associate Prevention Specialist by an independent certification board offering a credential approved by the Substance Abuse Services Division of the State Department of Mental Health/Mental Retardation.	The person conducting prevention programs is certified as an Associate Prevention Specialist.	____	____	____
9109	An individual who does not meet the requirements listed in 580-9-47-.07 may provide prevention services under the following conditions:				

Standard		Measurement Criteria	YES	NO	N/A
9109	a) Be under the direct supervision of a individual meeting the above requirements, and	The person meets the required qualifications and is under direct supervision of a qualified individual.	____	____	____
	b) Be in a structured and documented training program that will lead to meeting the above requirements within one year of employment. (All work performed by such individuals who fail to meet the above requirements within one year of employment are subject to a charge back.)	The person is involved in a structured and documented training program.	____	____	____

Standard	Measurement Criteria	YES	NO	N/A
9200 Continuing Education				
(a) Each prevention professional/service provider shall receive a minimum of 20 contact hours of continuing education training each year. At least six of these contact hours shall be obtained through a state sponsored or approved course.	The prevention provider meets the minimum standard of 20 contact hours.	____	____	____
(b) Each prevention service provider shall be trained in HIV/AIDS education/prevention within 90 days of employment.	The person providing the service has the required specialized training in HIV/AIDS.	____	____	____
(c) Each prevention service provider shall be trained in procedures for managing disruptive behavior within 90 days of employment.	The person providing the service has the required specialized training in Managing Disruptive behavior.	____	____	____
(d) Each prevention service provider shall be trained in Prevention Ethics within 90 days of employment.	The person providing the service has the required course on Prevention Ethics within 90 days of employment.	____	____	____
(e) Documentation of all education/experience qualifications, professional certification, and all continuing education training shall be maintained within a folder for each individual prevention professional/service provider and retained on file by the Prevention Coordinator.	A current file maintaining the documentation for education experience is maintained on file.	____	____	____

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Standard		Measurement Criteria	YES	NO	N/A
9300	**Prevention Records**				
9301	(1) Each prevention activity/occurrence that is provided for reimbursement under contract with the DMH/MR shall be recorded on an activity sheet.	An activity sheet is available to reflect each prevention program.	____	____	____
	(2) Documentation of all prevention services shall be completed by the person who delivers the service.	Person responsible for prevention activity is identified on the activity sheet.	____	____	____
	(2) Documentation shall contain:	Prevention records are supported with the required documentation.	____	____	____
	a. The date and location of each service delivery;	Date and location of prevention activity is recorded.	____	____	____
	b. The topic addressed;	The topic addressed is documented.	____	____	____
	c. Description of activities provided;	A description of activities is documented.	____	____	____
	d. The length of the presentation	The number of hours is documented.	____	____	____
	e. The number of recipients by gender, age, and race;	The clients' gender, age, and race are documented.	____	____	____
	f. The prevention objective code;	Each prevention activity must denote the prevention objective code.	____	____	____
	g. The attendance log or roll; and	Attendance log or roll recorded.	____	____	____
	h. The signature of the person providing the service.	Each prevention activity reflects the signature of person providing service.	____	____	____

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Standard		Measurement Criteria	YES	NO	N/A
9302	Each prevention objective shall have a separate individual folder (or notebook) containing the written objective, documentation of the service delivery, the outcome measurement instrument used, and the outcome evaluation results.	A file reflects the written objective, documentation of the service delivery, outcome measurement used and the outcome evaluation results.	____	____	____
9303	The activity sheets, attendance logs/rolls, and annual outcome summaries shall be maintained for the past three (3) fiscal years,	Documentation shall be maintained for the past three (3) fiscal years.	____	____	____

Standard		Measurement Criteria	YES	NO	N/A
9400	**Participant Protection**				
	The program must report all cases of suspected abuse, neglect, exploitation of clients being served in the program where the alleged perpetrator is an employee, client, or other person in the program to the SASD Associate Commissioner's office in accordance with DMH/MR abuse reporting procedures.	Suspected cases of abuse, neglect, and exploitation of clients are reported as required.	___	___	___
	Suspected cases of abuse and neglect will be reported to the local DHR office in accordance with applicable state law.	Suspected cases of abuse, neglect, and exploitation of clients are reported as required.	___	___	___
9500	**Quality Assurance Program**		___	___	___
	A service provider organization shall have in place a quality assurance plan in which a designated person is responsible for the periodic review of all documentation related to staff qualifications and service provision.	A prevention review is conducted as required.			
		The review includes periodic review of staff qualifications.	___	___	___
		The review includes periodic review of service provision.	___	___	___
9501	As a result of the review, any problems identified, action taken, and follow-up shall be documented and communicated through organized discussion with all concerned staff.	The review is documented and communicated to all concerned staff.	___	___	___
9600	**Prevention Plan**				
	Each DMH/MR contracted prevention service provider shall develop and maintain a comprehensive prevention plan. This plan shall set forth the agency's prevention philosophy and outline all prevention services provided by the organization. This plan should state the amount and type of prevention services that are being provided to each county within its catchment area and shall be updated annually. This plan shall be in conformance with the State and Region plan.	A comprehensive prevention plan is documented.	___	___	___

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Standard		Measurement Criteria	YES	NO	N/A
9700	**Prevention Reporting** At the end of each fiscal year each prevention organization shall submit to the DMH/MR within sixty days a detailed evaluation report outlining the outcome results of each prevention objective. This report shall list the total number of recipients for each objective broken down by age range, gender, and race; a copy of the type(s) of measurement used; what was being measured; size of the sample(s); and the outcome evaluation results.	An end of the year report shall reflect the required documentation.			
9800	**Request for Proposal** All prevention objectives shall conform to the guidelines as outlined within each annual Request for Proposal (RFP) and shall be in accordance with the state and regional plan.	Prevention objectives contain the required guidelines.			
9900	**Waiver Requests** All requests for waivers must be submitted in writing to the DMH/MR Director. The DMH/MR Director shall review this request then render a written decision to the program within 30 days. Services delivered during the same period shall be reimbursed provided they are not otherwise in violation of these standards or laws.	Waiver Requests must be in writing in accordance with time guidelines.			

Goal #5
Attachment #2

Alabama Department of Mental Health

SUBSTANCE ABUSE SERVICES DIVISION

Contract and SAPT Block Grant

Program Compliance Monitoring Survey

	Priority Populations: 45 CFR 96.131	Yes	No	N/A	Comments
1.	The program gives preference in admission to individuals with substance use disorders in the following priority:				
	a. Pregnant individuals with intravenous (IV) substance use disorders.				
	b. Pregnant individuals with substance use disorders.				
	c. All other individuals with IV substance use disorders.				
	d. Women with substance use disorders and dependent children.				
	e. All other individuals with substance use disorders.				
2.	The program provides written documentation of its compliance with this section.				

Findings/Corrective Action:

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Priority Populations: 45 CFR 96.131

Findings/Corrective Action:

Set Aside for Pregnant Women and Women with Dependent Children: 45 CFR 96.124			Yes	No	N/A	Comments
3.	The program provides services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children.					
4.	The program treats the family as a unit and therefore admits both women and their children into treatment services, if appropriate.					
5.	The program provides or arranges for:					
	a.	Primary medical care for women, including prenatal care.				
	b.	Child care while the women are receiving services.				
	c.	Primary pediatric care for the women's children, including immunizations.				
	d.	Gender specific treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting.				
	e.	Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual/physical abuse, and neglect.				
	f.	Sufficient case management and transportation to ensure that women and their children have access to services needed during the course of treatment.				
6.	The program provides written documentation of its compliance with this section.					

Findings/Corrective Action:

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Set Aside for Pregnant Women and Women with Dependent Children: 45 CFR 96.124
Findings/Corrective Action:

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Intravenous Substance Abuse: 45 CFR 96.126			Yes	No	N/A	Comments
7.	The program provides treatment and related therapeutic services to individuals who are IV substance abusers.					
8.	No later than 7 days after reaching 90% of its capacity to admit individuals, the program notifies the Substance Abuse Services Division of that fact.					
9.	Each individual who requests and is in need of treatment for IV drug use is admitted not later than:					
	a.	14 days after making the request for admission; or				
	b.	120 days after the date of the request for admission if no such program has the capacity to admit at the time of the initial request; and				
	c.	Interim services are provided not later than 48 hours after the initial request for admission.				
10.	The program provides interim services that include:					
	a.	Counseling and education about HIV and Tuberculosis, including:				
		i. Risks of needle sharing;				
		ii. Risks of transmission to sexual partners and infants; and				
		iii. Steps that can be taken to ensure that HIV and Tuberculosis transmission does not occur.				
	b.	Referral for HIV or Tuberculosis treatment services if necessary.				
	c.	In addition to "a." and "b." above, interim services for pregnant intravenous substance abusers shall include:				

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		i.	Counseling on the effects of alcohol and drug use on the fetus; and				
		ii.	Referral for pre-natal care.				
11.	The program has established a formal waiting list process that includes:						
	a.	A unique identifier for:					
		i.	Each injecting drug abuser seeking treatment.				
		ii.	Each injecting drug abuser receiving interim services while awaiting admission to treatment.				
	b.	Implementation of written procedures for maintaining contact with individuals awaiting admission for IV drug treatment.					
	c.	Implementation of written procedures for submission of data to and utilization of the capacity management functions of ASAIS to admit clients into treatment for IV drug use:					
		i.	Within a reasonable geographic area.				
		ii.	At the earliest possible time.				
	d.	Implementation of written procedures to ensure that clients actively awaiting treatment admission remain on the program's waiting list unless:					
		i.	The person cannot be located for admission into treatment when a slot becomes available.				
		ii.	The person refuses treatment.				
		iii.	The person requests to be removed from the waiting list.				

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12.	The program carries out formal activities to encourage individuals in need of IV drug use treatment to undergo such treatment, that consist of:						
	a.	Scientifically sound outreach models; or					
	b.	An approach which reasonably can be expected to be an effective outreach model.					
	c.	Implementation of written policies and procedures that include a process for:					
		i.	Selecting, training, and supervising outreach workers.				
		ii.	Contacting, communicating and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality and privacy requirements, including 42 CFR Part 2, and 45 CFR parts 160 and 164.				
		iii.	Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV.				
		iv.	Recommending steps that can be taken to ensure that HIV transmission does not occur.				
		v.	Encouraging entry into treatment.				
13.	The program provides written documentation of its compliance with this section.						

Findings/Corrective Action:

Intravenous Substance Abuse: 45 CFR 96.126

Findings/Corrective Action:

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	Tuberculosis Services: 45 CFR 96.127	Yes	No	N/A	Comments
14.	The program implements written policies and procedures developed in cooperation with the state or local Department of Public Health and in compliance with rules established by the Substance Abuse Services Division of the Alabama Department of Mental Health for the provision of tuberculosis services.				
15.	The program directly or through arrangements with other public or nonprofit entities, routinely makes available the following tuberculosis services to each individual receiving treatment for substance abuse:				
	a. Counseling the individual with respect to tuberculosis.				
	b. Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual.				
	c. Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.				
16.	The program has implemented infection control procedures that are consistent with standards established by the Alabama Department of Mental Health to prevent the transmission of tuberculosis and that address:				
	a. Screening clients.				
	b. Identification of those individuals who are at high risk of becoming infected.				
	c. Meeting all State reporting requirements, while adhering to Federal and State confidentiality requirements, including 42 CFR Part 2, and 45 CFR parts 160 and 164.				
	d. Case management to ensure that individuals receive all tuberculosis services described herein.				
17.	For individuals who are denied admission to treatment due to a lack of the program's capacity, the program refers the individual to another provider of tuberculosis services.				
18.	The program provides written documentation of compliance with this section.				

Findings/Corrective Action:

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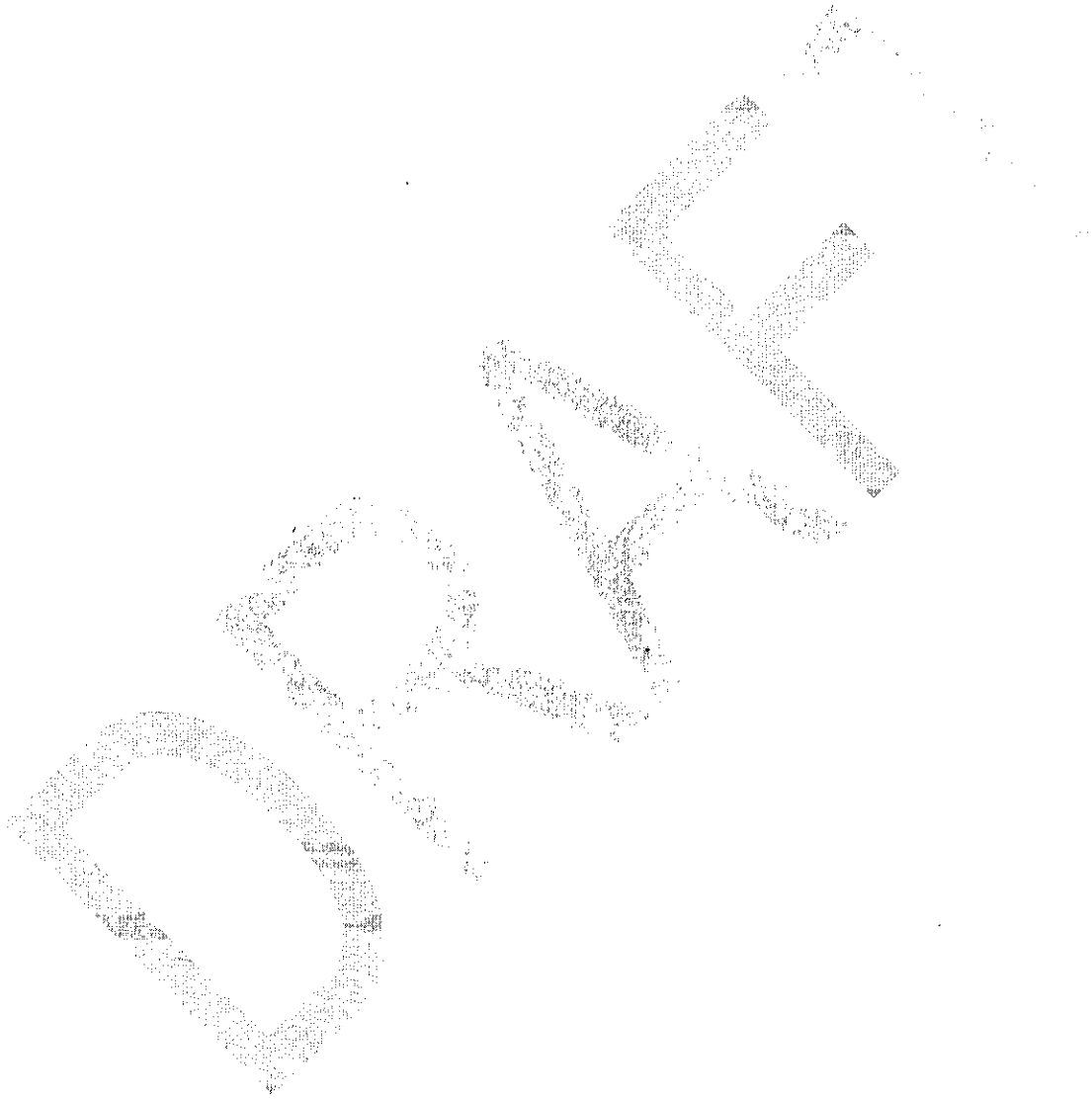
Tuberculosis Services: 45 CFR 96.127
Findings/Corrective Action:



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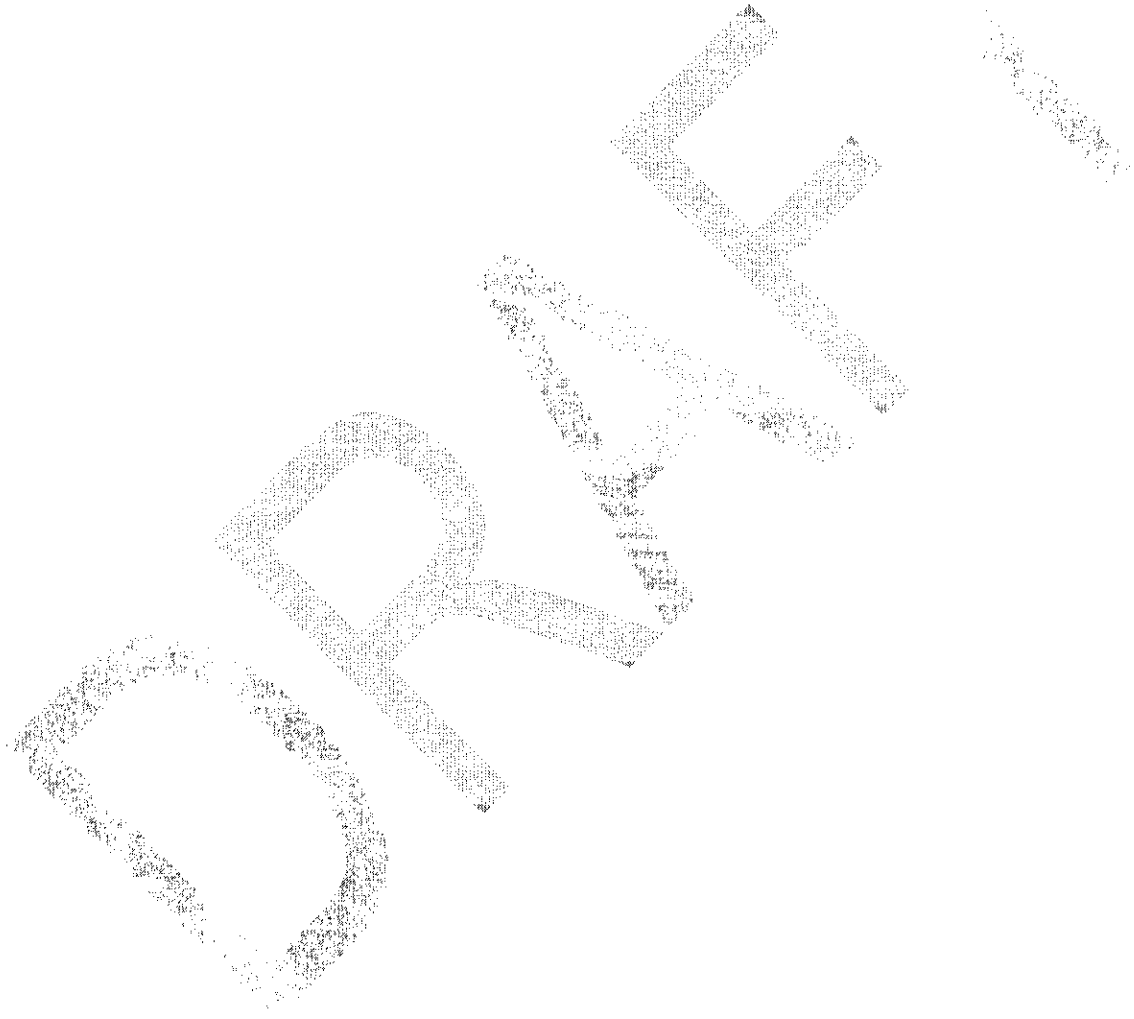
HIV Services: 45 CFR 96.128				Yes	No	N/A	Comments
19.	The program makes available early intervention services for HIV disease to individuals undergoing treatment for substance abuse at the sites where individuals are undergoing such treatment, including						
	a.	Appropriate pre-test counseling for HIV and AIDS.					
	b.	Tests for individuals with respect to such disease, including tests to:					
		i.	Confirm the presence of the disease.				
		ii.	Diagnose the extent of the deficiency in the immune system.				
		iii.	Provide information on preventing and treating deterioration of the immune system.				
		iv.	Provide information on appropriate therapeutic measures for preventing and treating conditions arising from the disease.				
	c.	Appropriate post-test counseling.					
	d.	Appropriate therapeutic measures for preventing and treating deterioration of the immune system, and for preventing and treating conditions arising from the disease.					
	e.	Case management to ensure that individuals receive all HIV services described in this section.					
20.	The program has linkages with a comprehensive community resource network of HIV/AIDS related health and social services organizations to ensure a wide-based knowledge of the availability of the program's HIV early intervention services and to facilitate referrals.						
21.	The program follows all procedures established by the Alabama Department of Mental Health, in cooperation with the Alabama Department of Public Health Communicable Disease Officer, in regard to the provision of HIV early intervention services.						
22.	The program implements written policies and procedures to ensure that :						
	a.	HIV early intervention services will be undertaken voluntarily by, and with the informed consent of, the individual.					
	b.	Undergoing such services will not be required as a condition of receiving treatment for substance abuse or any other services.					
23.	The program provides written documentation of compliance with this section.						

HIV Services: 45 CFR 96.128
Findings/Corrective Action:



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Treatment Services for Pregnant Women: 45 CFR 96.131			Yes	No	N/A	Comments
24.	The program publicizes the availability of treatment services for women and the fact that pregnant women receive preference for admission.					
25.	The program utilizes the following mechanisms to publicize admission preference for pregnant women:					
	a.	Street outreach programs.				
	b.	Ongoing radio public service announcements.				
	c.	Ongoing television public service announcements.				
	d.	Regular advertisements in local/regional print media.				
	e.	Posters placed in targeted areas.				
	f.	Frequent notification of availability of such treatment distributed to a network of community-based organizations, healthcare providers, and social service agencies.				
26.	When the program has insufficient capacity to provide treatment services for a pregnant woman who seeks services from the facility, the program refers the woman to the State, the Substance Abuse Services Division of the Alabama Department of Mental Health, for referral to another appropriate treatment facility.					
27.	When the State determines no treatment facility has the capacity to admit a pregnant woman, the program makes available interim services within forty-eight hours of the woman's request for care.					
28.	The program submits data to and utilizes ASAIS' functionality, as required to support proper functioning of the state's capacity management program and to ensure that pregnant women receive priority treatment and referral services as appropriate.					
29.	The program provides written documentation of compliance with this section.					

Findings/Corrective Action:

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Treatment Services for Pregnant Women: 45 CFR 96.131
Findings/Corrective Action:

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Additional SAPTBG Requirements: 45 CFR 96.132				Yes	No	N/A	Comments
30.	The program has developed and implements a formal admissions waiting list system.						
	a.	The program utilizes the capacity management functions of ASAIS, as required by the Substance Abuse Services Division (SASD) of the Alabama Department of Mental Health, for maintenance of an admissions waiting list.					
		i.	Clients are enrolled in ASAIS as prescribed by SASD.				
		ii.	Client admission records are established in ASAIS as prescribed by SASD.				
		iii.	Referrals for admission/continued care are made to other providers through ASAIS utilizing SASD prescribed protocol.				
		iv.	Client referral/transfer records are established in ASAIS as prescribed by SASD.				
		v.	Client discharge records are established in ASAIS as prescribed by SASD.				
		vi.	Referrals received through ASAIS are managed by the program as prescribed by SASD and are either accepted for or denied placement on the program's waiting list.				
	b.	The program prioritizes individuals on the admissions waiting list as according to SASD established propriety populations.					
	c.	The program has a developed and implements a formal process for maintaining contact with individuals placed on the waiting list.					
	d.	The program provides interim services for clients on the waiting list.					
31.	The program provides continuing education for employees as according to rules established by SASD.						
32.	The program coordinates the provision of treatment services with the provision of other appropriate services, including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services.						
33.	The program has in effect a system to protect client records from inappropriate disclosure that is in compliance with all applicable State and Federal laws and regulations, including 45 CFR Parts 160 and 164 and 42 CFR Part 2.						
	a.	The program provides employee education on confidentiality requirements.					

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	b.	The program provides for employee disciplinary action upon inappropriate disclosure of client information.				
34.		The program provides written documentation of compliance with this section.				

Comments/Corrective Action:

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	Restrictions on Expenditures of the SAPT Block Grant: 45 CFR 96.135			Yes	No	N/A	Comments
35.	The program does not expend SAPT Block Grant funds on the following activities:						
	a.	To make cash payments to intended recipients of health services.					
	b.	To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.					
	c.	To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.					
	d.	To provide financial assistance to any entity other than a public or nonprofit entity.					
	e.	To provide individuals with hypodermic needles or syringes.					
	f.	To provide treatment services in penal or correctional institutions of the State.					
	g.	To provide inpatient hospital services, except when the service has been determined to be medically necessary and when it has been determined by a physician that:					
		i.	The primary diagnosis of the individual is substance abuse, and the physician certifies this fact.				
		ii.	The individual cannot be safely treated in a community-based, nonhospital, residential treatment program.				
		iii.	The service can reasonably be expected to improve an individual's condition or level of functioning.				
		iv.	The hospital-based substance abuse program follows national standards of substance abuse professional practice.				
36.	In the case of an individual for whom a grant is expended to provide inpatient hospital services, the daily rate provided by the program to the hospital does not exceed the comparable daily rate provided for community-based, nonhospital, residential programs for substance abuse.						
37.	The program provides written documentation of compliance with this section.						
Findings/Corrective Action:							

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Restrictions on Expenditures of the SAPT Block Grant: 45 CFR 96.135
Findings/Corrective Action:

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Payment Schedule: 45 CFR 96.137				Yes	No	N/A	Comments
38.	The program has established the SAPT Block Grant as payment of last resort for the provision of treatment services.						
39.	The program expends SAPT Block Grant funds to provide services, including services for pregnant women and women with dependent children, Tuberculosis services, and HIV services, for individuals who have no other financial means of obtaining such services.						
40.	The program has established:						
	a.	A process for determining client eligibility for available payment resources, including the SAPT Block Grant.					
	b.	Client billing and collections procedures which enable collections for the cost of providing services from:					
		i.	Private insurers.				
		ii.	Insurance under the Social Security Act, including programs under Title XVIII and Title XIX.				
		iii.	Any State compensation program.				
		iv.	Any other public assistance program for medical assistance.				
		v.	Grants.				
		vi.	Donations.				
		vii.	Clients in accordance with their ability to pay.				
	c.	A client fee schedule that provides for discount fees to be charged to clients, based upon the income of the client and the number of other persons who are dependent upon the client for support.					
	d.	A process describing access to care for individuals who cannot pay fees assessed by the program.					
41.	The program does not refuse services to clients due to their inability to pay a service fee, to the extent that other resources are available for payment.						
42.	The program does not bill multiple payment sources for the same client service procedure.						

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43.	The program provides written documentation of compliance with this section.				

Findings/Corrective Action:

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	Other Requirements	Yes	No	N/A	Comments
44.	The program provides unimpeded access to clients by Department of Mental Health advocates.				
45.	The program verifies U. S. citizenship for all clients for whom services are billed to the Alabama Department of Mental Health.				
46.	HIV risk education is provided to each client.				
47.	The program admits clients with co-occurring disorders who are appropriately stabilized on medication. (PROGRAM SPECIFIC)				
48.	The program provides vocational assistance and housing support. (CORRECTIONAL PROGRAMS)				
49.	The program provides written documentation of compliance with this section.				

Comments/Corrective Action:

May 26, 2009

Bob,

The survey is a very important component of the program compliance monitoring process. However, it is just one step in the process.

I realize that you and your staff have had several meetings to discuss program monitoring, and perhaps have already addressed the issues I will put forth below. If so, please provide me with copies of the policies and procedures you have developed to date. If not, you must develop such policies and procedures before you can begin the monitoring process. The following issues, among those of you and your staff, should be considered:

1. The Block grant requires that we develop specific strategies for monitoring program compliance, and be able to identify compliance problems and corrective actions to be taken to address identified problems. What will happen when we identify problems? What will be the next steps? What happens if a program can't or won't take corrective action? Who will be responsible for what actions during each step of this process? What time frames will be involved?
2. In regard to the survey, what specific onsite documentation will be required to verify the "yes," "no," and "n/a" answers for each section? Will the monitoring process include staff and/or client interviews?
3. How will the providers be notified of the reviews? Will they take place during the same time as certification site visits?
4. Who will conduct the reviews? How will this be determined?
5. How will it be determined which programs treat IV dug users and thus should comply with the related block grant requirements?
6. Who will be taking the calls, monitoring capacity, etc. in our office from providers in regard to IV drug users and pregnant women?
7. How often will monitoring visits take place?
8. Are there other forms that need to be developed? For example, most states require an annual compliance report as part of the monitoring process. Should there be forms for notifying providers of visits, forms for providers' response to findings, etc.
9. The survey did not contain any information relative to "indigent offenders" which is a contractual issue. Perhaps this area should be revisited.

Sarah

Goal #9
Attachment #1

Alabama
department of mental health & mental retardation

Management Information Systems

Provider Training Manual
ASAIS

01/27/2009

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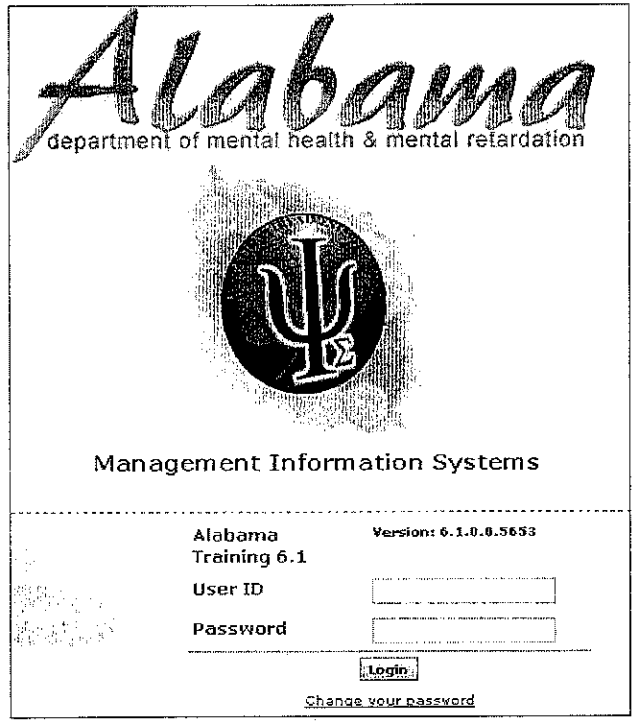
ASAIS Basics

Welcome to the Alabama Department of Mental Health and Mental Retardation claims and client management system.

The ASAIS application only works using Internet Explorer. Your PC may need to be configured by your IT department to allow ASAIS and all its functionality to work properly.

The ASAIS application knows who you are based upon your assigned User ID. What you can see and do in ASAIS is determined by a pre-determined security level: your view of ASAIS screens may differ from those shown in this manual.

Any issues that you encounter during your use of ASAIS should be reported to your group's system administrator or IT department.



Pop-Up Blockers

The ASAIS application uses pop-up windows to present information to users. It is important to set up your Internet Explorer to allow these.

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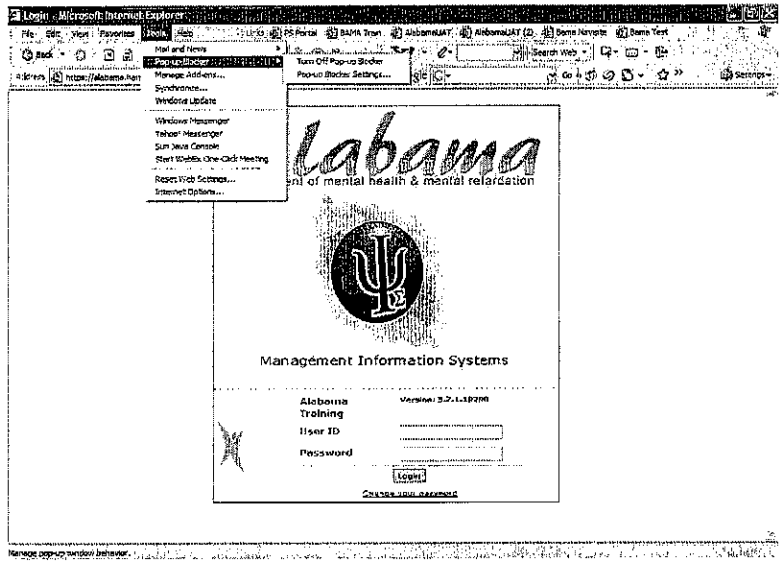
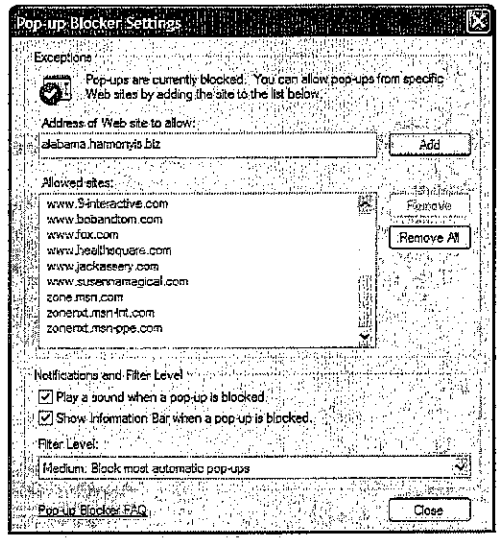
1. Go to the Tools menu in Internet Explorer
2. Mouse over "Pop-up Blocker"
3. Select "Pop-up Blocker Settings"



4. In the *Address of Web site to allow* field, type alabama.harmonyis.biz
5. Click the *Add* button.
6. Click the *Close* button.



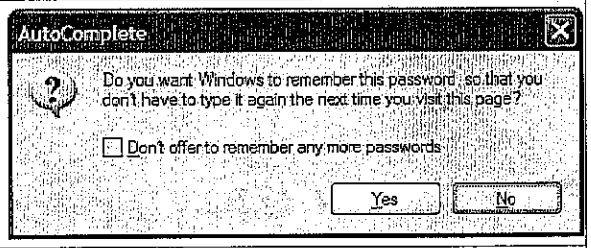
If you use any other type of pop-up blocker (Yahoo, Google, etc.), follow their instructions to permit the alabama.harmonyis.biz site to use pop-up windows.

The ASAIS Sign In Page

Signing In To ASAIS – For Training

CAUTION

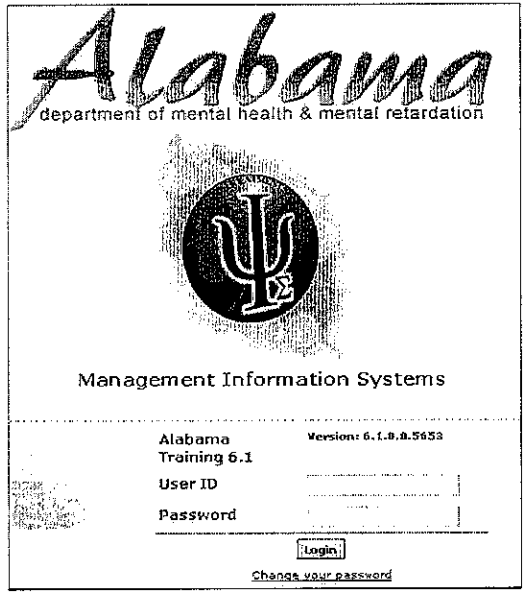
The first time you log in to *ASAIS,* you may receive the following message:



It is important that you respond "No" to this message. Otherwise, it is possible that an unauthorized person could access *ASAIS* and view confidential client information by simply guessing your User ID.

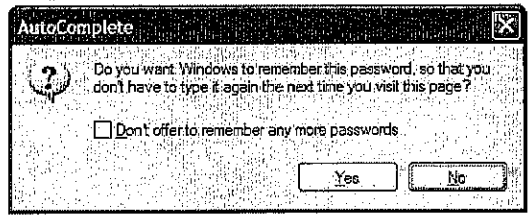
1. Open your Internet Explorer
2. Type the address to the right to navigate to ASAIS. (*This is the URL for Training purposes.*)
3. Sign on with *Username* and *Password* that your trainer has provided to you. (password is same as username). (Passwords are case sensitive, User ID's are not.)
4. Click on the *Login* button (or press Enter).
5. Press F11 on keyboard to clear Explorer menus

https://demo.harmonyis.biz/AlabamaTraining/



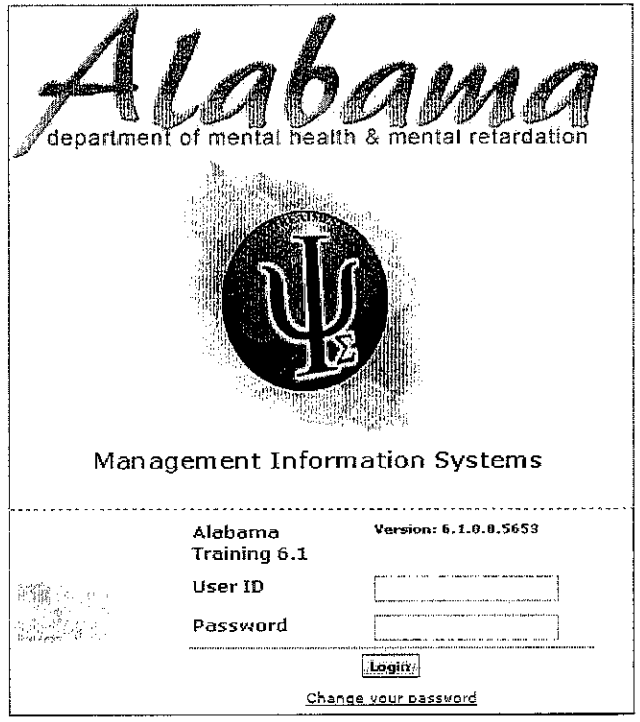
Signing In To ASAIS – in the Live (Production) Environment

CAUTION
The first time you log in to ASAIS, you may receive the following message: It is important that you respond "No" to this message. Otherwise, it is possible that an unauthorized person could access ASAIS and view confidential client information by simply guessing your User ID.



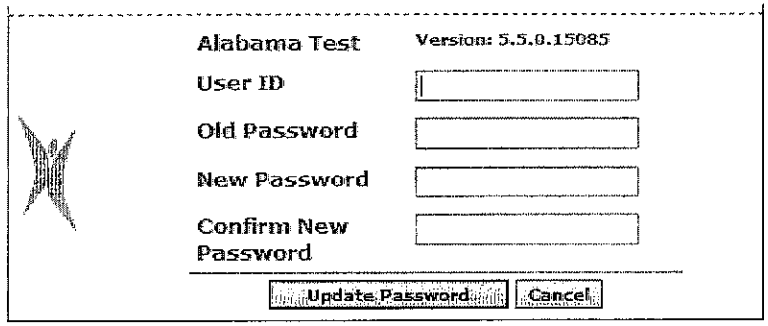
1. Open your Internet Explorer
2. Type the address to the right to navigate to ASAIS. (*This is the URL for LIVE.*)
3. Sign on with *Username* and *Password* that has been sent to you from a System Administrator for ASAIS. (Passwords are case sensitive, User ID's are not.) You must complete training and a user account request form in order to receive the log on information.
4. Click on the *Login* button (or press Enter).
5. ASAIS may force you to change your password at this point. Instructions on what needs to be in a password are in the information from the System Administrator.

https://alabama.harmonyis.biz/AlabamaLive



Changing Your Password

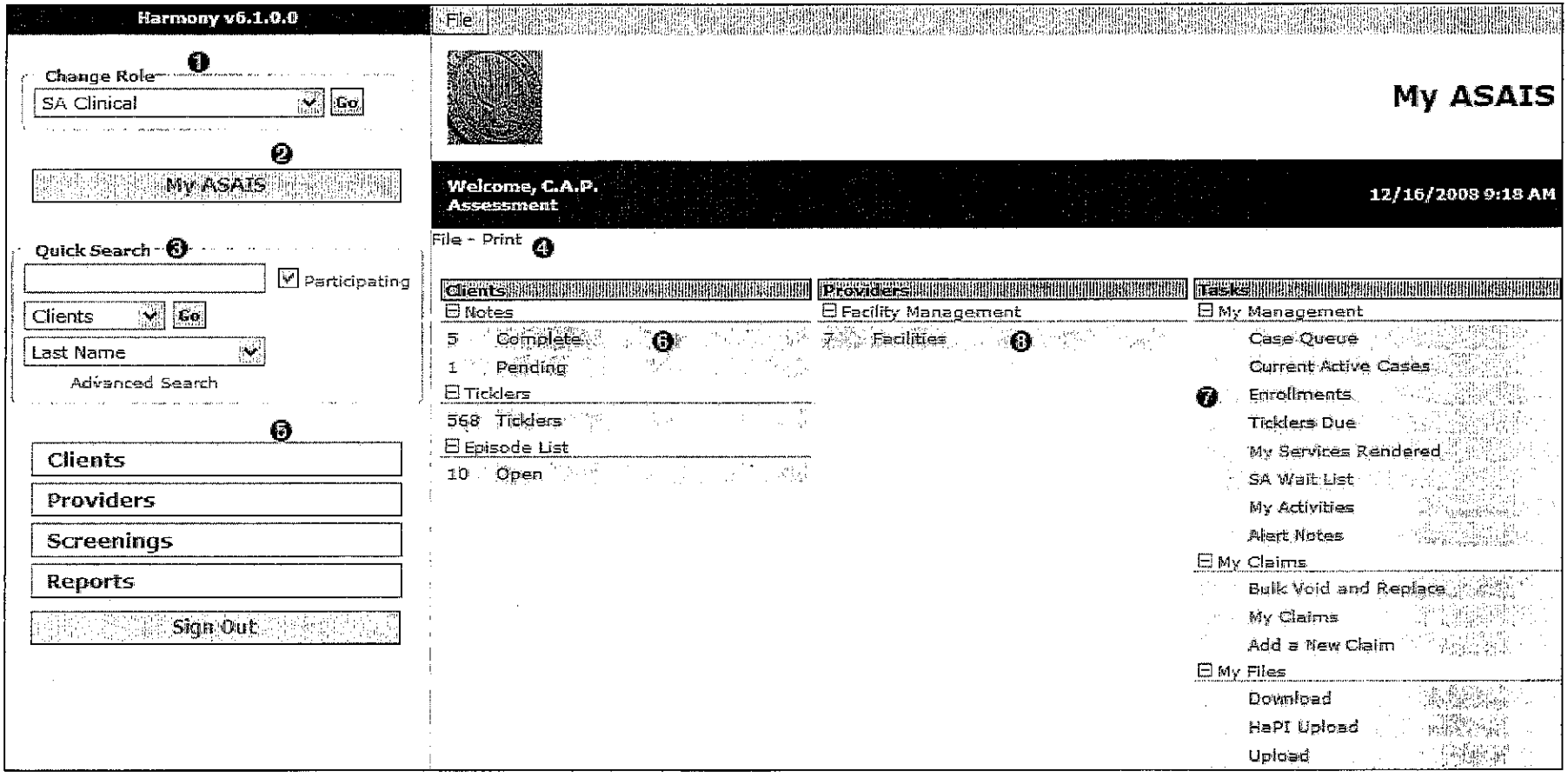
1. Click on the *Change Your Password* link.
2. Enter your *User Name* (User ID), *Old Password,* and *New Password.*
3. Click on the *Update Password* button. ASAIS will tell you that your password has been changed.
4. Click *OK.*
5. Sign in with your new password.



Note: ***Each ASAIS user must have his or her own logon (user name and password). The system tracks who enters/edits information. Be sure that you are logged on as yourself and not using someone else's user name. If your agency needs more users, please contact SASD to set this up.***

My ASAIS Page

Navigating the My ASAIS Page



The Main Menu screen in *ASAIS* is called **My ASAIS**. The My ASAIS screen presents the user with up-to-the-minute links to all-

important elements of their personal *ASAIS* usage. The *My ASAIS* link located at the top of the left-hand menu is always available, allowing the user to quickly return to the My ASAIS screen. Your screen may look slightly different depending on your access level.	
1. Role	Displays the role under which you are currently viewing ASAIS.
2. My ASAIS	Clicking on **My ASAIS** at any time will bring you back to this page. Clicking on **My ASAIS** will also refresh the data listed on the page.
3. Search	Use the **Quick Search** to find Clients, Providers or Claims.
	• Clients can be searched for by ASAIS ID, Last Name, SSN, DOB, or Medicaid ID.
	• Providers can be searched for by Provider Name and Provider Number (you only have access to your provider record).
	• Screenings can be searched for by Current Member ID, Provider Number, Agency, Consumer Name (Last Name, First Name) or Data Entry Date.
	• ASAIS will return a list of all possible matches. Open the desired record by clicking on it in the list. If there is only one match, ASAIS will take you directly to that record.
	• You may also enter just the first few letters of a Client or Provider.
	• Use **Advanced Search** to find clients with a more common name. Use the filter to enter Last Name, First Name or other additional fields to narrow down the selection.
4. ASAIS Menu Bar	The **ASAIS Menu Bar** contains various tools that allow you to perform many tasks, such as adding new records, editing records, or printing a Report. The tools that are available depend upon which page the user is currently viewing.
5. Chapters	**Chapters** are links to different areas of ASAIS. The Chapters that a User may see and access are dependent upon their assigned security level.
6. Clients	The **Clients** section in My ASAIS provides quick links to information concerning clients and tasks assigned to the User. Each section has sub-sections.

7. Tasks	The **Tasks** section provides quick links to tasks and reports. The sections are described below:
• My Management	**My Management** provides supervisors with access to information regarding the cases of their direct reports:
	• **SA Wait List** – used to review and act on clients assigned to the SA Wait List
	• **Ticklers Due** – displays a list, by worker, of all incomplete ticklers
• My Claims	You may have access to **My Claims** if your role requires it.
	• **Bulk Void and Replace**
	• **Add a New Claim** – opens an add new claims screen
	• **My Claims**
• My Files	You may have access to **My Files** if your role requires it. My Files provides links to file import and export tools:
	• **HaPI Upload**
	• **Upload**
	• **Download**
8. Providers	The **Providers** section gives you easy access to Facility Management. Clicking on this will show all facilities and their current capacity and enrollment levels.
Signing Out	
Sign Out	You may log out at any time by selecting **Sign Out.** It is important that you use the **Sign Out** link versus the Internet Explorer controls to ensure that information is properly saved before exiting.

List Views and Search Filters

List View Screens

In various areas of ASAIS, records may appear on a List View screen. The List View screens limit the number of records returned at one time.

List View screens allow a user to quickly review a list to retrieve the desired record. If the desired record does not appear on the initial list view, users can click on one of the following buttons to scroll through the records:

<< First – This button will call the list view containing the first record.

< Previous – This button will call the previous list view.

Next > – This button will call the next list view.

Last >> – This button will call the list view containing the last record.

Users can also modify the number of records returned in the list view by entering the desired number in the "Retrieve [ ] records at a time" field and clicking on one of the record search buttons (i.e., First, Previous, Next, Last).

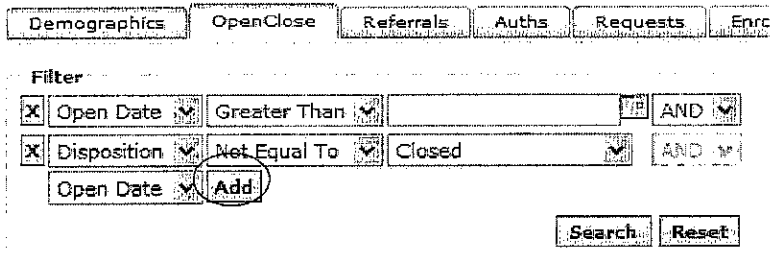
Tip

By clicking the column header (green header) in a list view, you can sort the records in ascending order. By clicking the column header a second time, you can sort the records in descending order.

Search Filters

Several List View screens allow users to search using multiple filters of their choosing.

Users can add additional filters by selecting the desired parameter from the bottom dropdown list and then clicking on the Add button.



Each of these filters allow the user to select from the following comparison search criteria:

- Equal To

- Begins With
- Ends With
- Not Equal To
- Greater Than
- Less Than

In addition, users can search on these filters using Boolean logic (AND or OR).

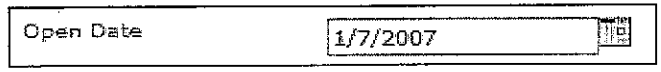
To remove a filter, click the  to the left of the filter criteria.

Miscellaneous ASAIS Features

Date Fields

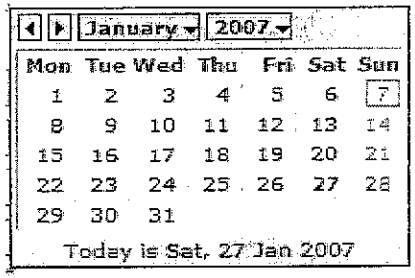
Wherever a date field appears in ASAIS, users have 2 options:

1. Click on the text box and enter the date (simply type the numbers – *mmddyyyy* - ASAIS will format the date with /'s) You must use all 4 digits to enter a year.



OR

2. Click on the calendar icon. Use the arrows to navigate through the calendar. Then click on the desired date to select it. (The current date is always highlighted in red.)



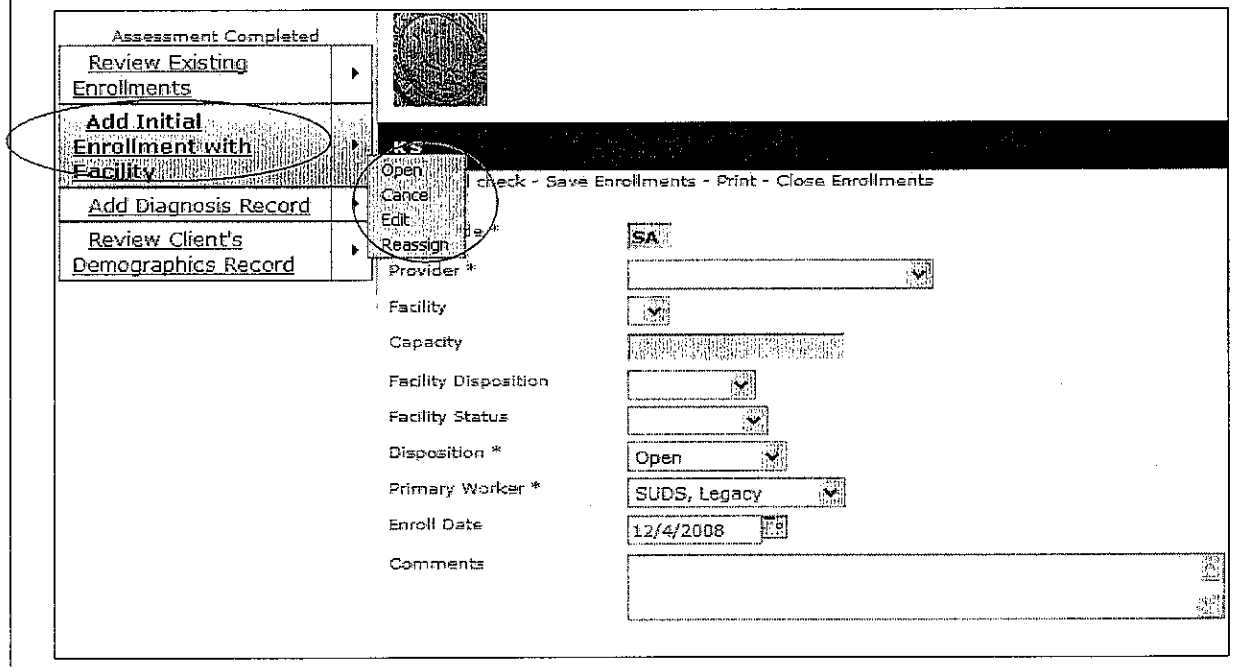
Workflow Wizards

Throughout ***ASAIS,*** Workflow Wizards (WFW's) are initiated by specific events to guide you through the tasks required at that time. Specific actions, screens (e.g., Enrollments, Diagnosis, etc.), and assessments (data collection forms like SA Profile) may be presented to you for completion.

Users can open a task in the list by clicking on its link or by using the fly-out menu.

Once a task is completed, it is struck off the list.

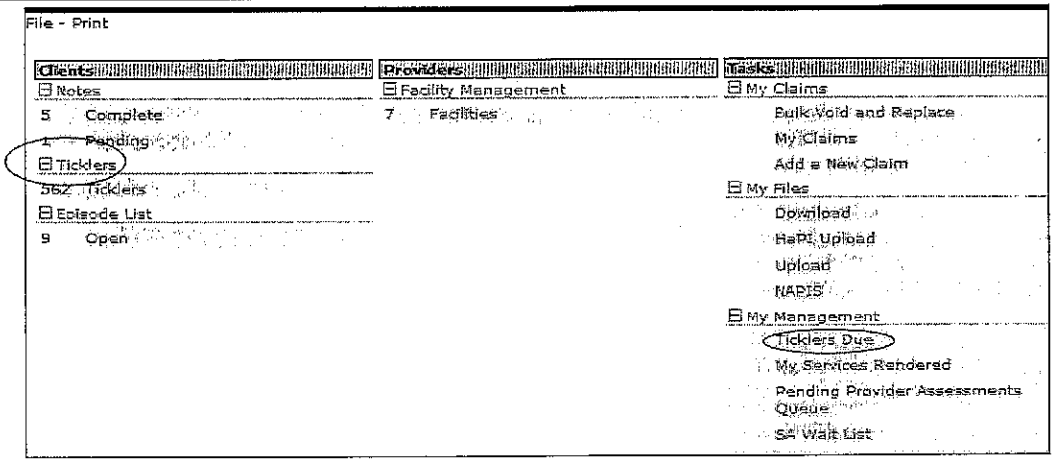
If the items are not completed at that time, Ticklers are created to remind users that the tasks remain outstanding.



Ticklers can be accessed in the following

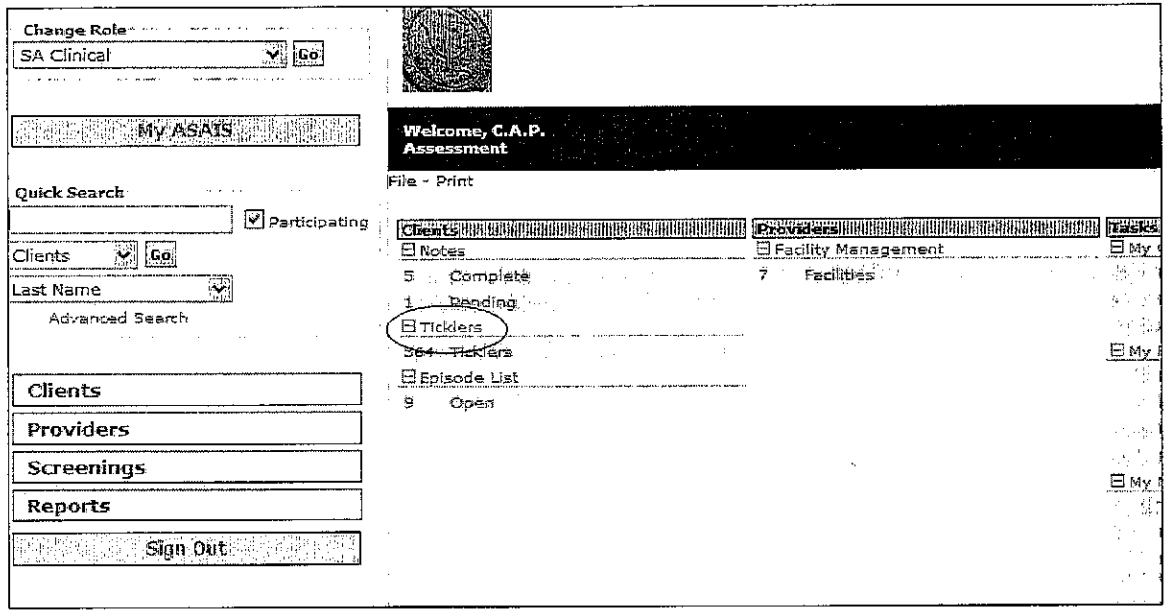
locations:

My ASAIS page



- **Clients>Ticklers –**

  Clicking on the link,

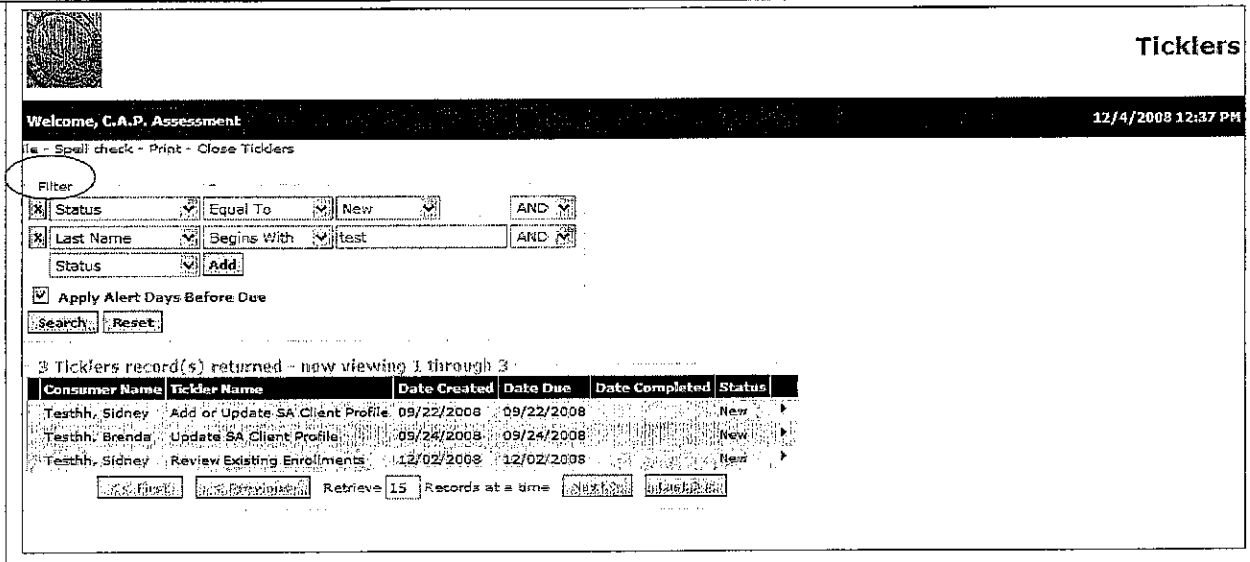


opens a list of the worker's pending or overdue ticklers.

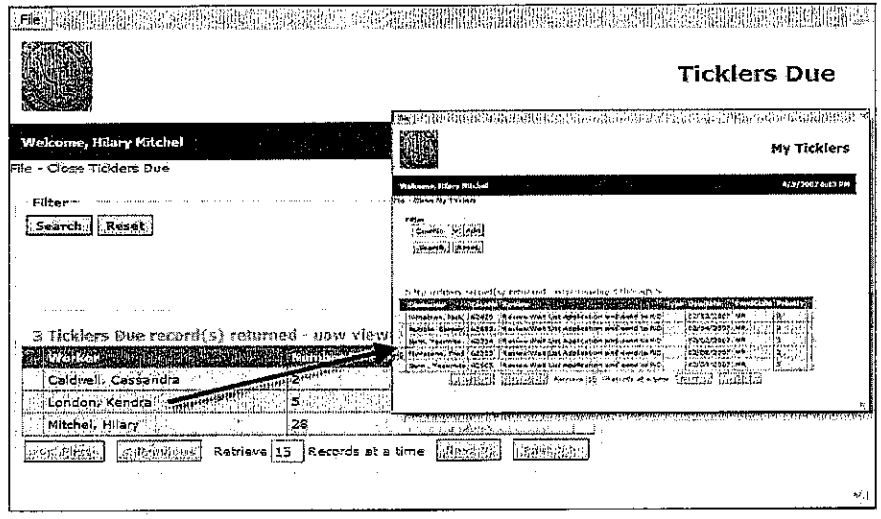
The Filter works like all other filters in the ASAIS and may be used to narrow down the list of ticklers by:

- Status
- Tickler Name
- Date created
- Last Name (*used in the example*)
- First Name
- Date Due
- Date Completed

This feature allows flexibility for the user and the ability to focus on the most critical ticklers.

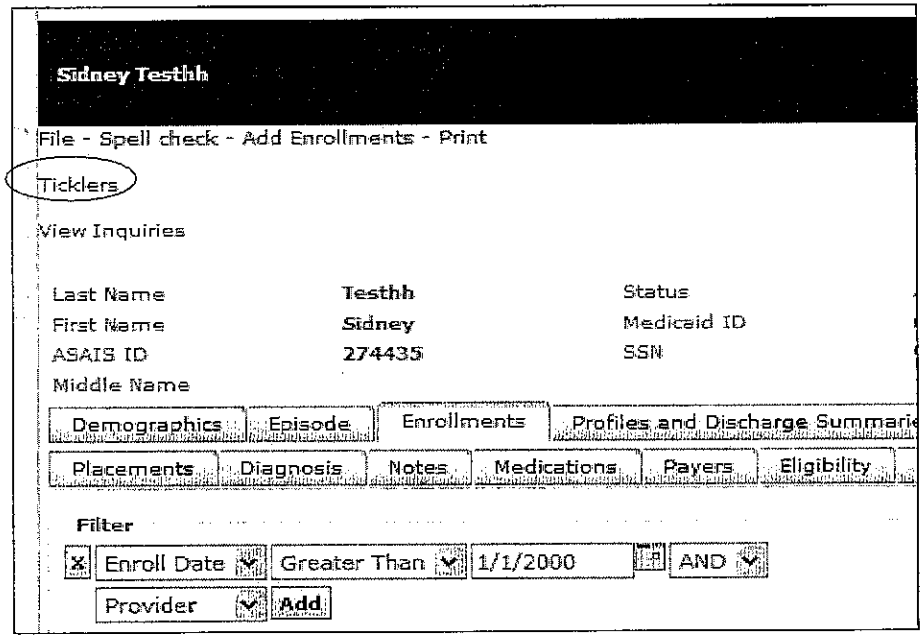


- **Tasks>My Management>Ticklers Due** - provides a list of incomplete tasks or ticklers by workers; clicking on a worker's name open a list of their ticklers; each task can then be reviewed or acted upon by clicking upon its link. This is especially useful for supervisors.

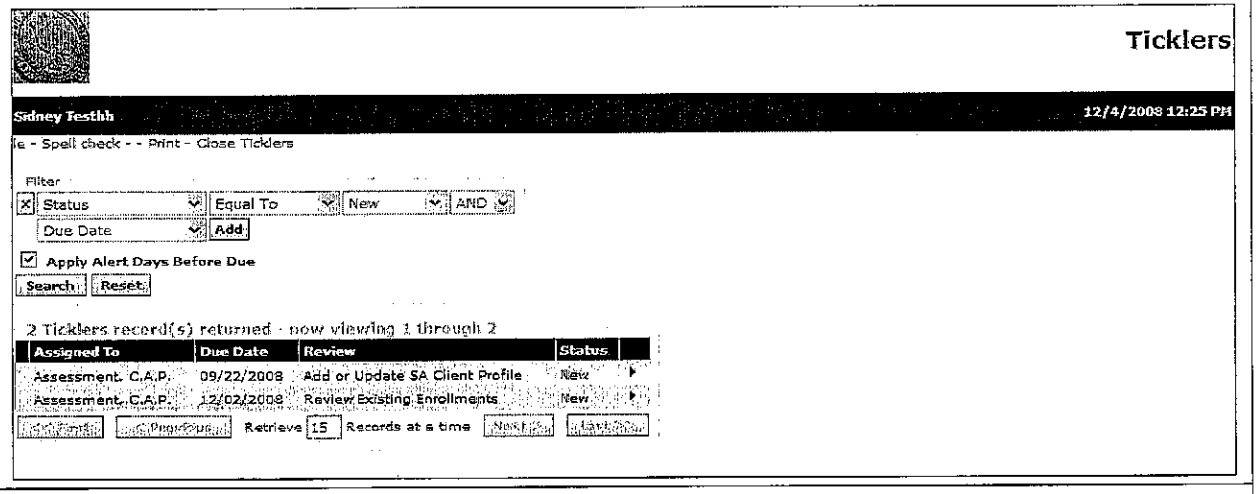


- **Client's record>Ticklers –**

  Click on the Ticklers link in the client's record,

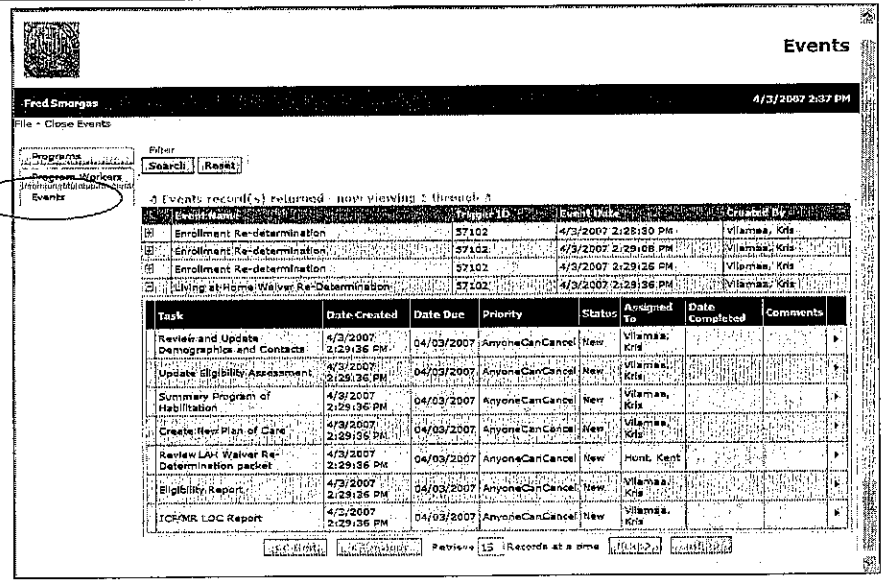


and you will get a list of ticklers just for this client.



To re-open a wizard:

1. Go to the event that prompted it (i.e. Enrollments tab then the Events button on the left) and open the record.
2. Click on the + sign to the left of the event to view the individual tasks.
3. Clicking on an item will re-open the WFW with the outstanding tasks.



ASAIS Provider Work Flow

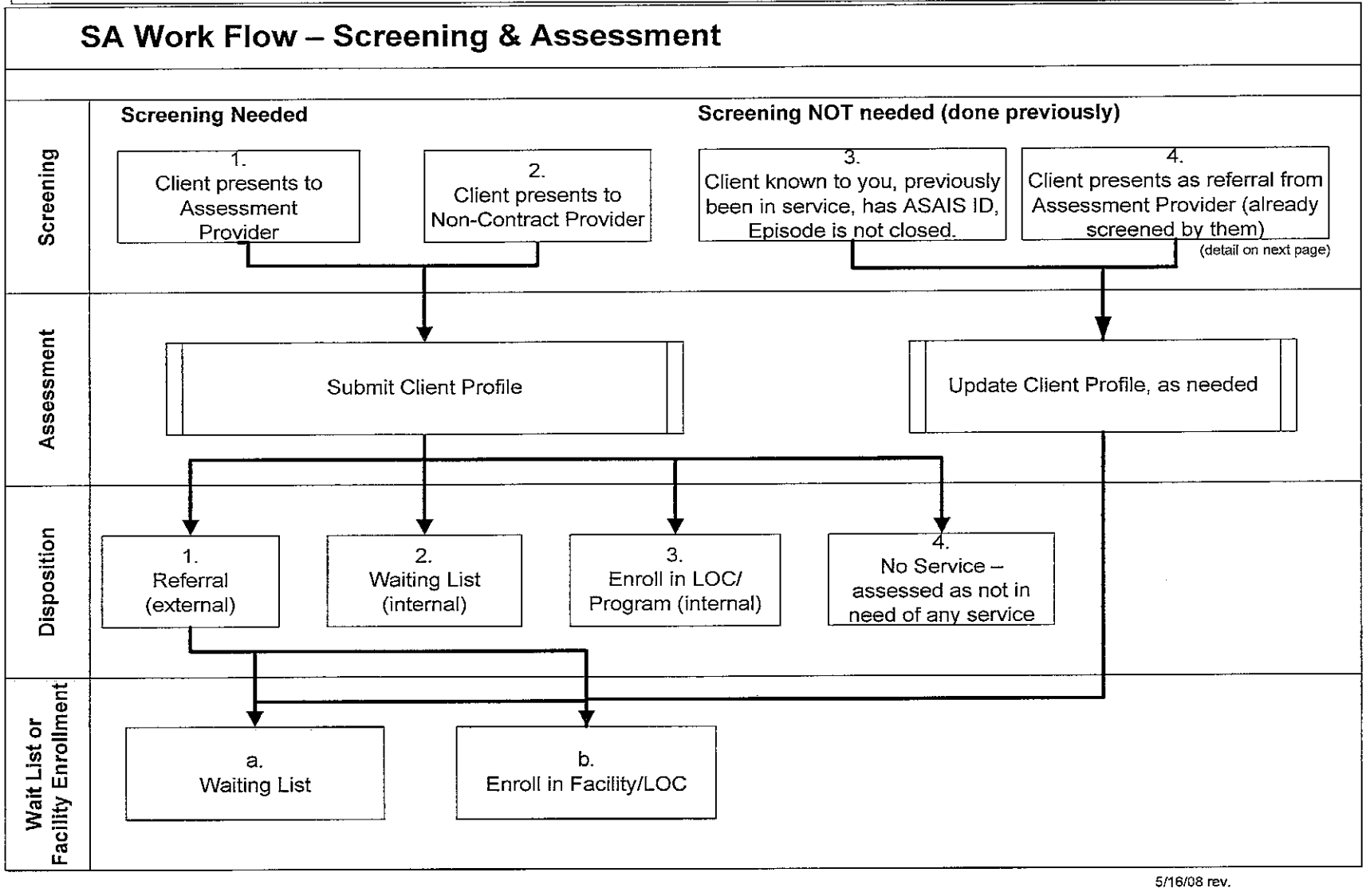
The ASAIS Provider workflow includes screenings, client profiles, enrollments, wait list and discharge summaries. The following describes the workflow and related processes. There is a graphic workflow as well as decision tree questions to clarify the processes. Definitions for all disposition options are listed as well as a description of the Facility Management tab under Providers. There is additional information on the SA Wait List functions in a later section of this manual.

If you are submitting data for Screenings, Client Profile and Discharges via HaPi (EDI) from your agency's information system, please follow the same parameters for when data needs to be captured and submitted. *SA Wait List and Enrollment/Facility management may not be performed via EDI.*

- ASAIS Flowchart
- Screenings
- Client Profiles & Diagnosis
- Dispositions
- SA Wait List
- Enrollments
- Internal Facility Management
- Discharge Summary
- Decision Tree

Substance Abuse Work Flow

The following workflow shows the various options for the enrollment process including the waiting list.



Screenings: (when, who)

Screenings are done the first time that a client presents for service. A Screening captures identifying information so that SASD can establish the client in ASAIS, assign an ASAIS unique ID number and/or create an enrollment to create a relationship to the screening provider. Screening includes a brief screening tool of 6 questions (one for adults and one for clients under 18). The screening tool is capturing information at a point in time. It is not dictating any clinical recommendation/approval or denial of service. If a screening has already been done by another provider, you do not need to do another one.

1. If this is a client already known to you, returning to service, already has an ASAIS ID and has an open ASAIS episode – you should **not** do another screening.

2. If the client is coming to you as a referral from another DMH contract provider, you should **not** do a screening as the Assessment provider has already done one and should refer the client to you in the system.

Decision Process for Screening – questions to ask/consider when a client presents for service

1. Is this client known to the agency (provider)?

    a. If yes, no screening is required. You have the ASAIS ID # and access to the client's record.

    b. If no, a screening may be required. Go to question **c**.

    c. Did the client come as a referral from another contract provider?

        i. If yes, then the screening and profile should already be done. When you accept the referral and open the client to your program, you will have access to the client's record.

        ii. If no, then a screening is necessary to get the ASAIS ID #, open the client in ASAIS and/or get access to their record. Submit a screening for this client.

SA Client Profile: (when to do it, assessments – update *, intake *)

1. A SA client profile needs to be submitted when you are the provider performing the assessment or if the client was assessed at a non-contract provider (who would not have had access to ASAIS and would not have done the profile).

Diagnosis –In ASAIS, the diagnosis MUST be entered via the Diagnosis tab in the client's record and the status must be set to Complete. Every SA client (for whom you are going to bill for SA

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services) must have at least one SA diagnosis under Axis I under the Diagnosis Detail in their ASAIS record. Diagnosis is tied to claims entry via the client's record.

2. Any time that you do an Assessment or an Assessment Update (for which you are billing DMH), you need to complete a SA Client Profile. ASAIS provides a Copy from Previous or Duplicate Assessment function so that once an original Profile is entered, you may copy that document using one of these two functions, and make any changes in the data. Save and close the assessment. Be sure that the Status is set to **Complete**. This will create a new SA Profile with updated information and keep the original as well.

3. Any time that you are enrolling a client into a level of care/facility that offers services covered by special funding sources (adolescent services, pregnant women, etc.) that the previous level of care was not covered by, you need to submit a new Profile that reflects the inclusion of that specialized funding source for this client. Use the Copy from Previous/Duplicate Assessment function and update the funding questions at the bottom. Save and close the assessment. Be sure that the Status is set to Complete.

4. If you are the receiving (client was referred to you via the waiting list) provider, the SA Profile should have already been done and submitted. You do not need to do another profile.

Disposition: (definitions below)

Once you have done an assessment or received a referral, you will make a determination of if and where to enroll this client.

1. Refer to an external provider (facility) (another contract provider who provides the needed level of care (LOC).
2. Place the client on one or more of your own waiting lists in anticipation of an opening.
3. Enroll (open) the client to the needed level of care (facility) at your own provider.
4. Determine that no service is needed at this time – no further data or documentation is required.

SA Wait List:

Please see the separate section on the SA Wait List for referrals to, accepting a client onto, denying a client to or enrolling a client from the Wait List. (begins on page 73)

Enrollments:

1. SASD (during the screening process) will have established an Enrollment record for the Assessment with the disposition of "Assessment".

2. If you are enrolling the client into one of your programs (facility/level of care) you will update the existing Enrollment record so that there will be just one enrollment record for this client for your organization. The previously created enrollment record for the Assessment will be changed to a disposition of Open and a facility/LOC record will be added.

    a. The "open" record covers all facility enrollments until they are discharged from the provider. The system will not allow you to have multiple enrollment records for the same provider in the same timeframe.

    b. You can have two open facility records at once (e.g., methadone and IOP) or any other allowable combination.

    c. You may have multiple facility (LOC) records for a client over time as they transfer from one LOC to another within your organization. Usually, only one Facility record will have a disposition of "Open" unless the situation in b above is present.

3. Enrollments at the Provider level should only have one of three dispositions:

    a. Assessment

    b. Open

    c. Discharged

    NOTE: The dispositions of "Waiting List", "Referred", "Not Accepted" and "Transferred" should not be used at the provider level.

4. Under the Provider Enrollment record, there is Facility Enrollment. These are the levels of care (LOC) that you provide and where you provide them. You can manage a client's disposition and facility enrollment at the individual client record

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level and/or via the Provider/Facility Management tab. A client must be enrolled in a facility to receive any service other than an Assessment. If the client only has an Assessment record in Enrollments, claims for other services will be automatically denied by the system. As you manage the wait lists for your facilities, facility enrollments will be created. For clients not on a wait list who are directly enrolled into a provider and facility, you must add the facility enrollment manually.

5. Facility Enrollment Dispositions: (definitions)
    a. Referred – this client has been referred to this facility waiting list
    b. Waiting List – this client has been accepted onto this facility waiting list
    c. Not Accepted – this client was referred but not accepted onto this facility wait list
    d. No Contact – this client was on the waiting list, but could no longer be contacted for service
    e. Open – this client has been opened (enrolled) to this facility program/level of care
    f. Transferred – this client has been transferred from one program/facility to another one in the same provider
    g. Cancelled – this is not a selection to the user but is the value that shows once the client who had been referred to this facility's waiting list has been accepted (opened/enrolled) into another provider's program/facility.
    h. Closed – Is not available in the menu, but is what displays when you discharge the client from the provider.

Internal Facility Management: (tab in Providers Chapter)

If you click on the Provider chapter button and then the Facility Management tab, you can view, filter, and sort all clients under all Disposition categories in all of your facilities. You should to manage referrals in and transfers (internal) from this grid. The grid provides an overview of who, how many, what disposition in all facilities.

1. Transfers – if a client is moved from one of your facilities to another due to change in level of care needed or change in location (if you have two facilities that offer the same level of care), the facility enrollment record should reflect the "transfer". Using the existing facility record, change the disposition of "Open" to "Transferred". Save the record. Then,

Add Facility Enrollment to create the "Open" record for the new facility/LOC to which the client has been transferred. Save this record.

Discharge Summary:

1. A Discharge Summary is required when the Provider enrollment (beyond assessment) has a disposition changed to discharged (not transferred).

2. When you change the disposition to discharged in the Provider Enrollment in a client's record, you will receive a Workflow Wizard (WFW) that will prompt you to complete the Discharge Summary. When you click on the WFW task, a blank Discharge Summary form will open on the screen. Fill in the form. Set status to Complete. Save the record.

3. Then you will have a WFW item for Discharge Diagnosis. Click on this item and a blank diagnosis record will open. Select Discharge for the disposition. Set the Status to Complete. Select the appropriate Axis !, Diagnosis ! Substance Abuse diagnosis (at a minimum). Save the Diagnosis Detail. Close the WFW.

4. If you lose the WFW or get interrupted, you can also complete the Discharge Summary by going into the client's record. Click on the Profile Discharge Summary tab. Click on the Add Assessment link. In this case, a header record will open and you will have to select which type of assessment you need to complete. Select Discharge Summary from the drop down. Fill in the form. Set the status to Complete. Save and Close the record. Then go to the Diagnosis tab and add diagnosis detail with a disposition of discharge as in #3 above.

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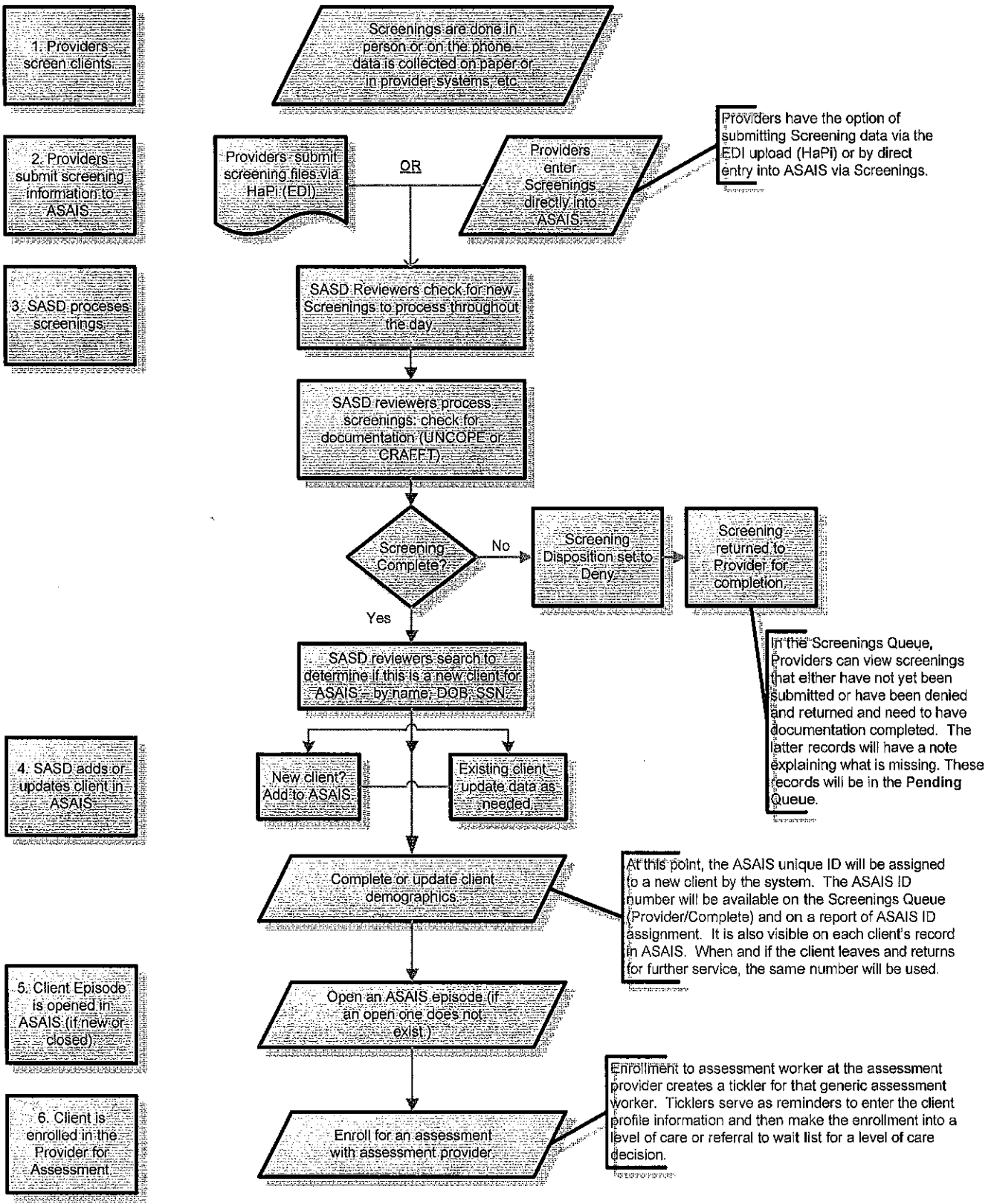
Screening, Episodes and Initial Enrollments in ASAIS

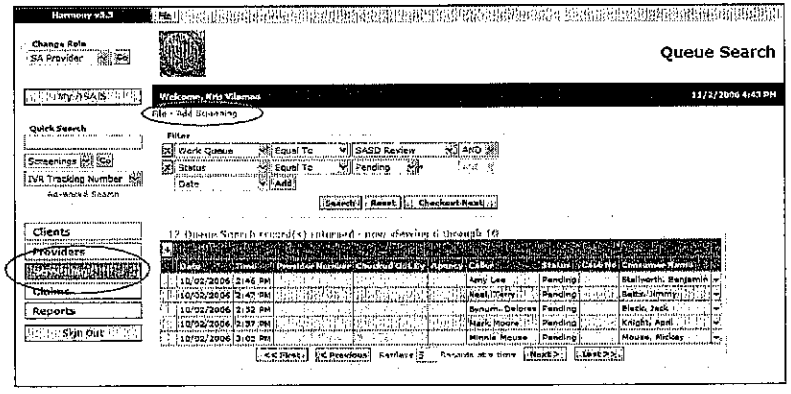


November 15, 2007

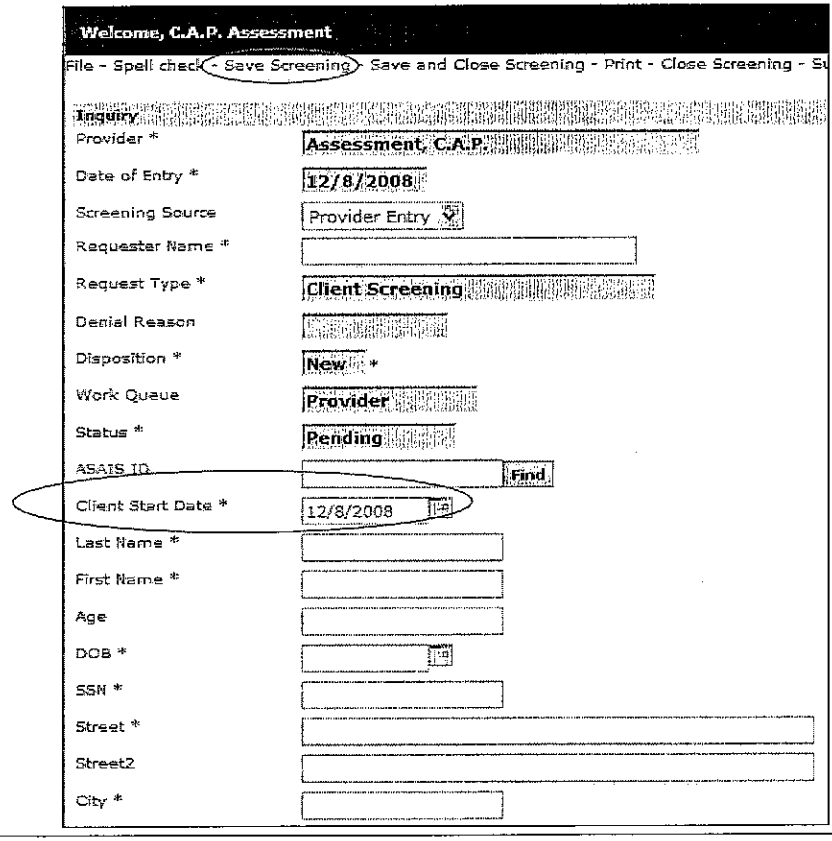
Submitting a New Client for Screening in the Screenings Chapter

Adding a New Screening

1. Click on the *Screenings* chapter button.
2. The *Screening Queue Search* screen will appear
3. Click *Add Screening* from the *File* menu bar.



4. The *Add Screening* page will appear
5. Record information regarding the client in the appropriate fields. (Field labels marked by a red asterisk are required.)
6. Enter information regarding the client in the appropriate fields. The Work Queue will default to *Provider*.
7. *Client Start Date* field – **pay close attention to the date that you enter here**. The field will default to today's date but if the client came in earlier than today and you wish to bill for any services prior to today, adjust the date here. The client's Episode Opening date will be set to the same date as the one that is entered here.



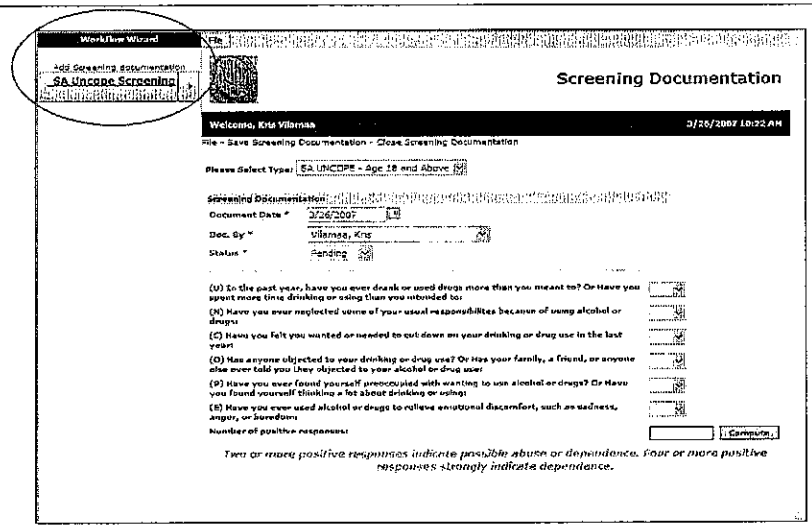
8. Select *Save Screening* from the *File* menu. (DO NOT use *Save and Close* at this point, you will save the record but may forget to submit the screening.)
9. Click on 'OK" in *The Save was Successful* message box.

Filling Out the Screening Documentation

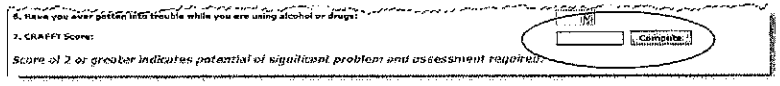
1. After saving the record, a WFW will open, prompting the user to complete required Documentation.
2. The user will be prompted to complete the Screening Questions:
   a. SA CRAFFT for clients less than 18 years old
   b. SA UNCOPE for clients age 18 and above.

Be sure to select the correct form for the age of this client.

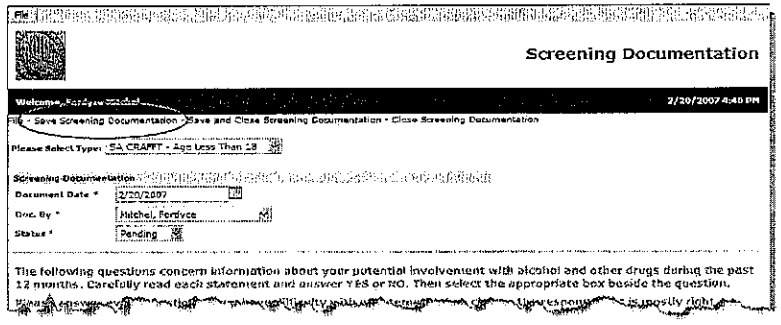
3. Fill out the appropriate information in the header and then in the form (*Yes* or *No*).



4. Click on the *Compute* button on the bottom of the form to compute the potential client's score.

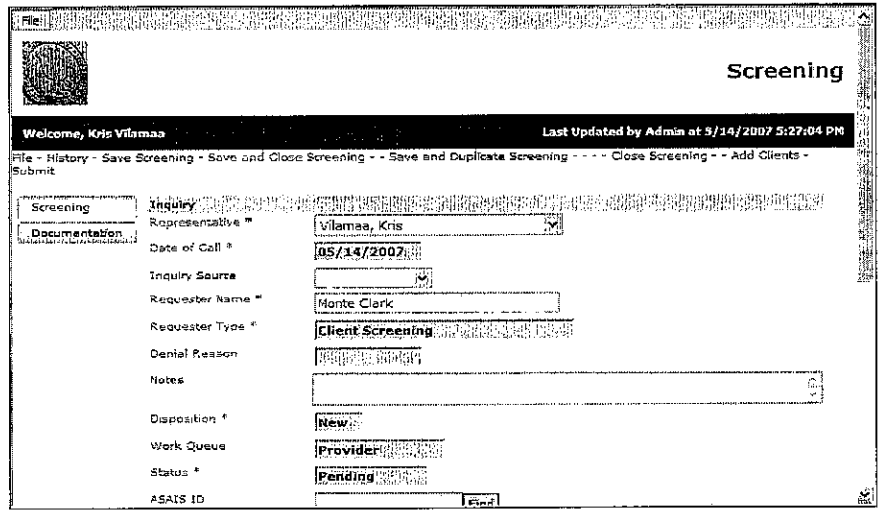


5. Ensure that the *Status* is 'Pending'.
6. Select *Save Screening Documentation* from the *File* menu.



7. Select *Close My ASAIS* from the *File* menu.
8. You will be returned to the *Screening Page.*

If you need to review the screening documentation at any time, click on the Documentation button under the Screening button on the left side of the screen.

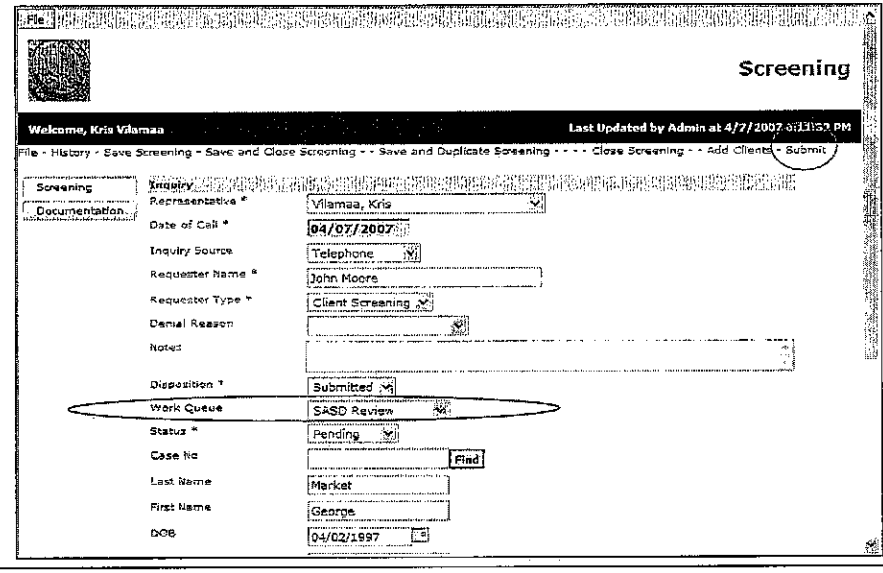


9. Select *Submit* from the *File* menu.

This sends the screening to the SASD Review Queue where the SASD Central Office staff can review and approve it. (You will notice that the *Work Queue* field changes from Provider to SASD Review after you click on Submit.)

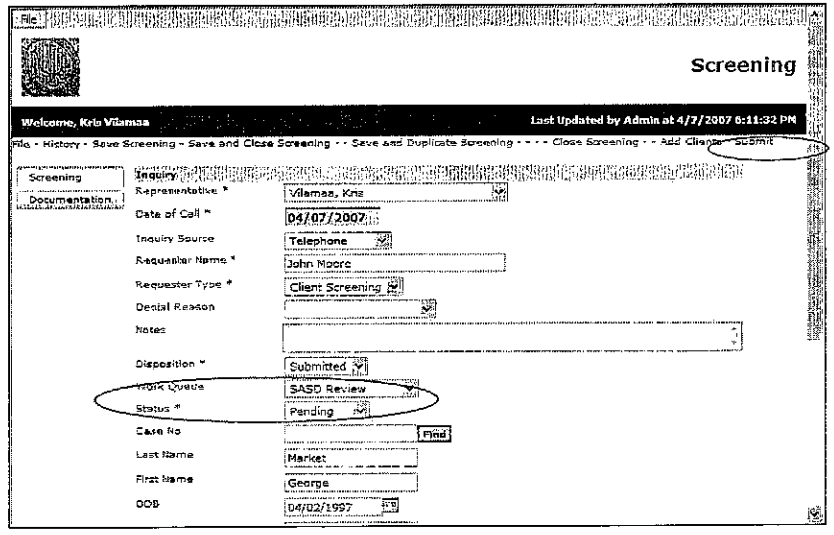
10. Click on *Close Screening.*

You have now finished submitting a screening to SASD.



Understanding the Screening Work Queues and Statuses

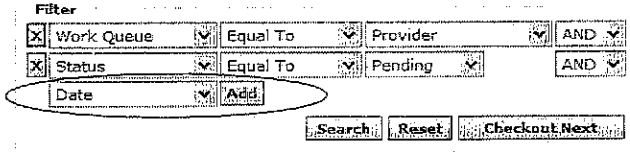
- In Screenings, *Work Queue* values are assigned after saving and submitting a screening.
- The value in the *Status* dropdown indicates whether the screening is still in process or not.
- The combination of the Work Queue and the Status will indicate a screening's current process status.

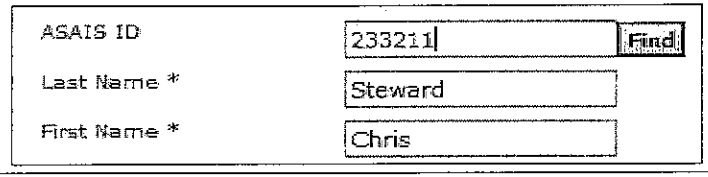


Reviewing the Work Queue

1. Click on the *Screenings* chapter button.
2. The *Screening Queue Search* screen will appear
3. In the *Filter*, select the desired combination (see the list below).

   You will want to add Date to your search to narrow down the records returned from the Search.
4. Click on the *Search* button.
5. A list of *Screenings* matching the criteria will be returned.



Work Queue/Status Combinations:	
• If the *Work Queue* is 'Provider' and the *Status* is 'Pending':	The screening has **not yet** been submitted to the S.A. Division. This screening is still in your queue and will not be seen nor approved until you submit it to SASD. ***Check this queue at least once a week to be sure no records are stuck in Pending status and have never been submitted to SASD. Records may also be here if they have been returned by SASD due to incomplete information. You may need to correct/complete information in a Screening and re-submit.***
• If the *Work Queue* is 'Provider' and the *Status* is 'Complete':	The Division has approved the screening and sent it back to the Provider with ASAIS ID number. 
• If the *Work Queue* is 'SASD Review' and the *Status* is 'Pending':	The Provider has submitted the screening for review but it has not been processed yet by the S.A. Division.

Screening Approval Process

Next Steps *(done by SASD staff)*

Connecting a Client to an Assessment Provider in ASAIS

Once a screening is submitted, SASD staff will go to Screenings and review each of the screenings that have been submitted. Documentation and its score will be reviewed. Documentation Status will be changed to *Complete*.

If the screening is approved, SASD staff will change the disposition to *Approved* and the Status to *Complete*. Staff will then add the new client to the ASAIS database and ensure that the client has an *Open* Episode of Care in the *SA* fund code. The new client will be enrolled in your Agency (Provider) with a Disposition of *Assessment* and an Enrollment Type of *Assessment*. The case will be assigned to your default worker, **Assessment, *Agency*.**

Withdrawing a Client

If a Provider decides to withdraw a screening, the Disposition of the Screening will be changed to *Withdrawn* and the Status to *Complete*.

Denial of a Screening

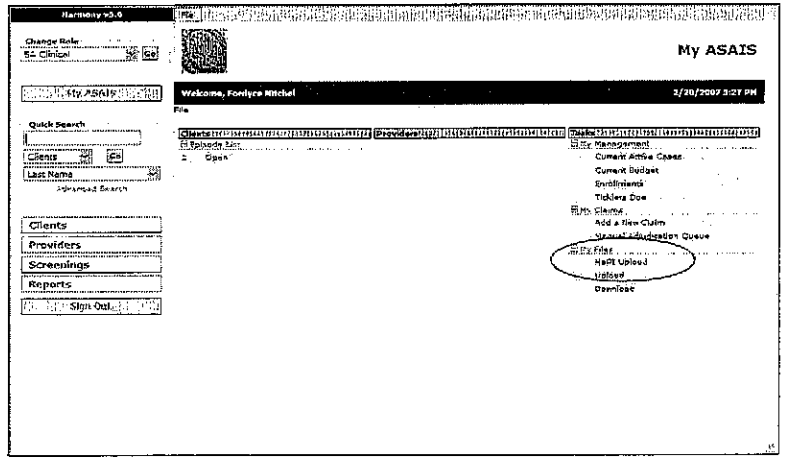
If SASD decides to deny a screening, they will change the Disposition of the Screening to *Denied* and the Status to *Complete*. They will then record a *Denial Reason* on the Screening page.

Using the HaPI Upload

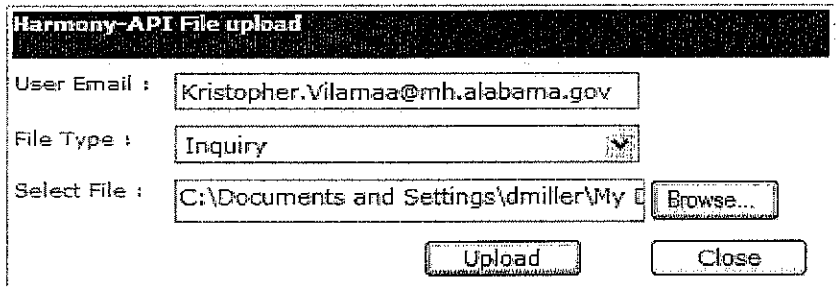
Submitting a New Client for Screening via the HaPI Upload

Adding New Screenings

1. On the *My ASAIS* page, navigate to the *HaPI Upload* link under *Tasks>My Files*.
2. Click on the *HaPI Upload* link.



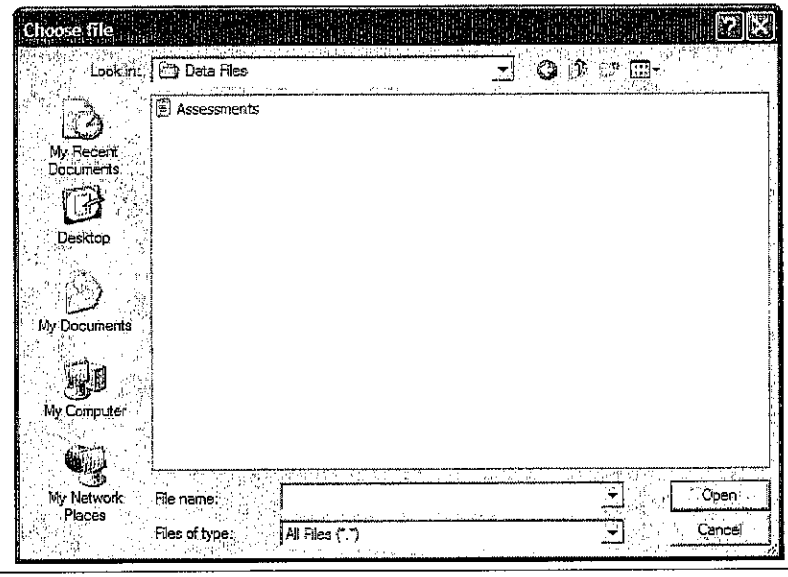
3. The *ASAIS-API File upload* window will open.
4. Enter your email address in the *User Email* field.
5. In the *File Type* field, select *Inquiry*.



6. Click on the *Browse* button to locate the file you wish to upload.

Check with your System Administrator as to the standard location of the files on your computer or network.

7. After browsing to the desired file, click on the *Open* button.



8. Back in the HaPI Upload window, click on the *Upload* button.
9. Click on *OK* in the *File Submitted Successfully* message window.
10. SASD staff will then review and process the screening (see page 51 for details).

Client Assessment

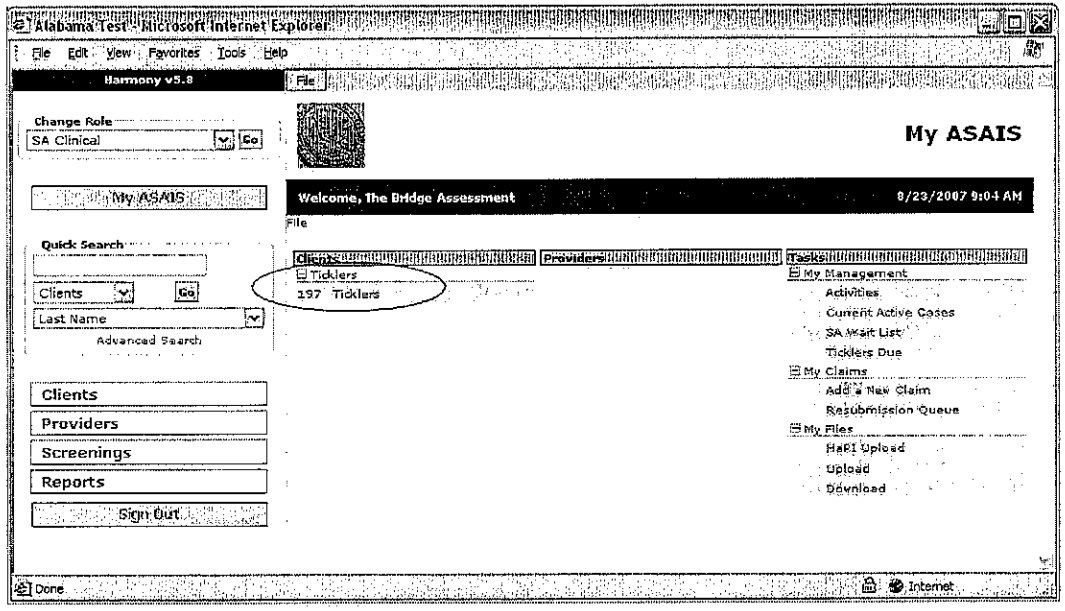
Completing Client Profile, Diagnosis and Enrollment

Once a client has been enrolled for an Assessment and the assessment has been performed, the following steps are taken:

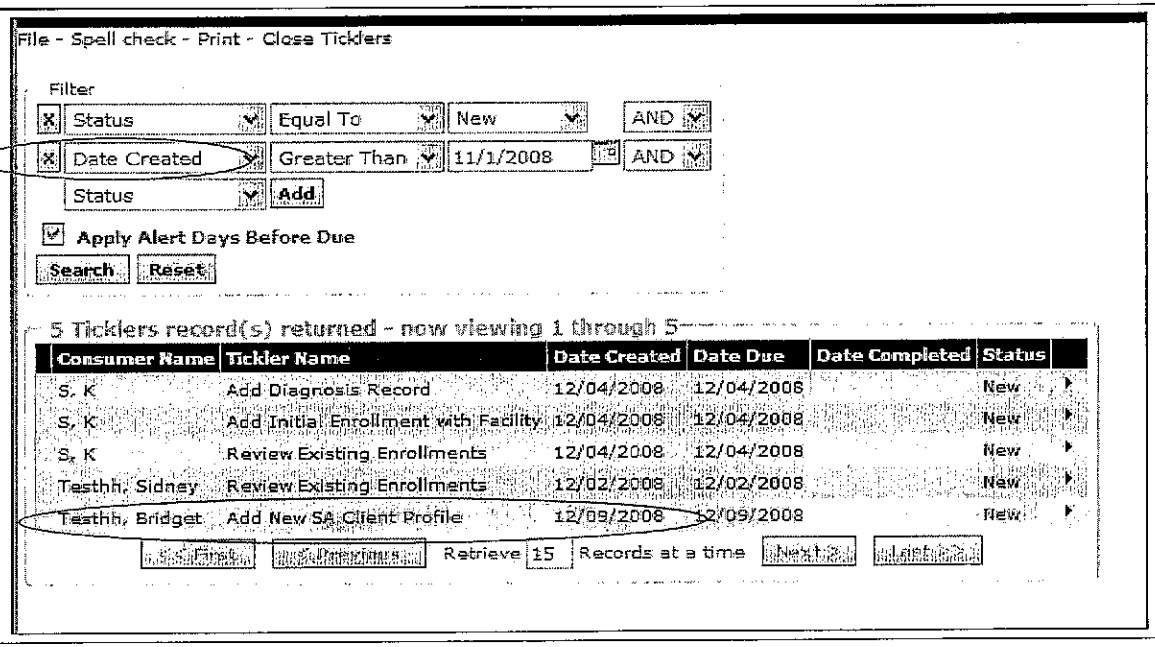
Completing a SA Client Profile Form (Role: SA Clinical)

1. Click on the *Ticklers* list on *the My ASAIS* page.

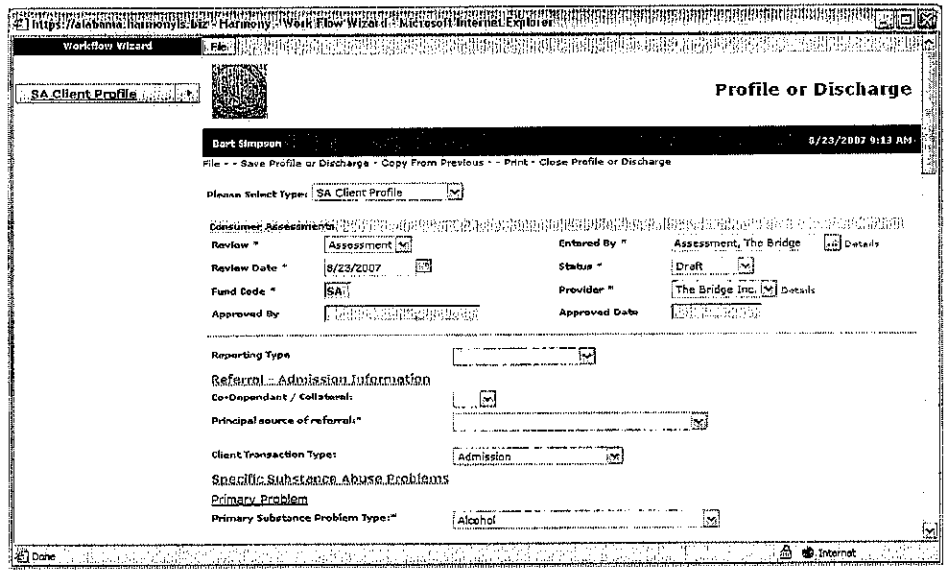
Check for ticklers at least once a week, though if you have a large volume of screenings and assessments, you may wish to do this more often.



2. If you have a large number of ticklers, use the filter to narrow down the list. Add *Date Created* and *Greater Than* and enter an appropriate date to get a smaller list. Click on *Search.*
3. In the list, click on the tickler named *Add New SA Client Profile* for the desired client.
4. The *SA Client Profile* will open in a workflow wizard.



5. Complete the form as required.
   a. For *Review*, select 'Assessment' from the dropdown list.
   b. Select the name of the worker who is completing the form in the *Entered By (worker)* dropdown list.
   c. Enter the date that the form was completed in the *Review Date* field. (The date will default to the current date but can be changed if needed.)
   d. Switch the *Status* to 'Complete.' (The *Status* will default to 'Draft.' This allows you to save a partially



completed form.)

e. Select your agency in the *Provider* dropdown list.

Important!!

At the bottom of the SA Profile form, there are questions that relate to **specific types of dollars** that may be applicable to this particular client and the services that you are providing. If your agency receives any of these special funds (*Indigent Offender, Special Womens, Special Adolescent, Pardons and Paroles*), it is very important that you identify the funds for each applicable client. It is equally important, that if you **do** not receive any of these funds, that you answer the questions as "No". Please complete each of the questions to assure that the right source of funds is used for the services that will be received by this client. Your answers will create the needed eligibility records to direct payment of claims. The questions default to No except for the last one (*HIV Early Intervention*) that defaults to Yes. Change the No to Yes for any special funds that apply to this client.

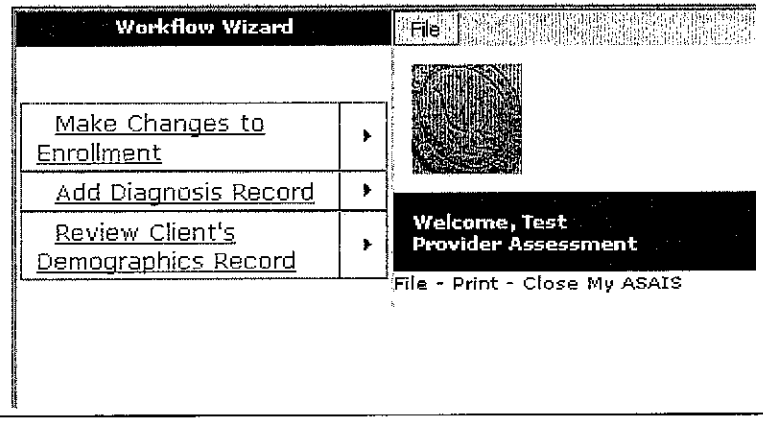
6. You may print the Profile form by selecting *Print* from the *File* menu.

7. When done, select *Save Profile or Discharge* from the *File* menu.

8. Click OK to *The Save was successful* message.

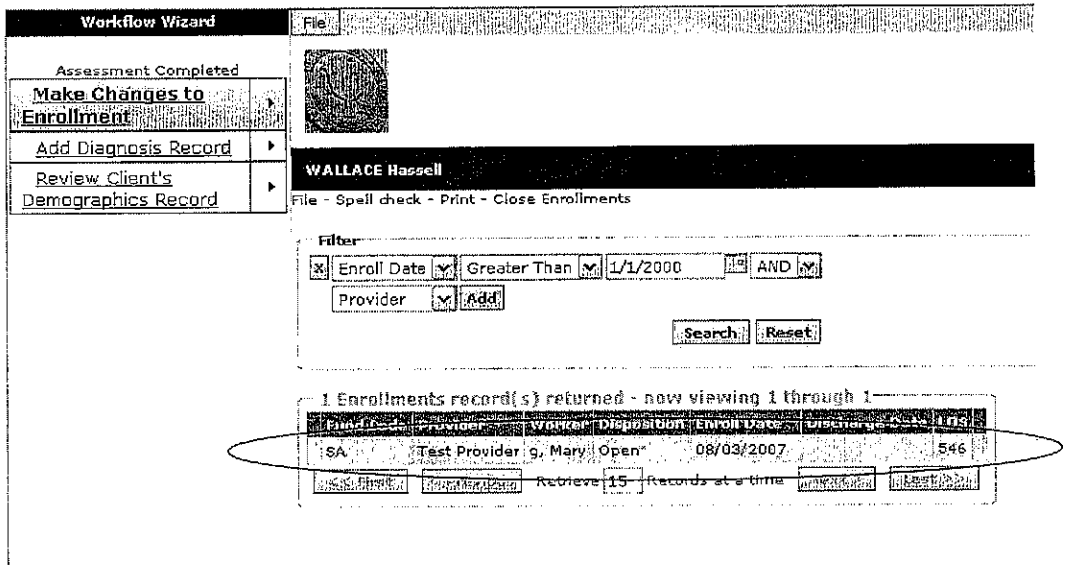
Note: When the client is discharged from this provider, you will complete the **Discharge Assessment** form.

1. When you save the SA Profile, you will get another workflow wizard.



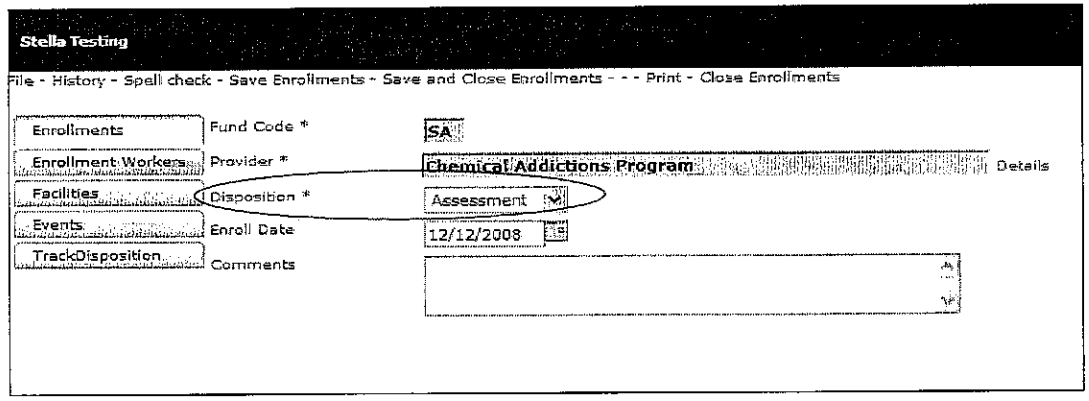
Program Enrollment (Role: SA Clinical)

1. Click on *Make Changes to Enrollment*, if the client is receiving a service beyond assessment. If not, cancel this tickler.
2. This will present a grid of any existing Enrollments for your agency.
3. Click on the most recent (if there is more than one) Enrollment record with the status of Assessment or Open, if there is a record that is Open.



4. The Enrollment record will display the current disposition

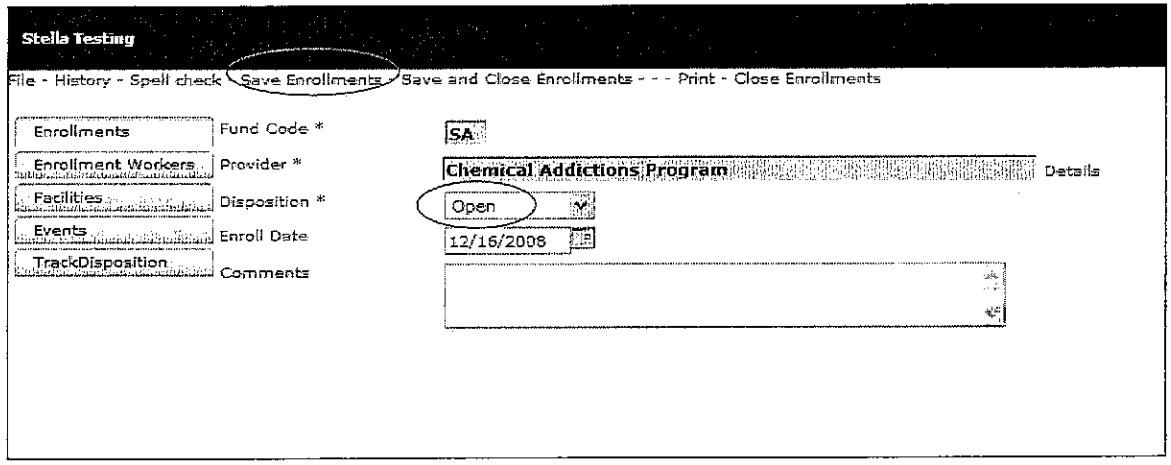
   In the example, this record shows an Assessment enrollment record.



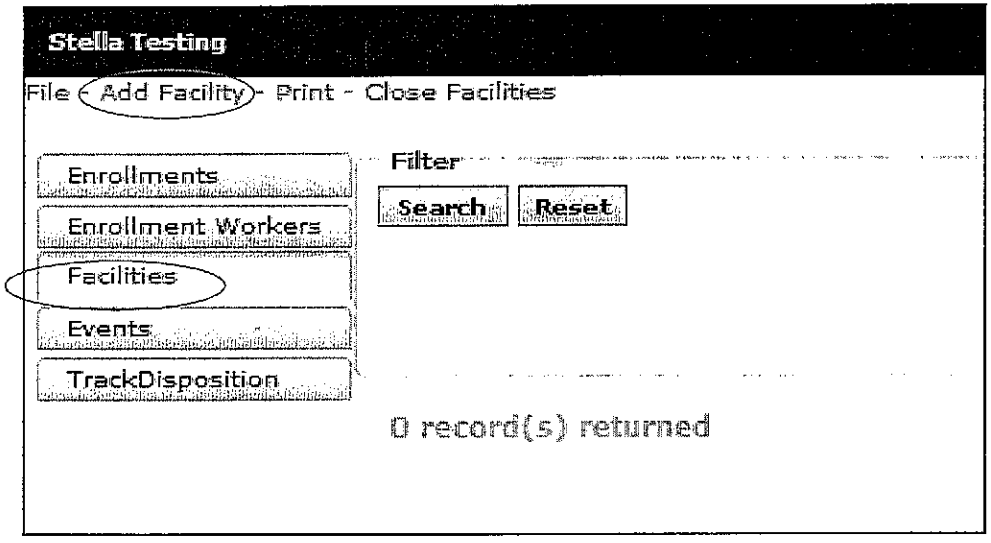
5. Change the Disposition to *Open* by selecting Open from the drop down at

Disposition.

6. Click on *Save Enrollments*. (Don't use Save and Close Enrollments here because you are now going to Add Facility from this same screen.)

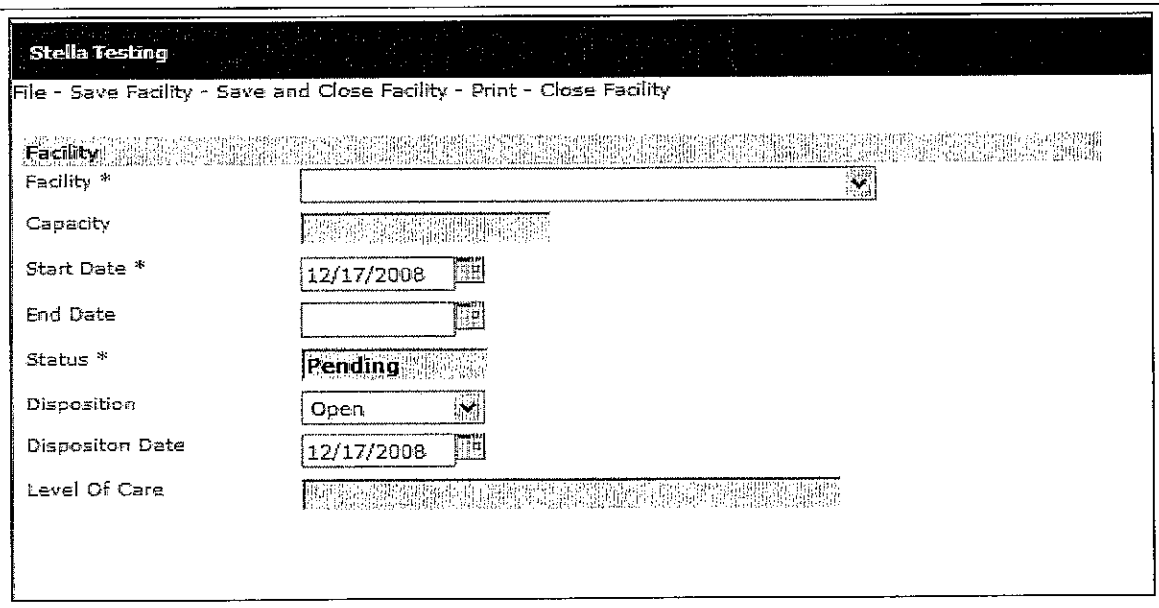


7. Now on the same page, click on *Facilities* to add the appropriate Facility/Level of Care for this client.
8. Click on *Add Facility*.

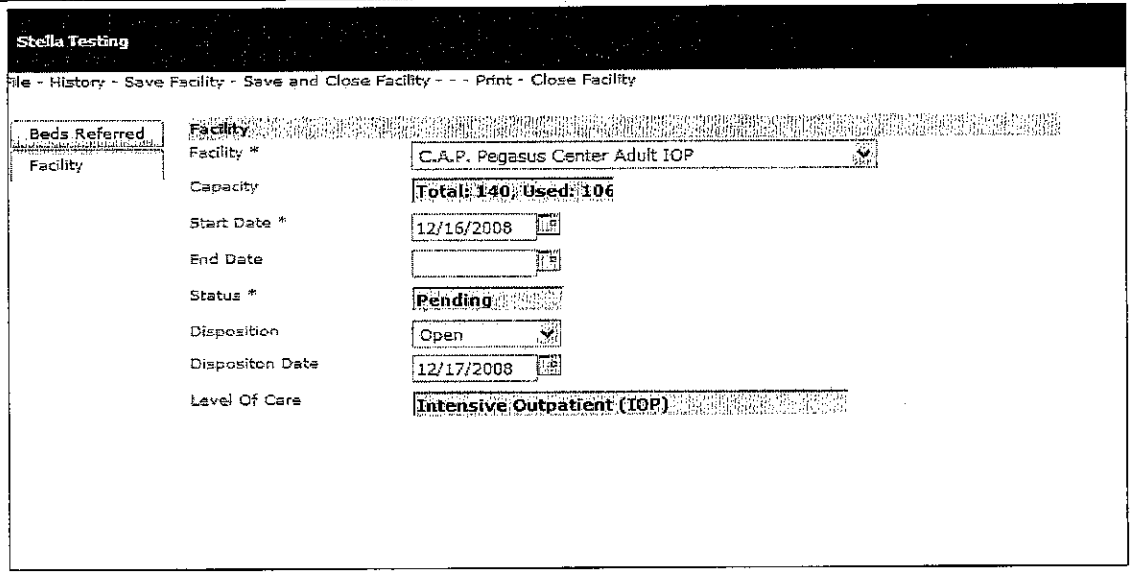


9. The Facility page will open.
10. Click on the drop down for Facility. All of your Provider's facilities will show. Select the correct one for this

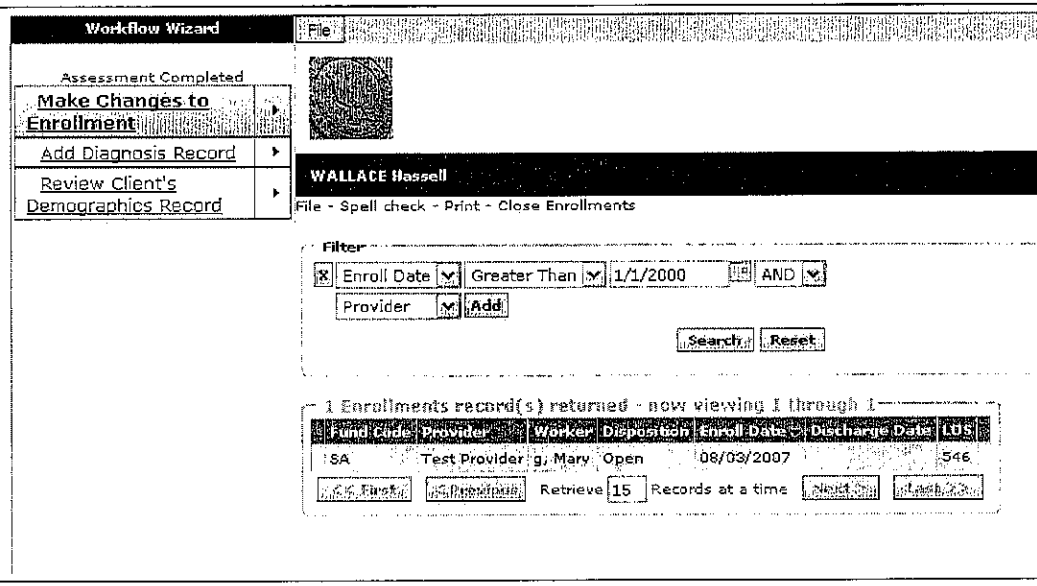
client



11. The system will refresh and show the current capacity for this Facility (if it is designated in the Provider record).
12. The *Start Date* will default to today's date. Adjust the date if the client started the program before today.
13. *Save and Close Facility.*

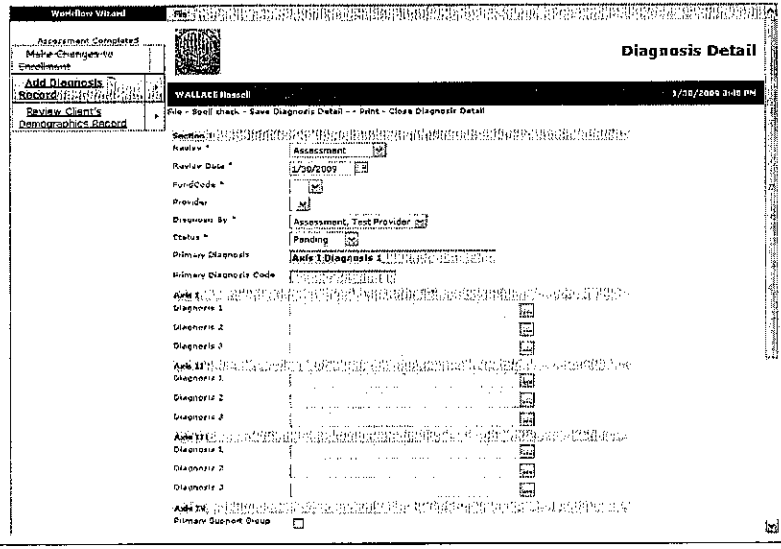


14. Now the Enrollment record will show the Open Disposition.
15. Mouse over the arrow next to "Review Existing Enrollment" and "Cancel" the reminder
16. Continue with the next item for *Diagnosis*.



Completing a Diagnosis (Role: SA Clinical)

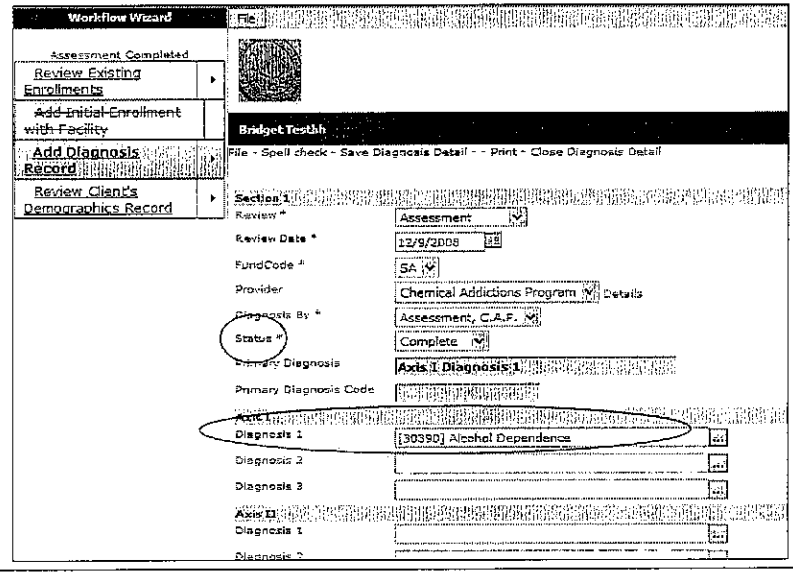
1. In the WFW, now click *Add Diagnosis*.
2. The *Diagnosis Detail* screen will appear.
3. Ensure *Review* is set to *Assessment* and *Fund Code* is set to *SA*.
4. The status defaults to *Pending*.
5. *Primary Diagnosis*, will default to *Axis 1, Diagnosis 1*. This will assure that the SA diagnosis is used in billing.



6. Click the ellipsis button (...) at the end of the Axis I, Diagnosis 1 row to search for the diagnosis codes. Click on the codes in the returned search results to choose. *You must have at least one SA diagnosis code for each client.*

7. Change the Status to *Complete.*

8. Select *Save Diagnosis Detail* when finished.

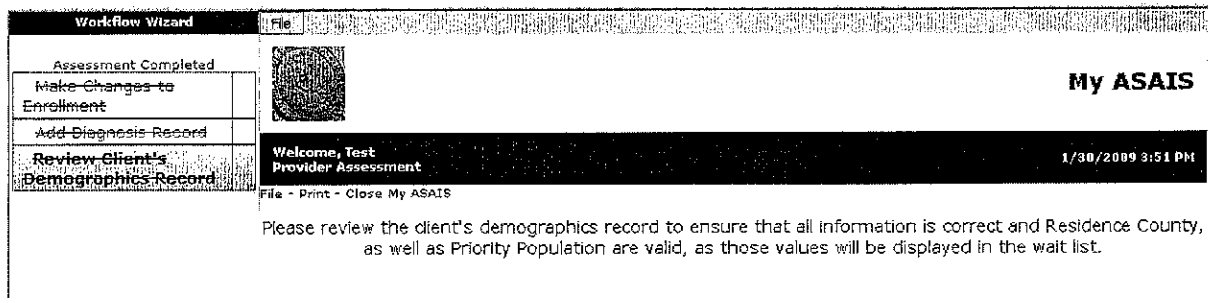


Review Client's Demographics Record (Role: SA Clinical)

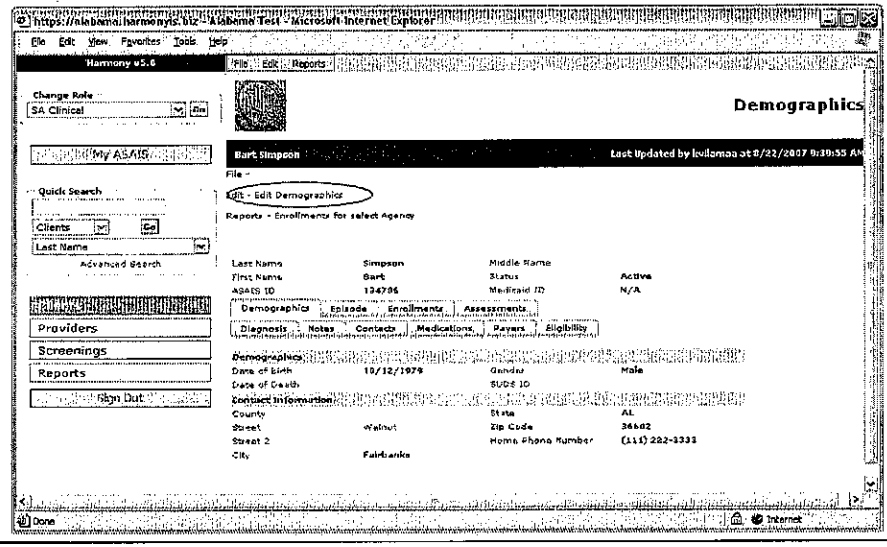
1. Click on *Review Client's Demographics Record.* A message appears that reminds you to review this client's demographic record to assure that it is up to date and accurate.

   It is particularly important to make sure that the client's *Residence County* and *Priority Population* fields have been completed in *Demographics.*

2. Click *Close My ASAIS.*



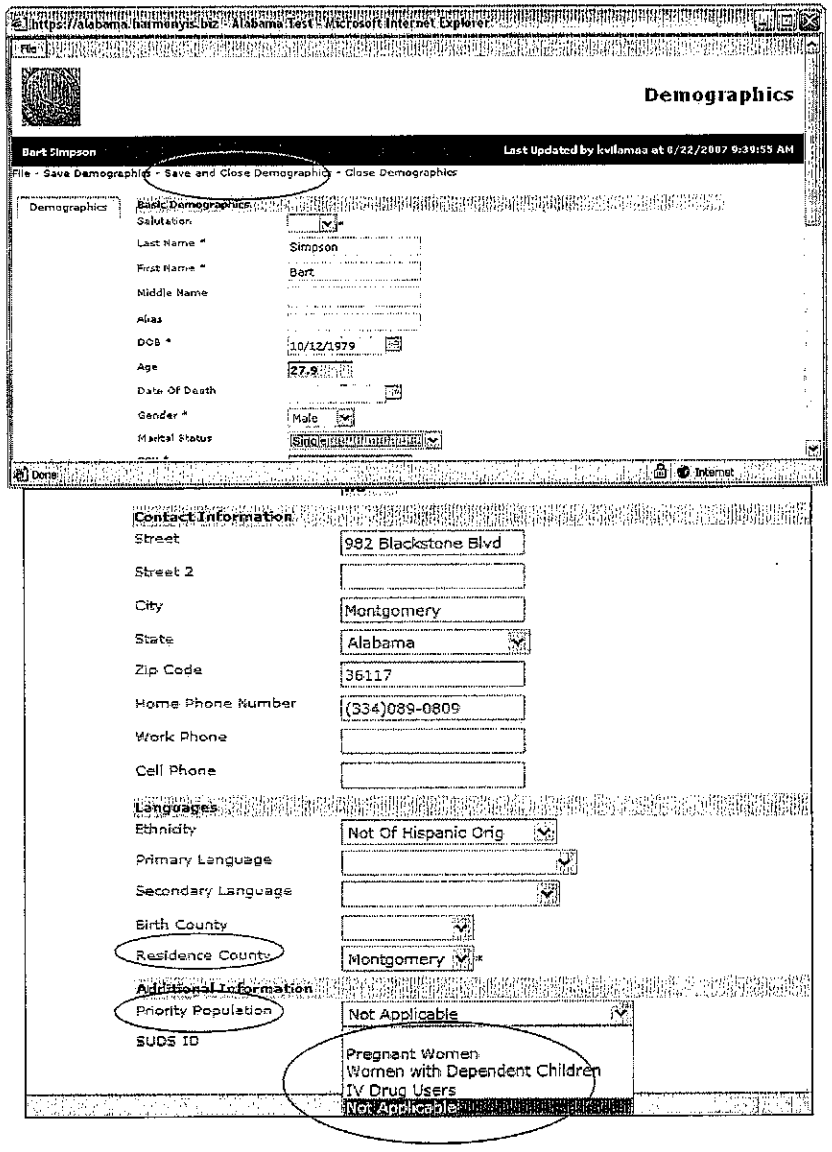
3. Navigate to the client's record.
4. Click *Edit Demographics.*



5. Update any changed or missing information and select the *County of Residence* and the relevant *Priority Population*, if blank.

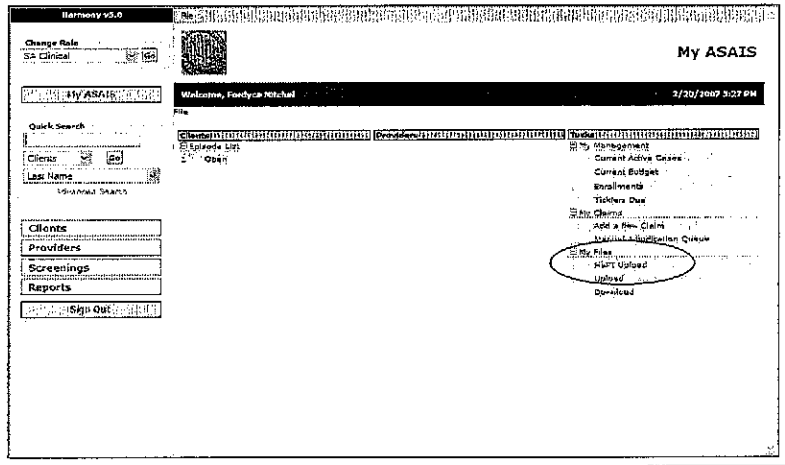
Be sure that the *Address* is complete.

6. Select *Save and Close Demographics* when finished.

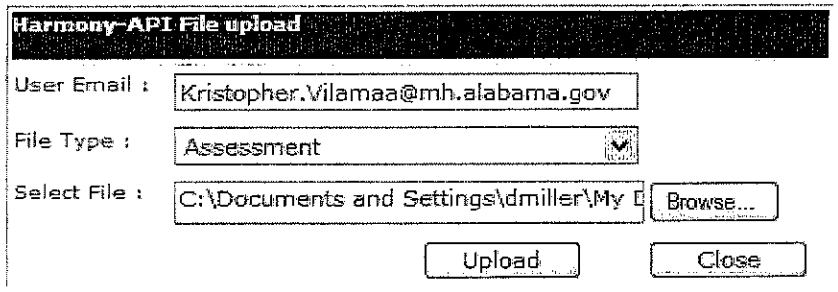


Submitting an Assessment or Discharge Summary via the HaPI Upload

1. Navigate to the *HaPI Upload* link under *Tasks>My Files* on the *My ASAIS* page.
2. Click on the *HaPI Upload* link.



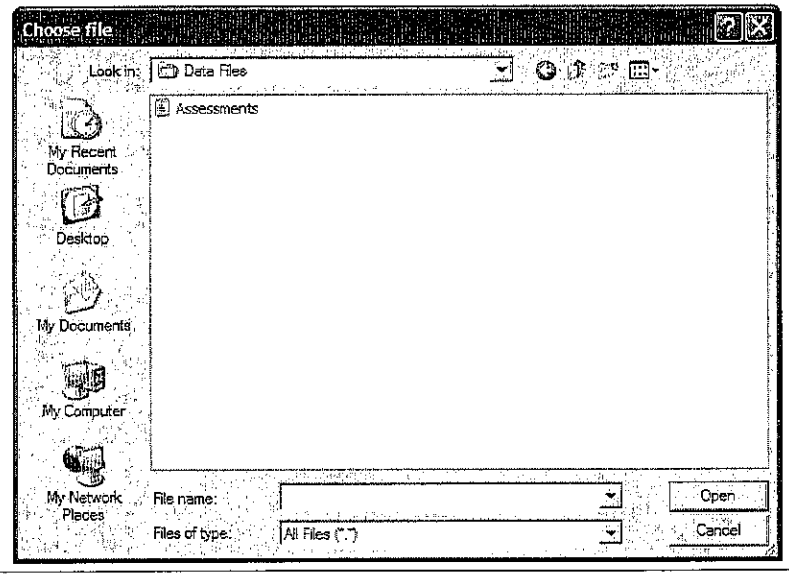
3. The *ASAIS-API File upload* window will open.
4. Enter your email address in the *User Email* field.
5. For an **Assessment or Discharge** file, select 'Assessment' in the *File Type* field



6. Click on the *Browse* button to locate the file you wish to upload.

Check with your System Administrator as to the standard location of the files on your computer or network.

7. After browsing to the desired file, click on the *Open* button.

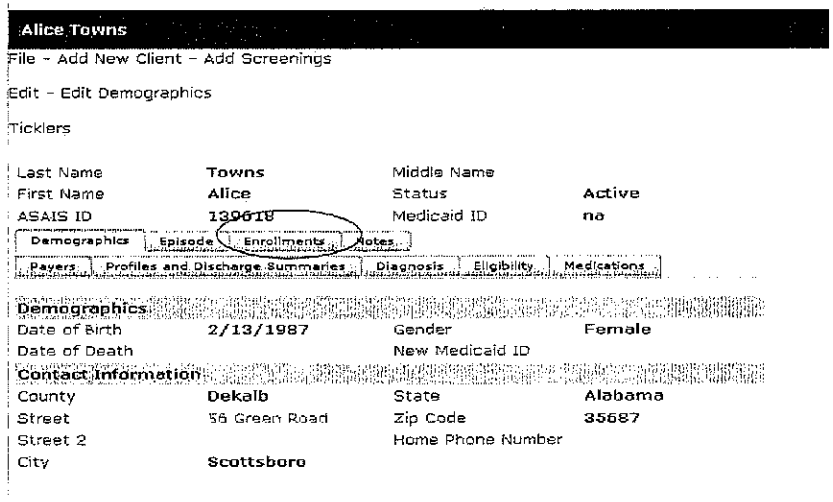


8. Back in the HaPI Upload window, click on the *Upload* button.
9. Click on *OK* in the *File Submitted Successfully* message window.

ASAIS Discharge Process

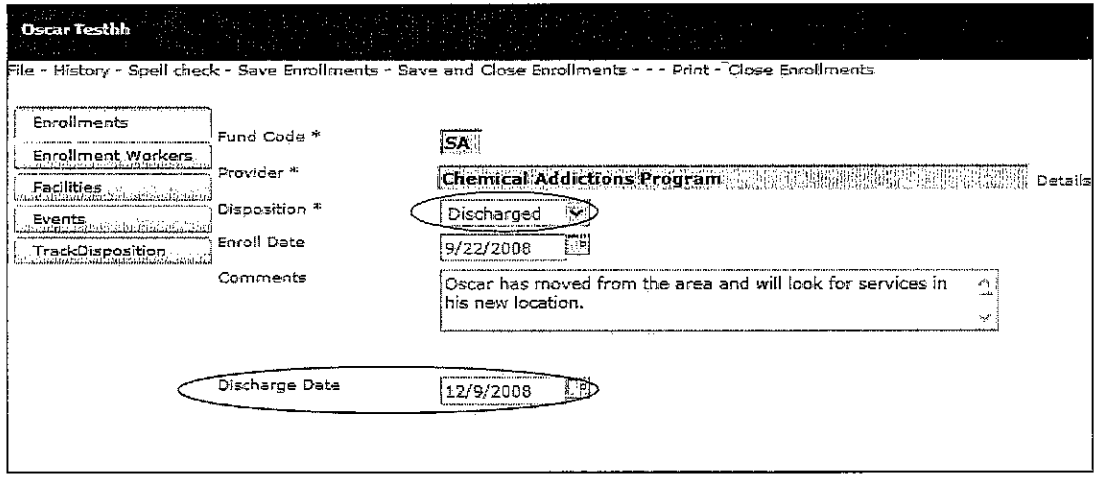
Discharging a Client from your Agency – Client has finished service, left service and not expected to return

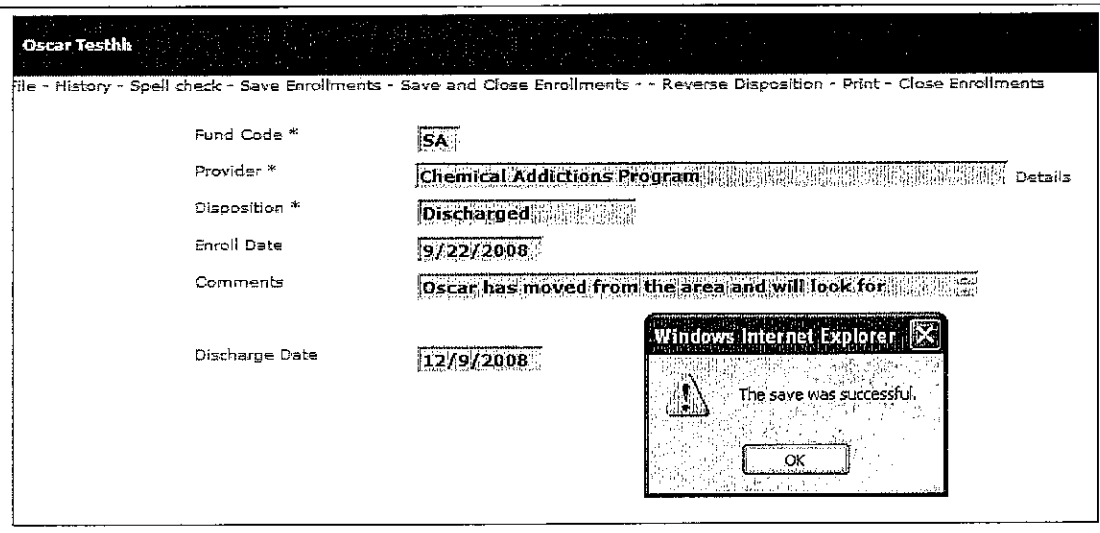
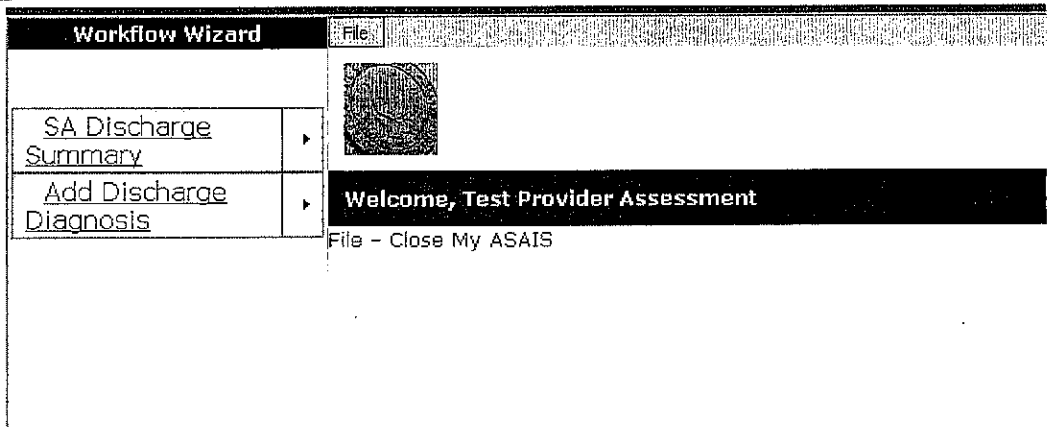
1. Find the client's record in ASAIS.
2. Click on the *Enrollments* tab.



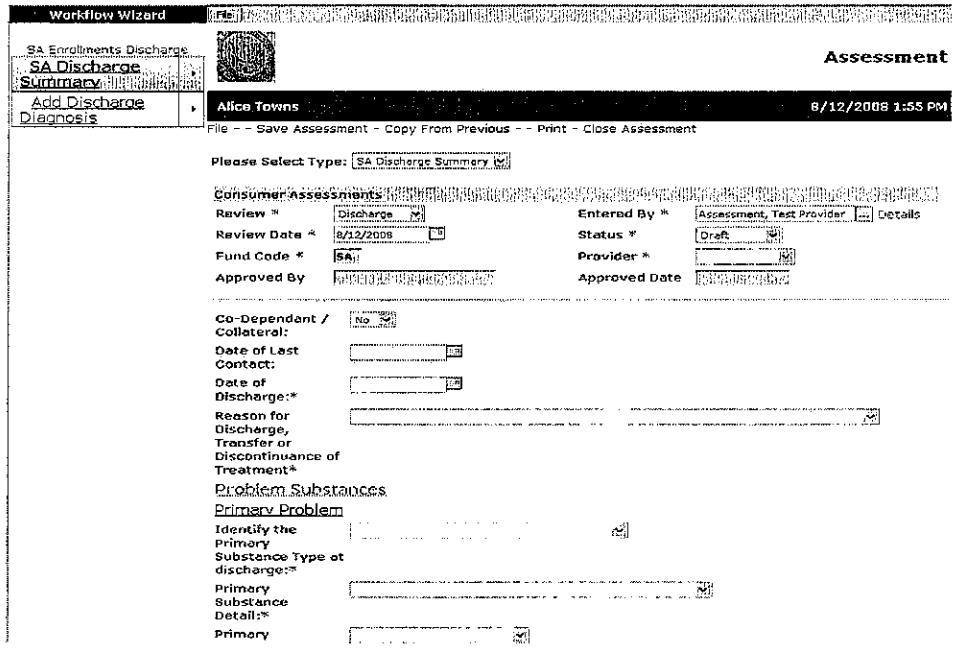
3. In the *Enrollments* screen, select *Discharged* for the *Disposition*.
4. The *Discharge Date* will default to today's date – correct the date if that is not the right date – no services can be billed after this date.
5. You may enter comments into the Comments field.
6. Click on *Save and Close Enrollments*.

(*Once you discharge the Enrollment record, the facility record will automatically change to discharge as well.*)

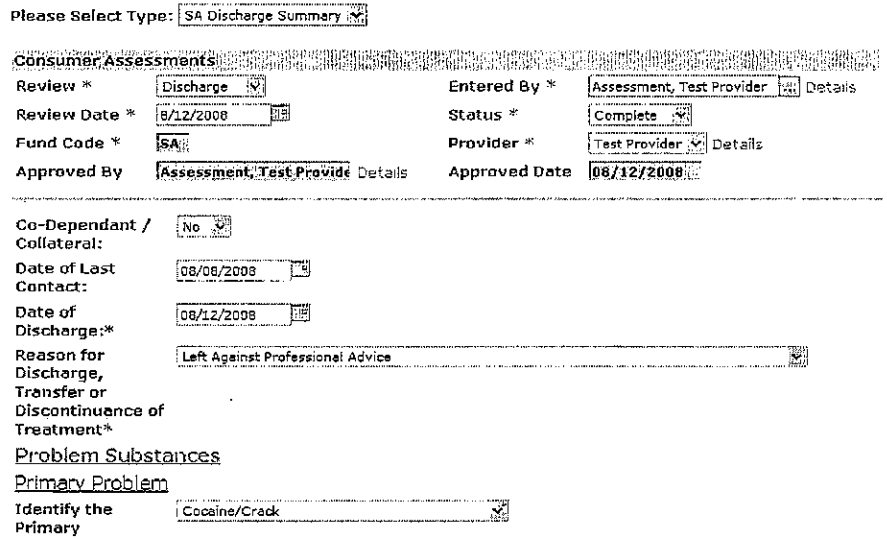


7. Click on OK.	
8. You will now get a WFW for discharge.	

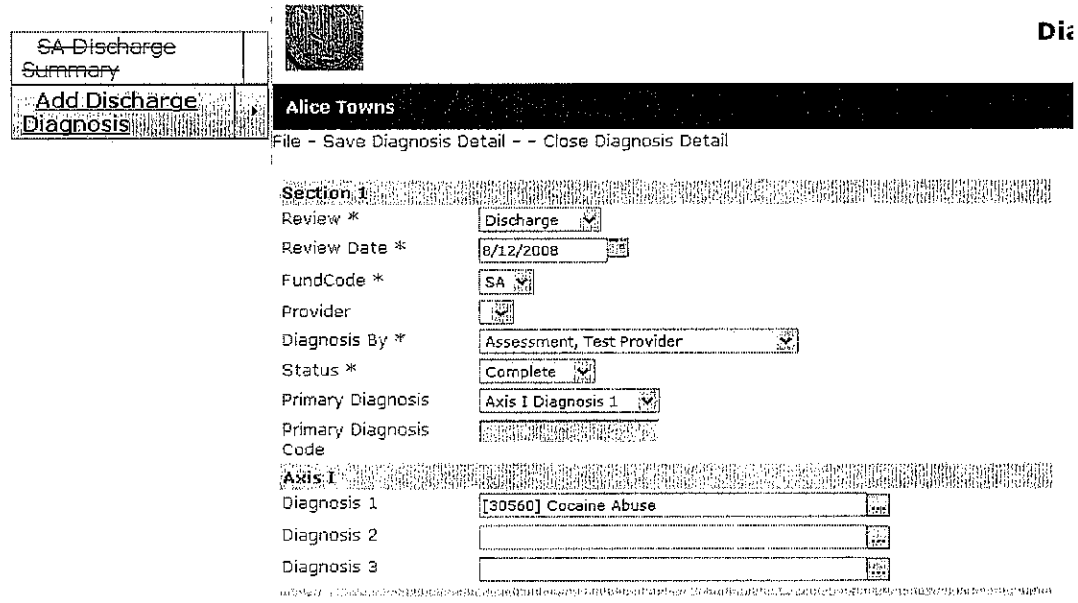
9. Click on *SA Discharge Summary*. A blank Discharge Summary will open.



10. Complete the SA Discharge Summary, setting *Status = Complete*, and *Save Assessment*.

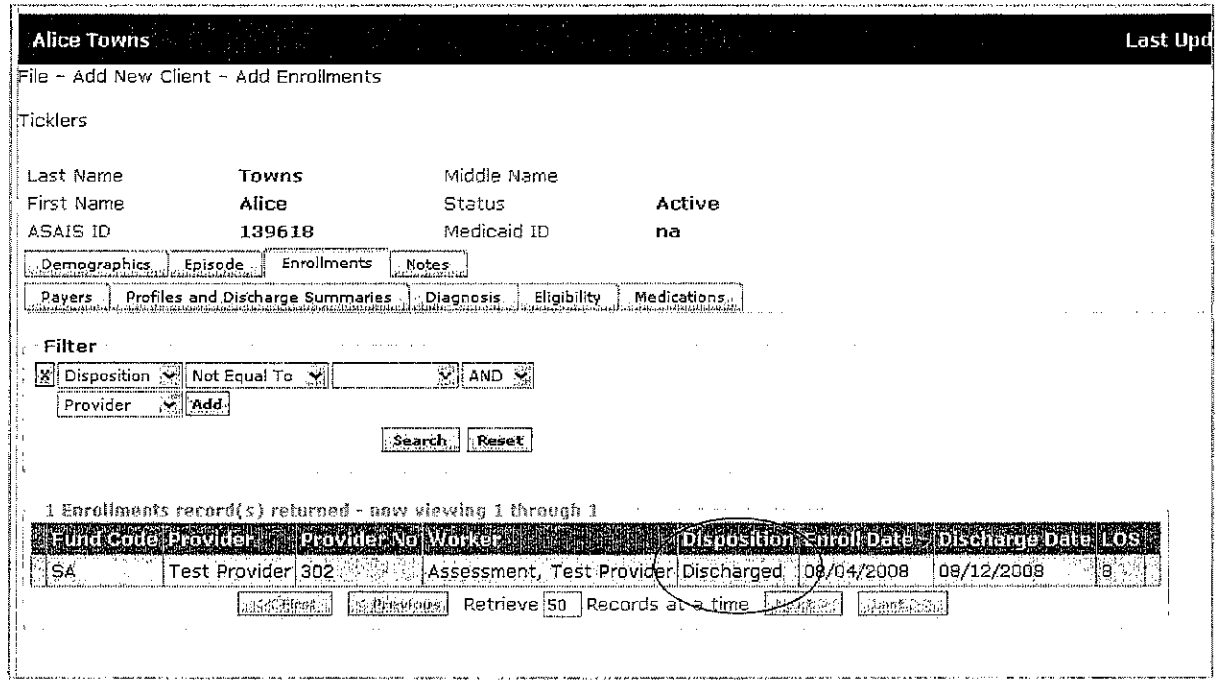


11. Click on *Add Discharge Diagnosis*. A blank Diagnosis Detail screen will open.
12. Complete Diagnosis Detail, setting Status = *Complete*.
13. Select a substance abuse diagnosis for *Axis I, Diagnosis 1*.
14. *Save Diagnosis Detail.*



15. Click on *Close My ASAIS.*

16. The Enrollment record now shows *Discharged* in the client's record.



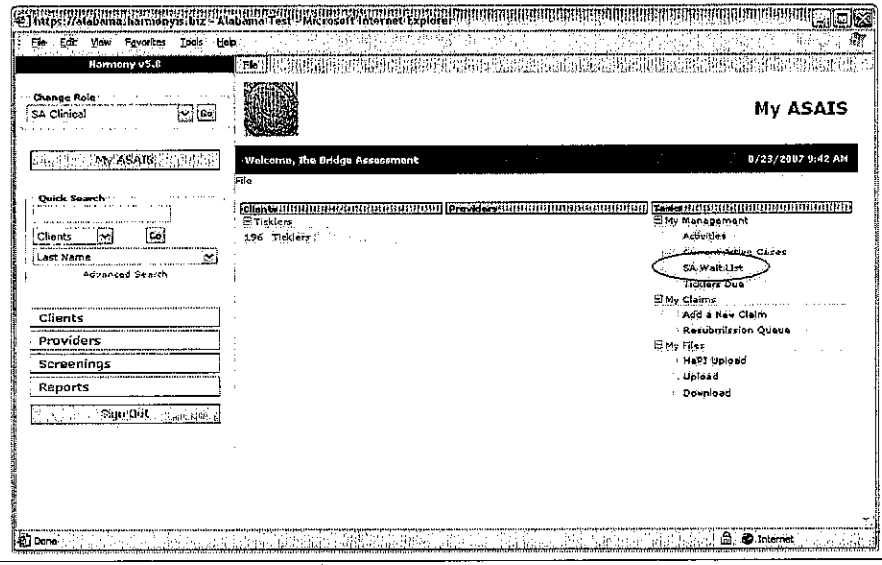
Wait List Management

SA Wait List (Facility Availability Queue)

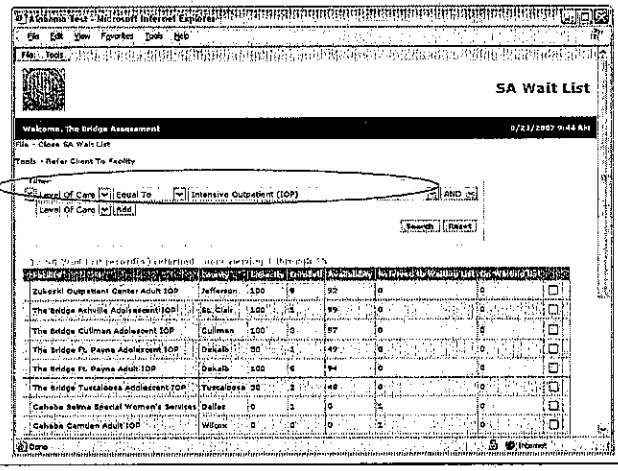
1. Users can refer clients to other providers using the *SA Wait List* from the *My ASAIS* page, under *My Tasks>My Management*.

NOTE: You will no longer have an "SA Wait List" role, the need for this role has been eliminated with the latest version.

2. Now click on the link under Tasks for *SA Wait List*.
3. The *SA Wait List* screen will open.



4. Users can filter the list by *Level of Care* by choosing it in the *Filter* dropdown and clicking on *Search*.



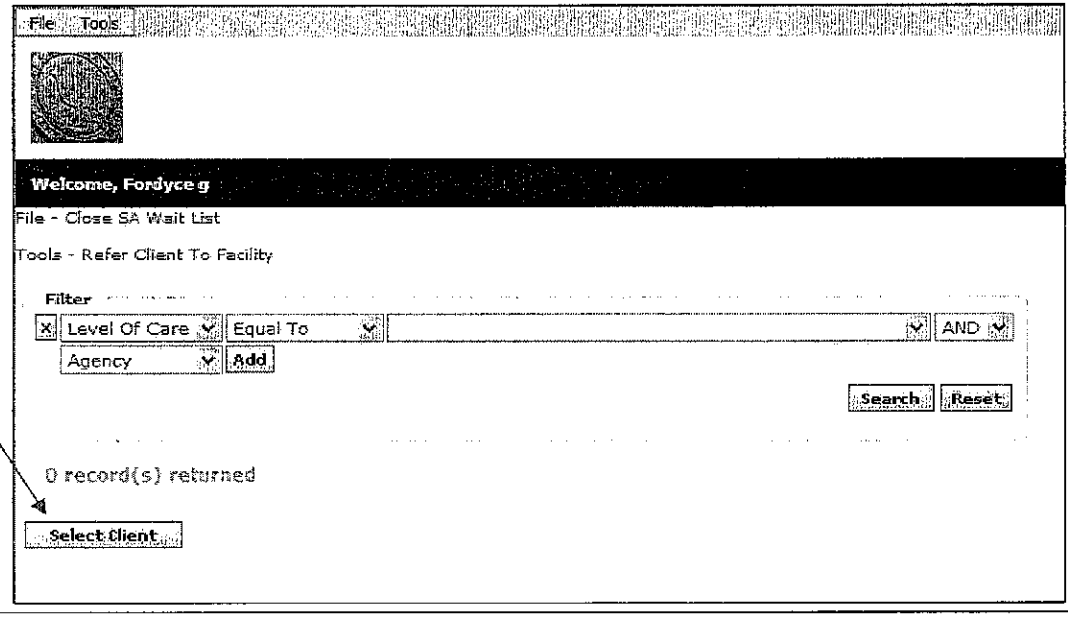
5. The list shows by facility/level of care, the following:

a. *Facility Name*
b. *County* where the facility is located
c. *Capacity* of this facility if restricted by license, size, etc.
d. Number of clients currently *Enrolled* in this facility
e. *Availability* – unused capacity for this facility
f. Number of clients who have been *Referred to Waiting List* of this facility
g. Number of clients who are currently (have been accepted) on the *Waiting List* for this facility

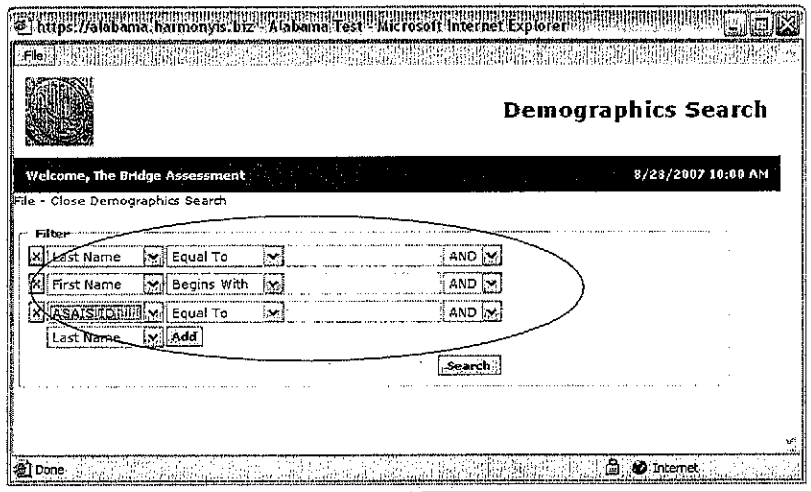
Referring a Client to a Wait List

To refer a client to a Wait List, follow these steps:

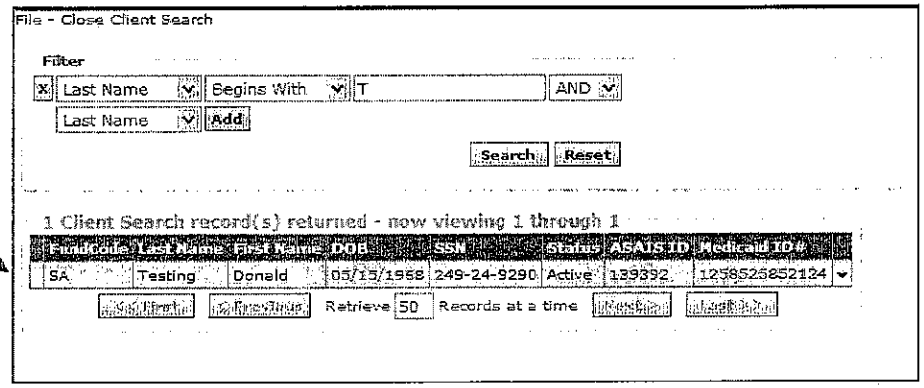
1. From the desktop, click on *SA Wait List*.
2. Before using the filter to select facilities, Click on the *Select Client* button at the bottom of the *SA Wait List* screen.



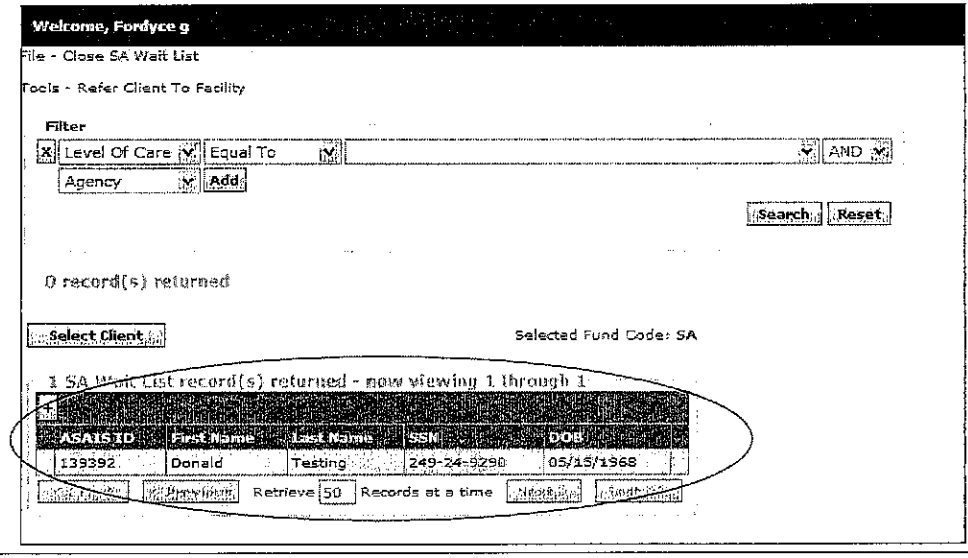
3. The Demographics Search screen will appear.
4. Use the Search Filter to locate the desired client record:
    a. Choose the Search criteria (options include Last Name, First Name, ASAIS ID, DOB, SSN and Medicaid ID)
    b. Click on the Search button.



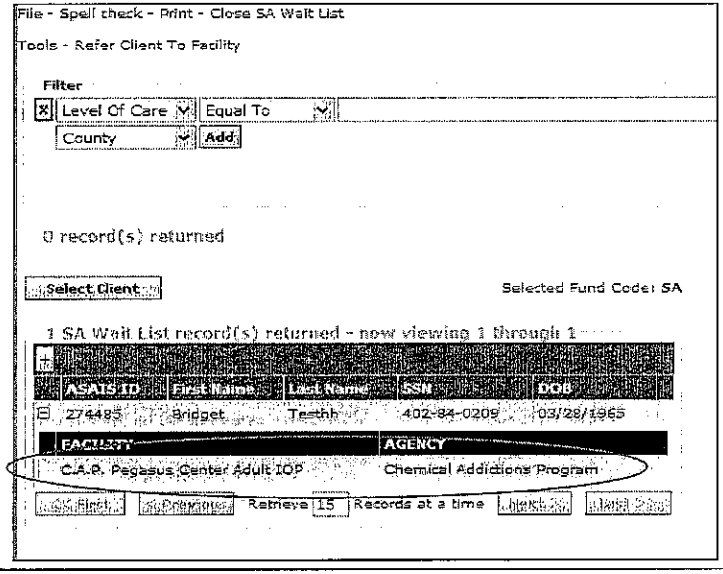
5. One or more clients will appear in the grid depending on the criteria that you used. Click on the client's record to select it for referral to one or more wait lists.



6. The Client will be listed on the facility wait list screen after the system refreshes.

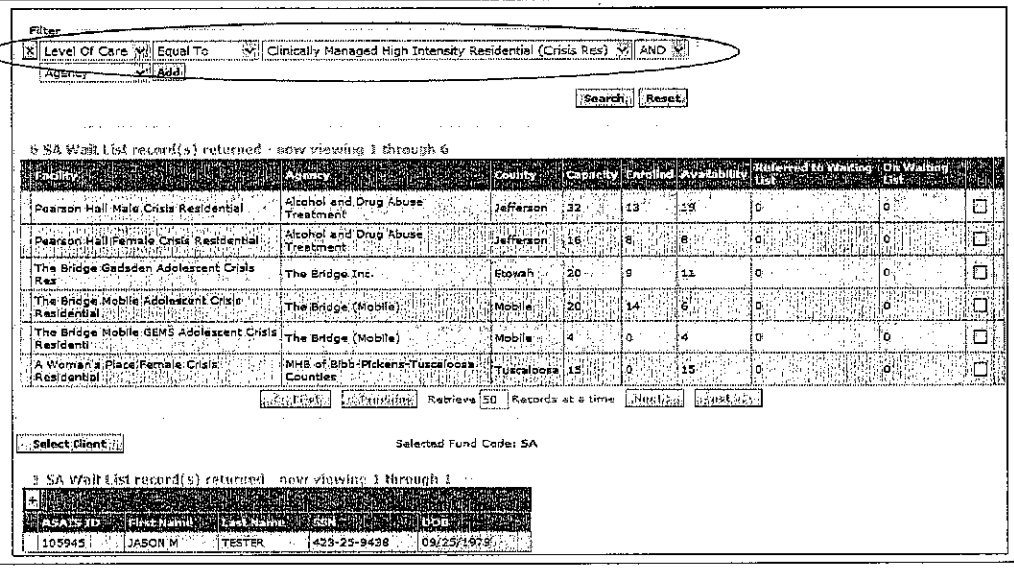


7. You can check any current enrollment for this client by clicking on the plus sign (if there is one) to the left of the client's ASAIS ID. The screen will expand and display the current enrollments.

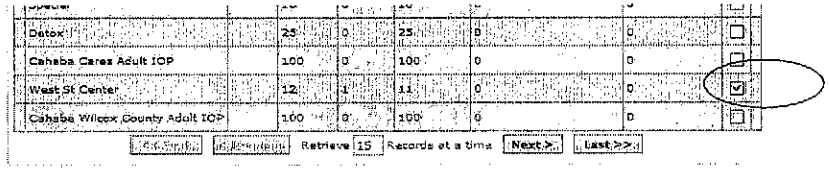


8. Now in the *SA Wait List* grid, filter for the correct level of care for this client. All facilities statewide will appear for that level of care.

   If you want to view facilities in a particular county, you can add County to the filter and Search for facilities just in that County.

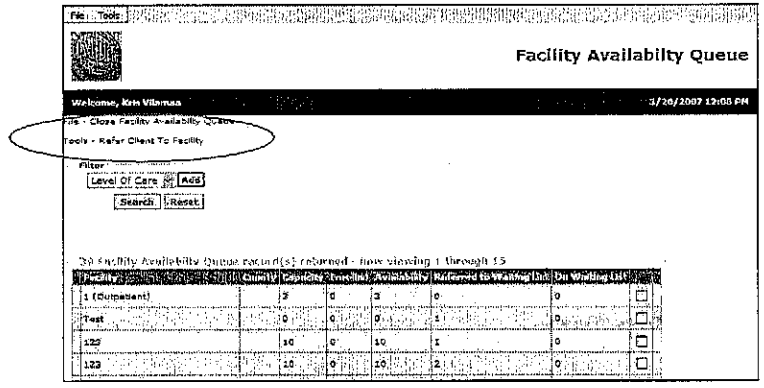


9. Select the desired facility (or facilities) for the referral by checking the box to the right of the facility. You can refer to one facility or to a number of facilities at once.

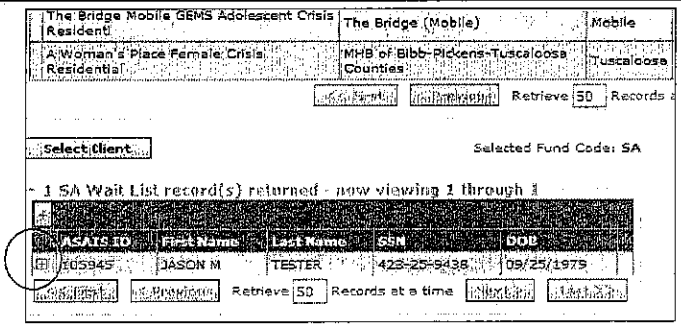


10. From the *Tools* menu, select *Refer Client to Facility.*
11. The client is now enrolled in the checked facility(ies) with a status of '*Referred.*'

NOTE: *The system may give you a failed message for some referrals. If a client is already open or referred to a facility, the wait list will not let you create another record for that same facility.*



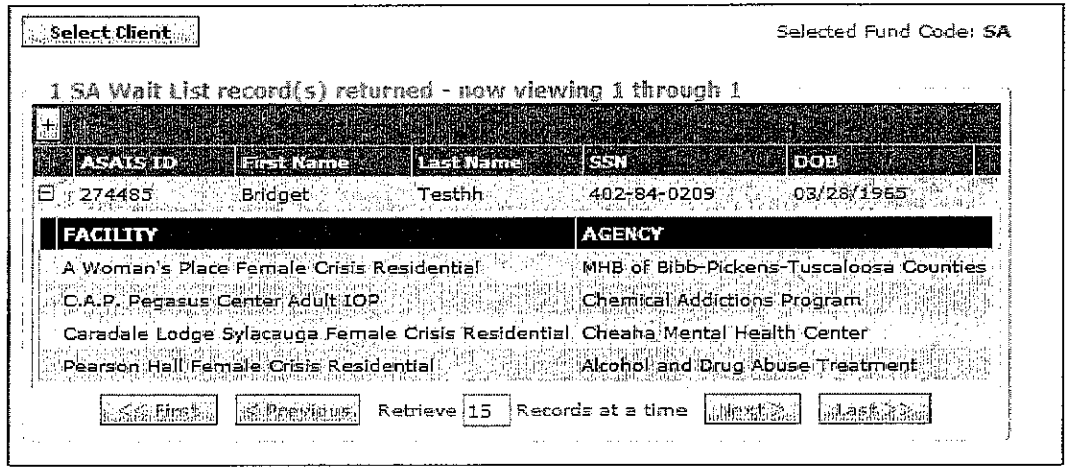
12. There will now be a + (plus) sign next to the client's name.



13. When you click on the + (plus) sign, the record expands to show all referrals. You have finished making your referrals for this client.

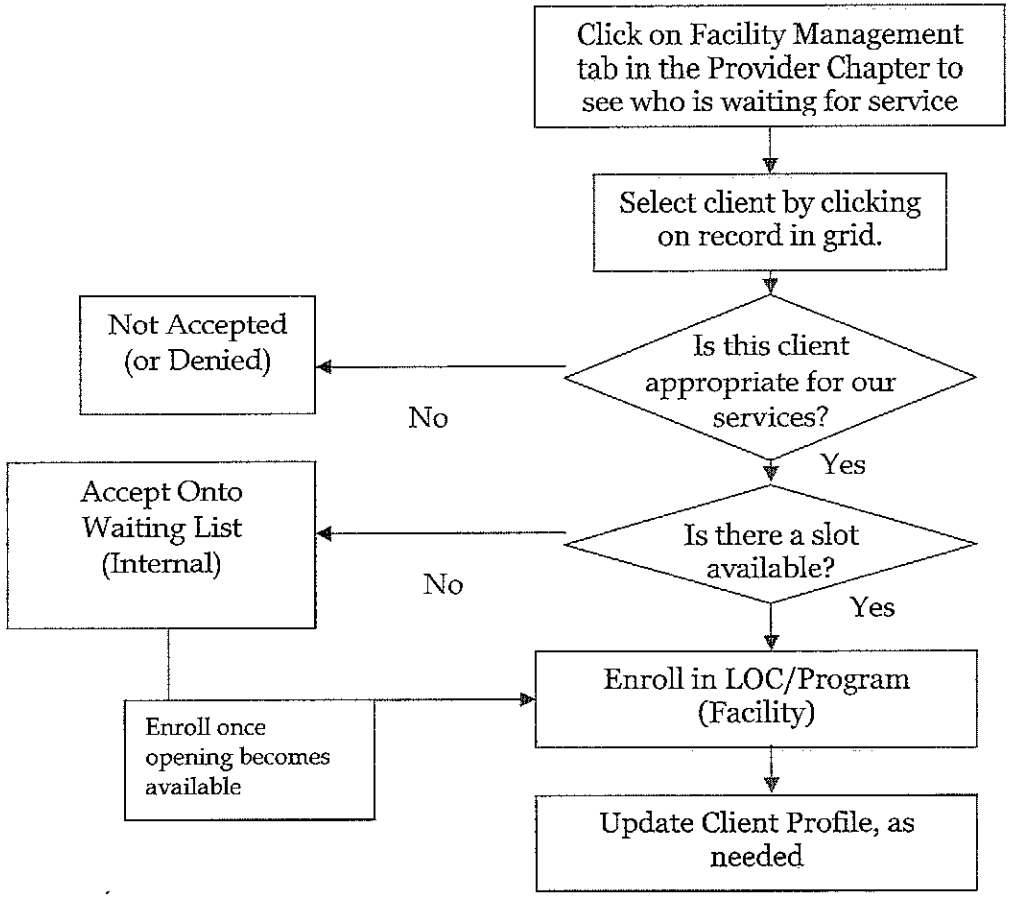
In this example, the client was already enrolled in an IOP program but has now been referred to 3 Crisis Residential programs.

Each of the referred to facilities must now review the referral and decide to accept this client onto their waiting list, deny the wait list referral or admit the client into the facility..



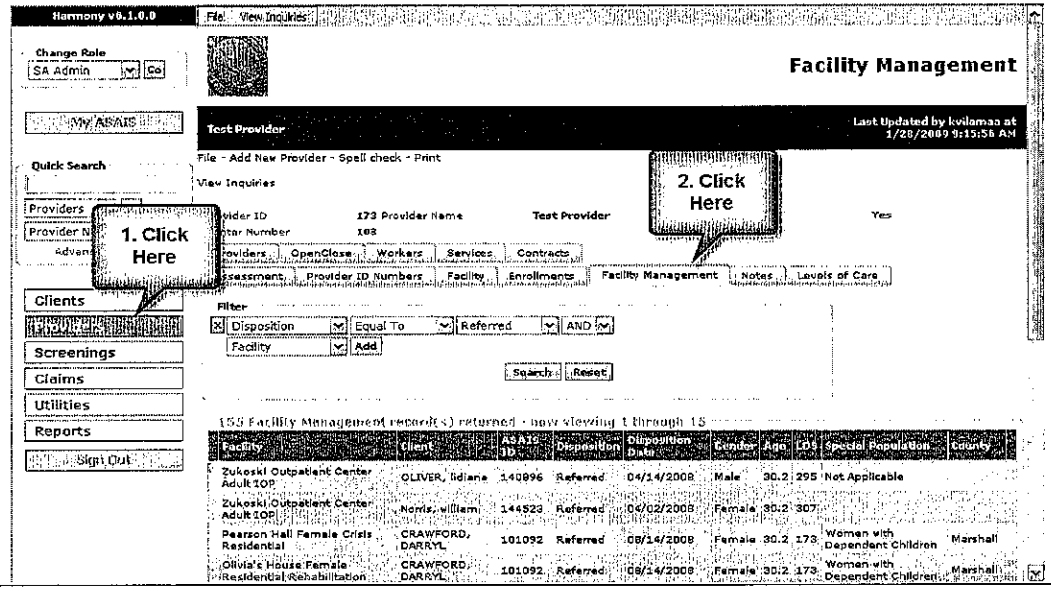
SA Work Flow – Receiving a Referral

4.
Client presents as referral from Assessment Provider (already screened by them)

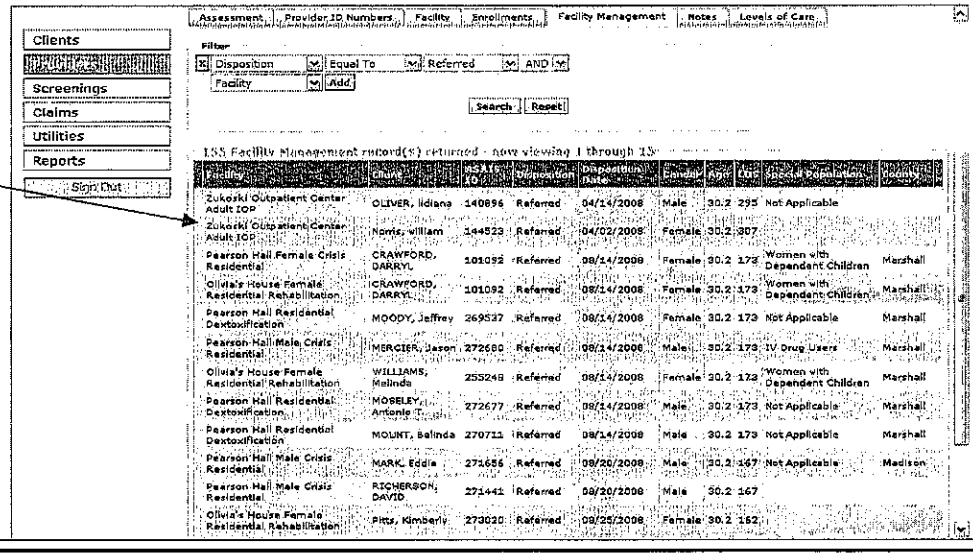


Accepting a Client on the Wait List

1. Click on the Provider Chapter on the My ASAIS desktop.
2. Click on the Facility Management tab in your provider record
3. The system defaults to show you all referred clients



4. Select the client whose disposition you want to change.

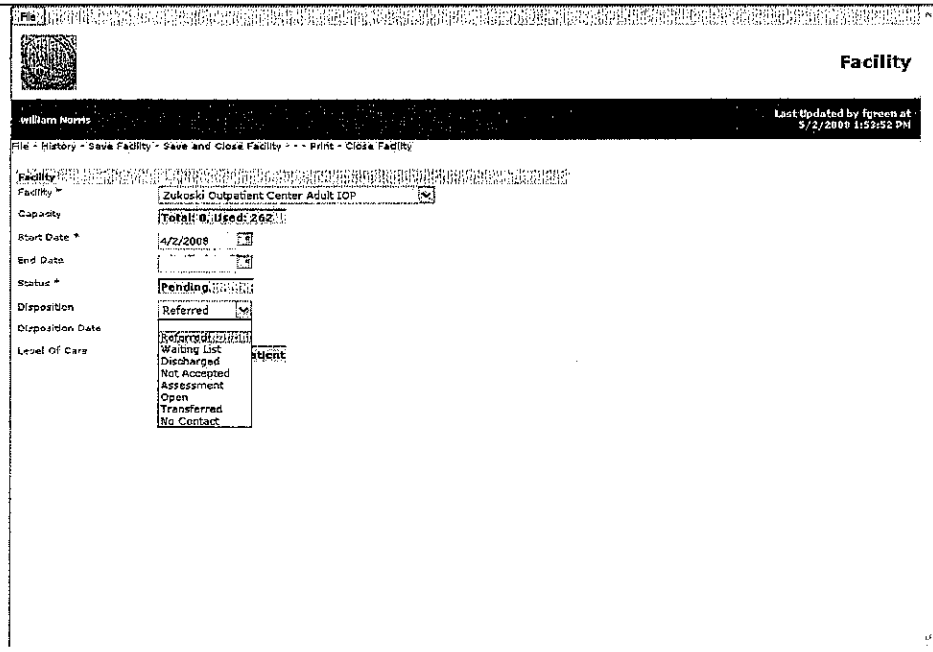


5. With referred clients, you would change the disposition to:
    a. Not Accepted (the client is not appropriate for service)
    b. Waiting List
    c. Open (you are immediately putting the client into service)

6. Click "Save and Close Facility"

7. A confirmation message will appear that says "Save Successful"

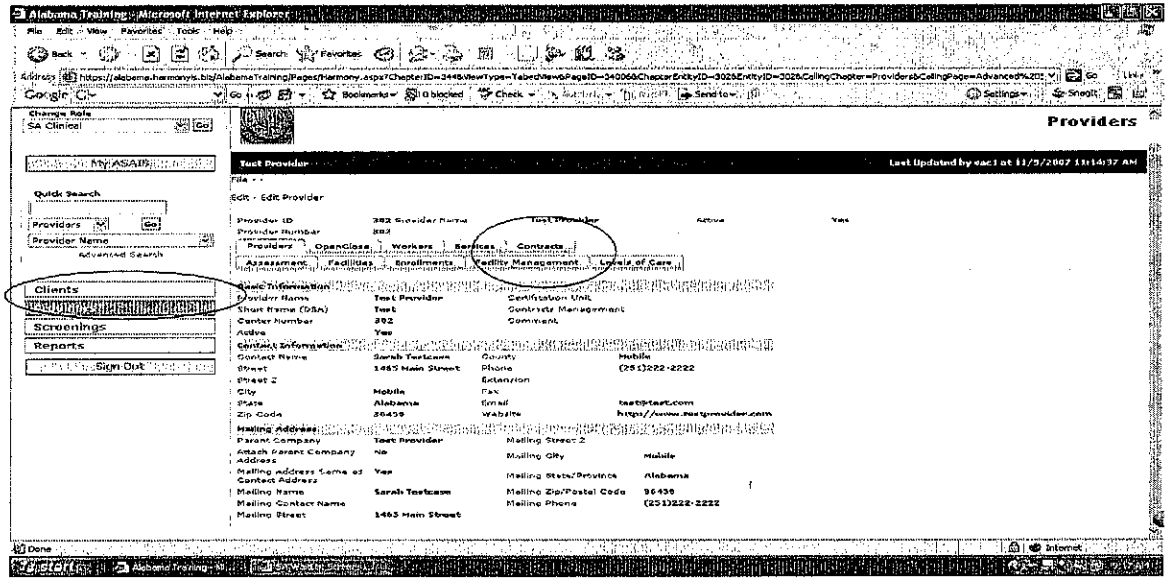
NOTE: There is no longer a warning when you move a referred or wait list client to open that they are being cancelled to other facilities with the same level of care. However, the action IS still taking place.



Provider Facility Management

1. Click on the Providers chapter button to arrive at the Provider screen. The screen will default to the Provider tab which is similar to the client's demographic screen.

2. Click on the Facility Management tab.

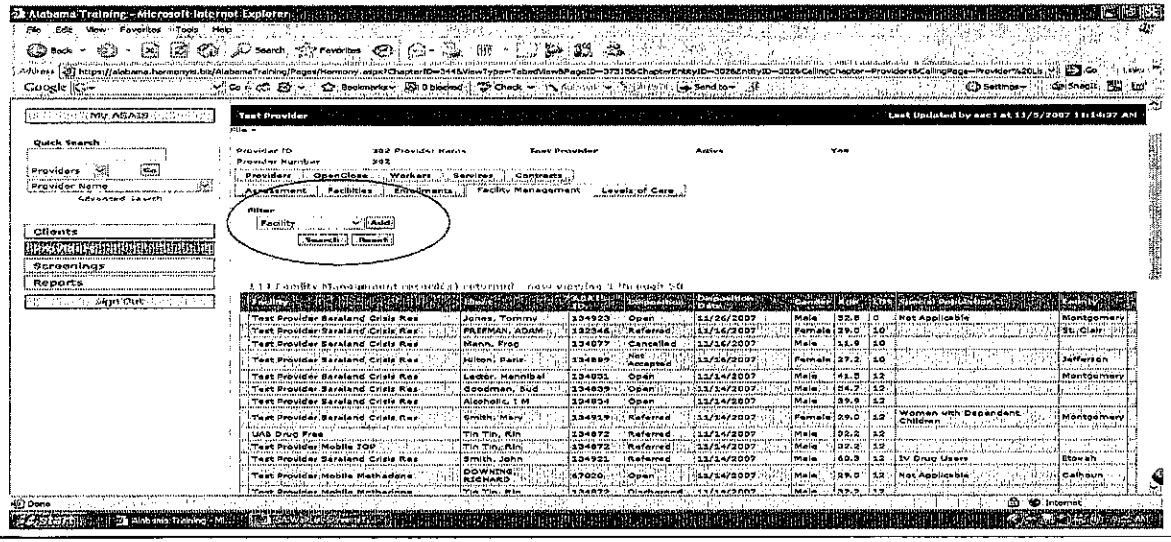


3. Use the filter to narrow down your search. Use the green column headers to sort the lists. Some examples follow.

4. Use this tab and these filters to view client placement and status.

5. Use this grid to accept or deny clients to your wait list or to move a client from the wait list to open.

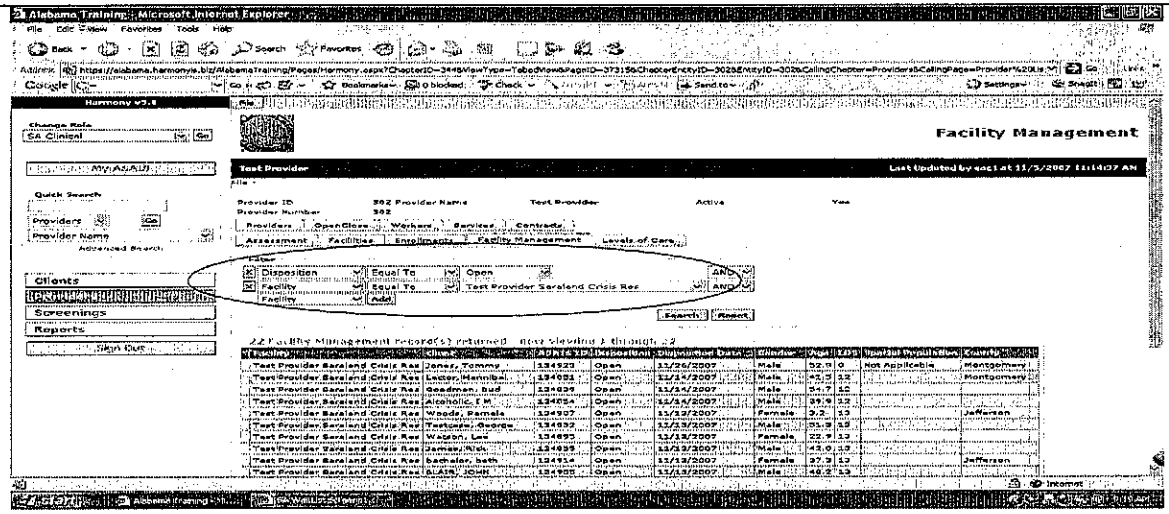
6. Use the *SA Wait List* grid to refer out clients.



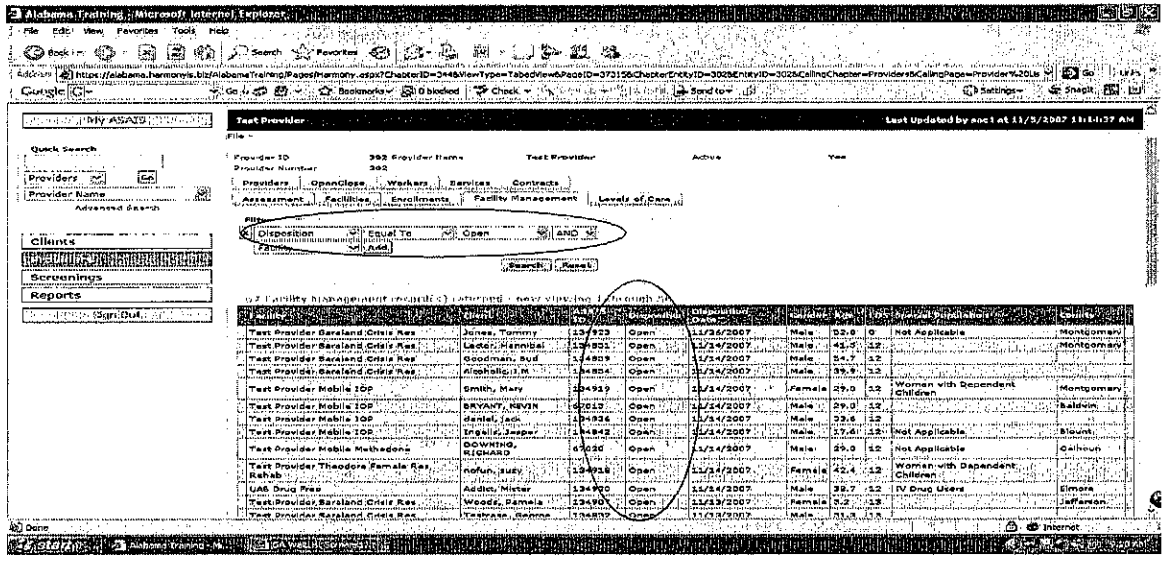
Examples:

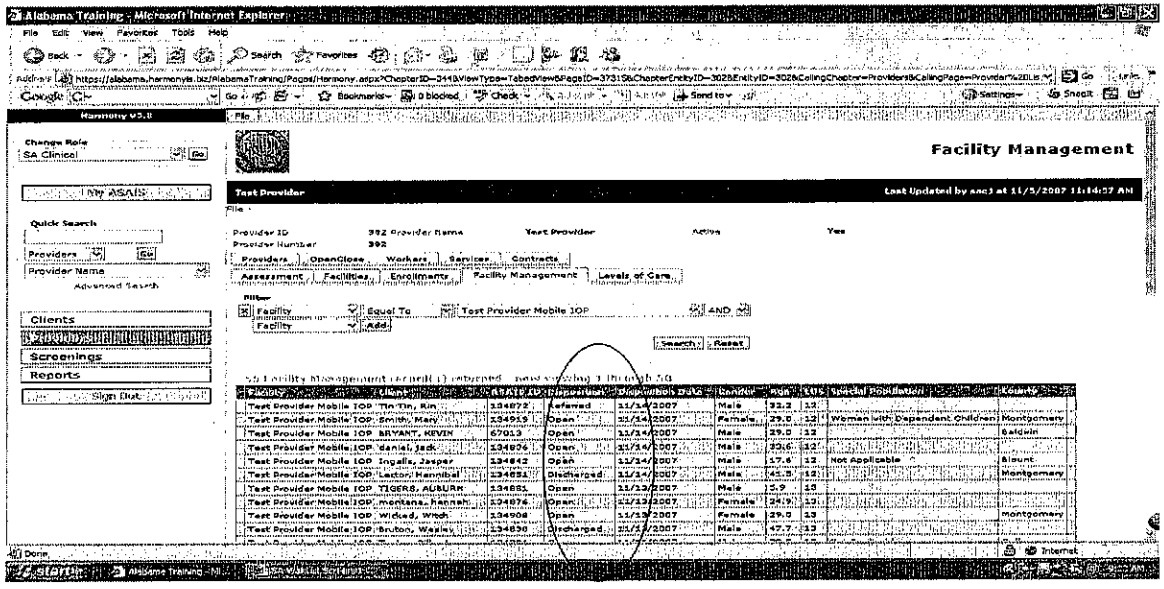
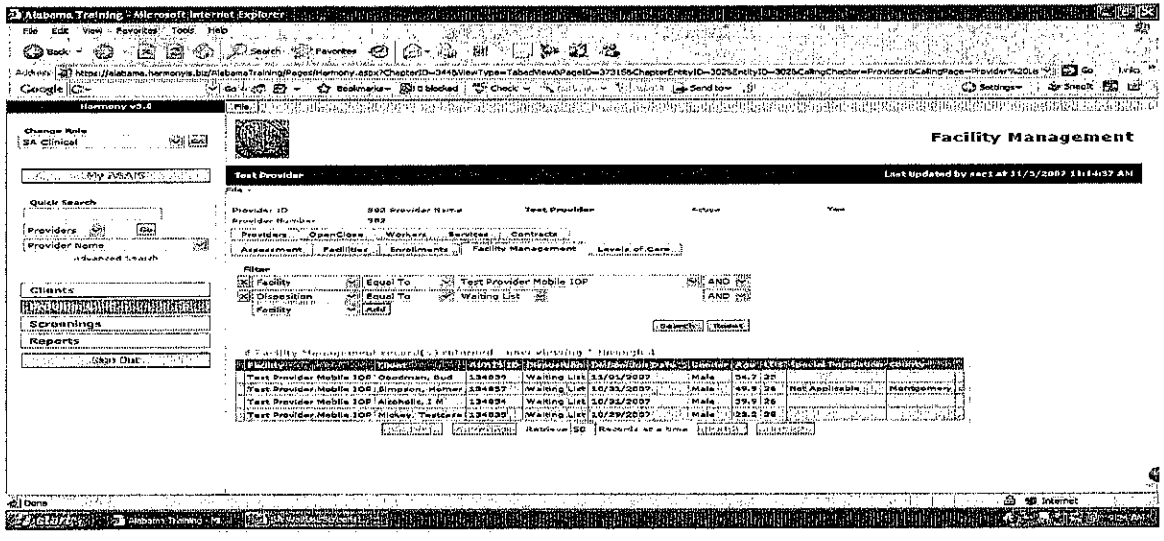
7. Filter here is set to:

Disposition = Open
Facility = Test Provider Saraland Crisis Residential



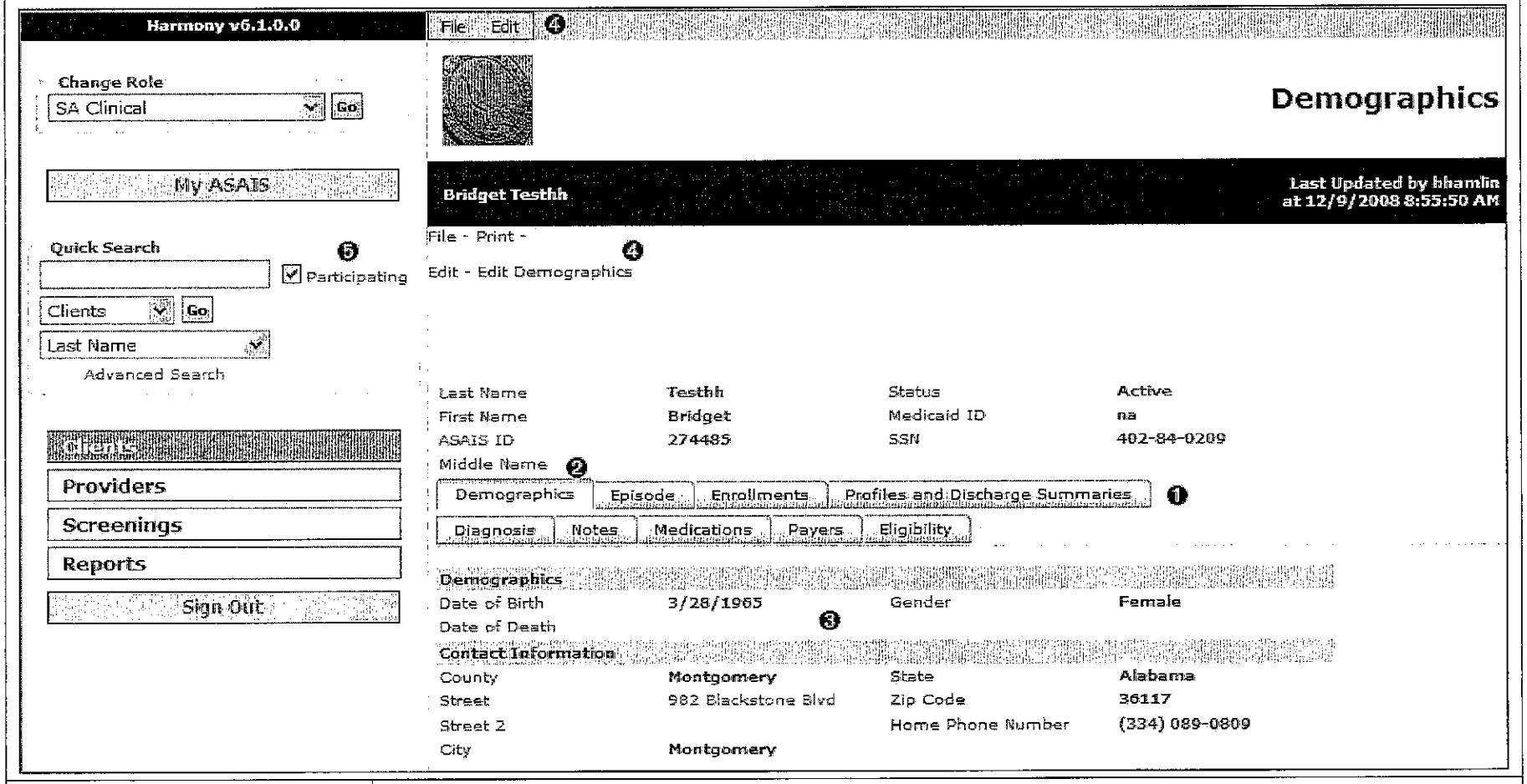
8. Filter is set to Open, no facility is specified so this gives you a list of all Open clients across facilities for your provider.



9. Facility is set to: Test Provider Mobile IOP Disposition is not used in the filter so all clients with any disposition will be listed.	
10. By adding a Disposition filter of: *= to Waiting list* The grid shows only those on the waiting list for this facility.	

Client Records Overview

Navigating a Client's Record



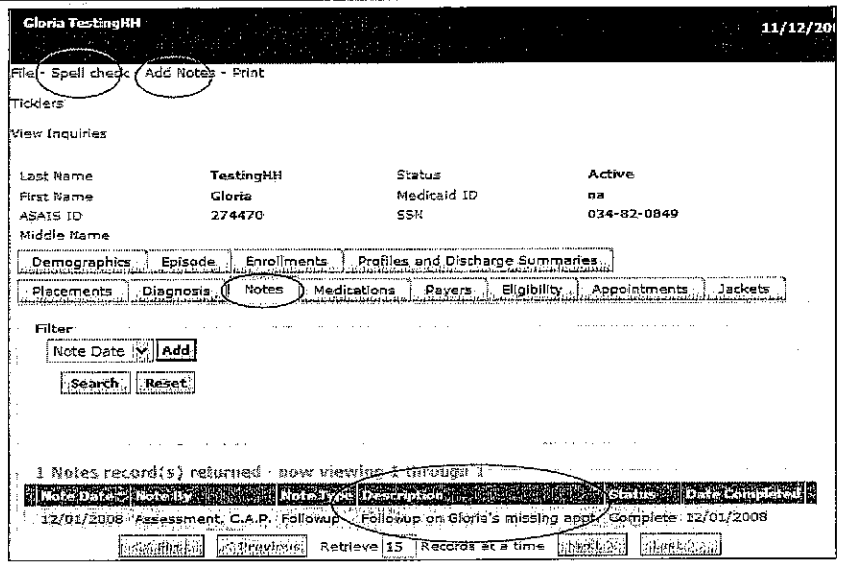
1. Tabs	A Client's record is broken up into different categories of data. These categories called Tabs (or

	sometimes pages) are displayed horizontally across the screen. Two rows of tabs will be seen.
2. Active Tab	The currently active Tab is highlighted. The ASAIS menu bar and the information displayed below the tabs correalates to the active Tab.
3. Data/List View	The information displayed below the tabs that correlates to the active Tab. Information may be displayed in a list. To open an item in the list, simply click on it. (Demographic information can be edited by selecting Edit Demographics from the Edit menu in the ASAIS menu bar.)
4. ASAIS Menu Bar	The Menu Bar contains a set of menus that allow the User to access different functions related to the Client's record. Alternatively, the same menu items are displayed as links that show all available options for any particular screen.
5. Participating Check Box	The Participating check box can be used during a client search to narrow down the records to be displayed but pulling only records who have a currently active enrollment with your agency.

Adding a Note to a Client's Record

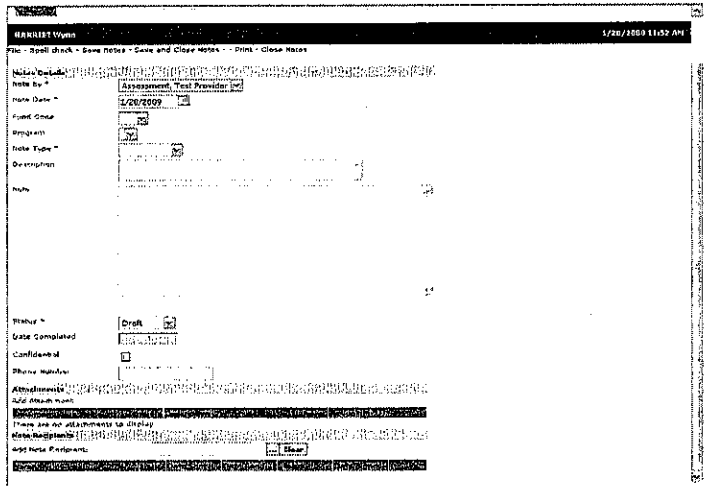
NOTE: Notes should be used to request changes to a client's info by Central Office Staff. **Changes should not be requested through a screening.**

1. To add documentation regarding the client, first locate their record using Search.
2. Click on the *Notes* tab.
3. Select *Add Notes* from the File menu.
4. ASAIS also has a *spell check* feature to apply to the text of your note as needed.

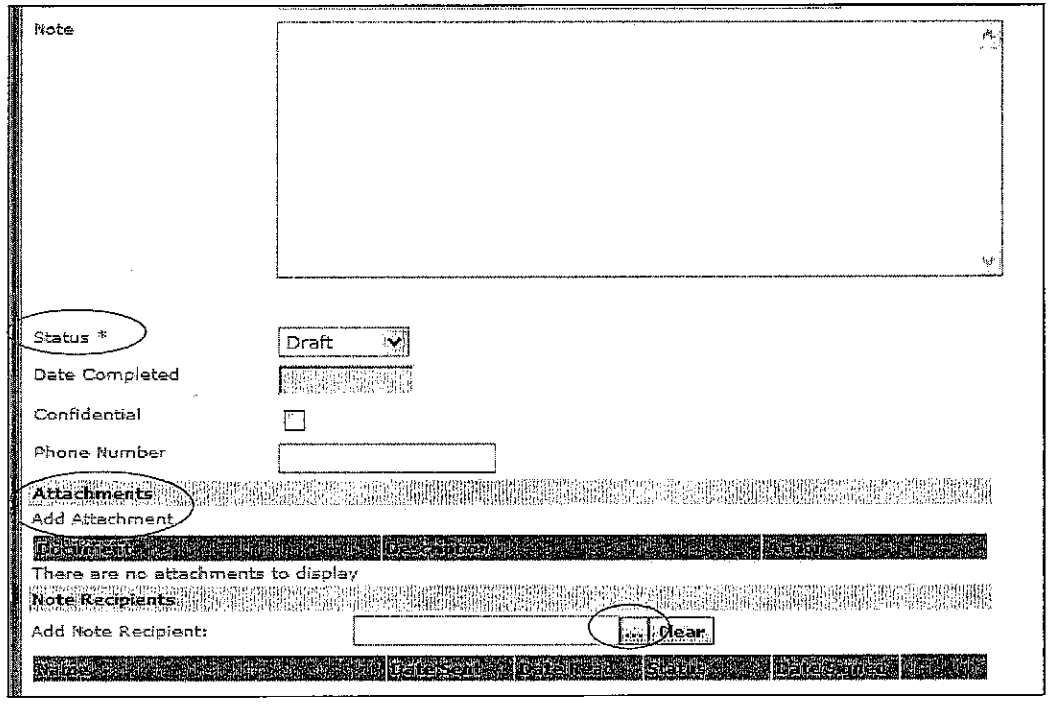


5. Enter a *Description* of the note. This is important since it is this field that shows in the grid in the client's record (see screenshot above.). The description will help you determine which note it is that you wish to read. The *Note Type* will tell you if there is an attachment to view.
6. In the *Notes* screen, fill out the required information, including *Note Type*. Add the text of your note in the *Note* field.

   When writing the note, remember that this note will be part of the client's record.



7. The *Status* field will indicate Draft, Pending or Complete. If you leave it as Draft, it will not get sent to the other recipients that you may identify in #9 below. If you leave the status as Pending, recipients can add text and send it back to you. Complete finalizes the note.
8. To add an attachment, click on the red *Add Attachment* link. A pop-up window will allow you to select a file (Word document, pdf file or other scanned image) to attach to this note. Once the file is uploaded, it will show under the Document section.
9. Under Note Recipients, click on the ellipsis button [...] to add *Note Recipients* if you want to send this note to one or more staff. (A search window will pop-up so you can select the staff.) A Note Recipient is <u>not</u> required to write or save a note. Only staff who are licensed users of ASAIS will show in the Search window.
10. Select *Save and Close Note* from the *File* menu when you are finished.



Editing Client Data

Editing an Existing Client

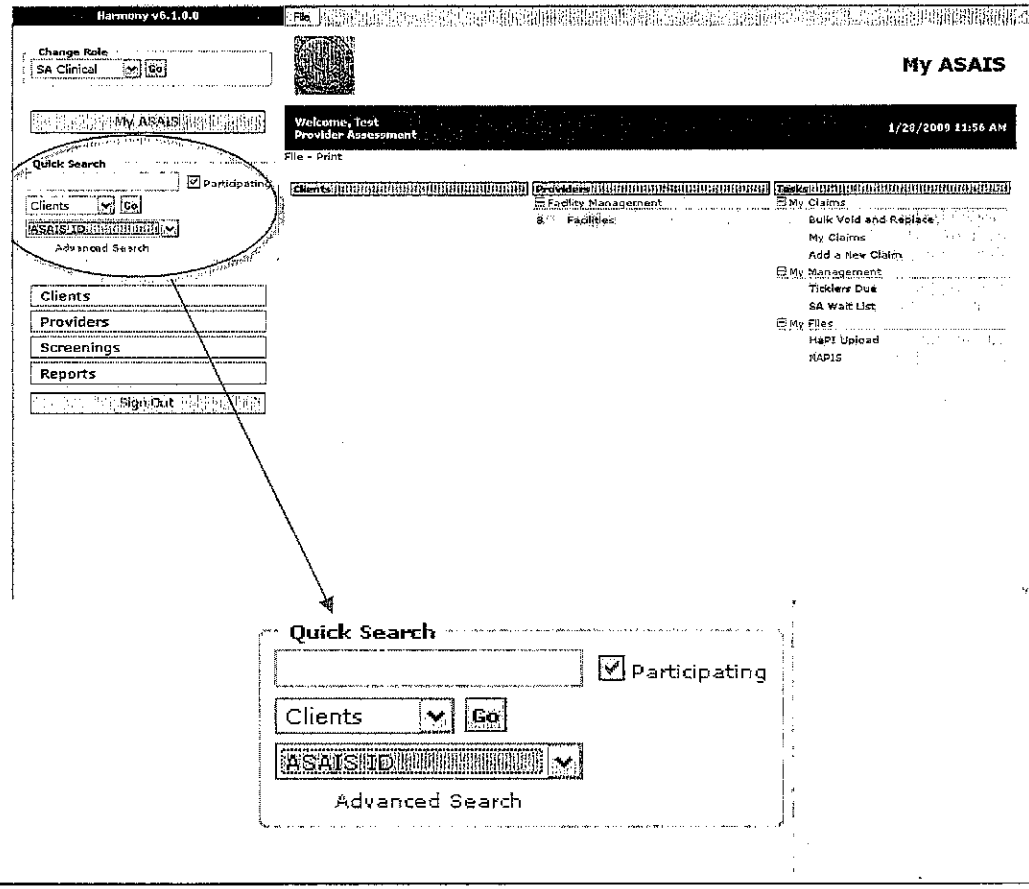
Searching for the client (Role: SA Clinical and SA Finance)

To search for a client in ASAIS, you have a number of options. One is using the *Quick Search* and the other is the *Advanced Search.*

1. In the *Quick Search* section, enter your client's last name and click on *Go* or enter. You can also search by ASAIS ID number, SSN, DOB or Medicaid ID by changing the value in the drop down.

If you check the Participating check box, your search results will include only those clients who have an Open Enrollment with your Provider agency, i.e., they are currently active.

If you do <u>not</u> check the Participating check box, your search results may include inactive clients or those who have had an Enrollment with your Provider agency but who are not currently active.

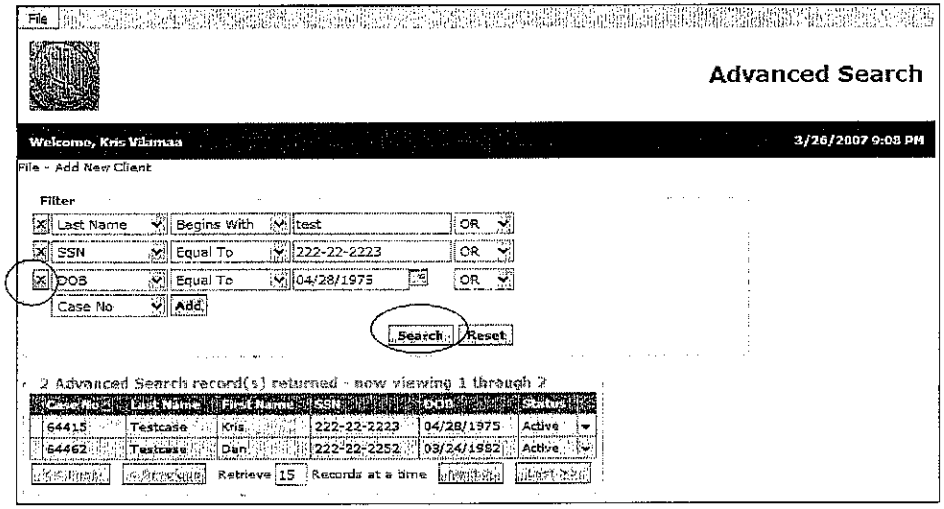


OR, a second Client Search option:

2. Click *Advanced Search* to enter more information to search for the right client. *This is especially helpful if the client has a common last name.*

3. In the filter, enter the client's last name and first name or first initial. You can also enter date of birth and/or social security number. Click on the x to the left of any filter item that you do not wish to use. This will eliminate it from your search. ASAIS will refresh the filter as you adjust the options.

4. Click *Search*. You will get a grid of possible matches to your search. Examine the information and select the client for whom you were searching.



Editing Demographic Information

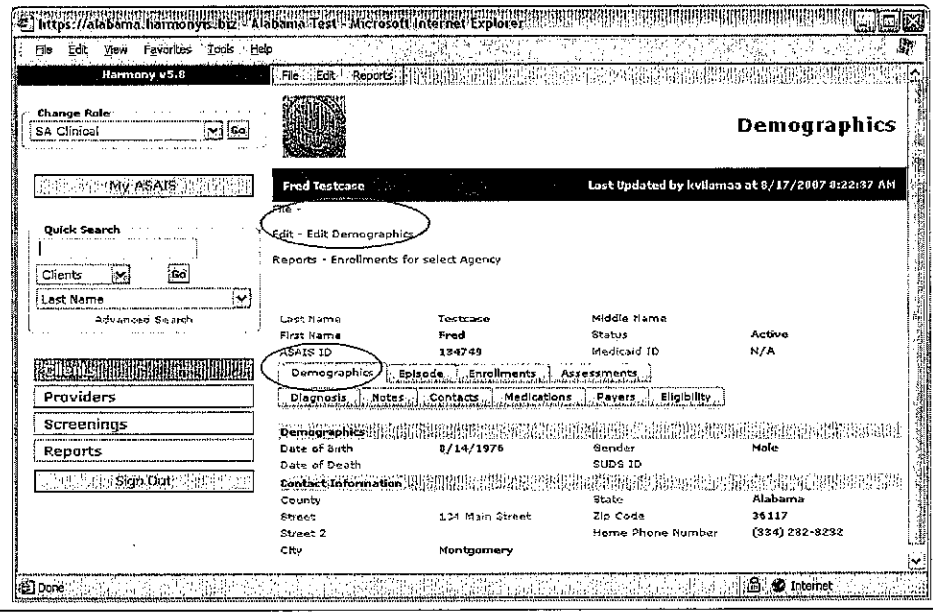
1. Once the client or a list of clients comes up, click on the client for whom you were searching. ***Examine all the information to make sure that this is the right person.***

2. After selecting your client, you are presented with the *client's record.*

3. Click on the *Demographics* tab. *(the record will normally open with this tab as the active one.)*

4. *Click on Edit Demographics* in the links. The full demographics screen will appear.

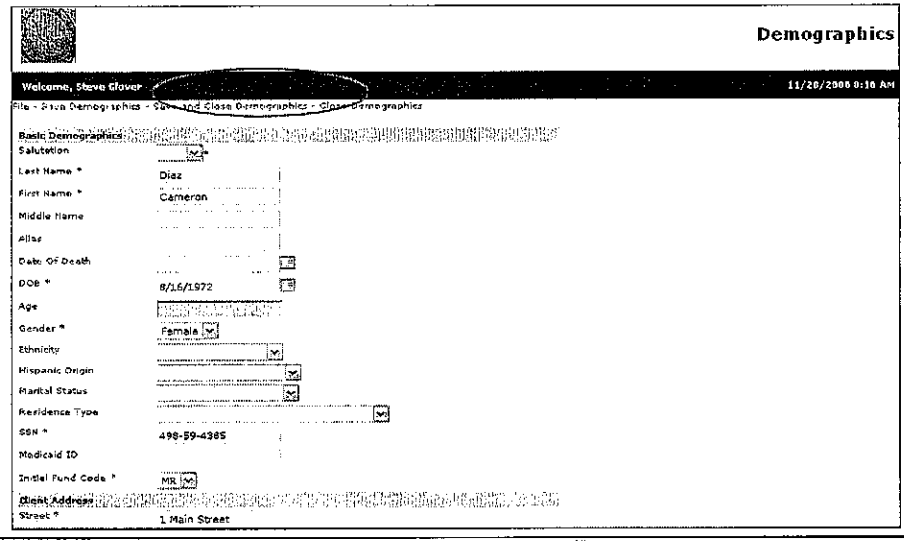
   Some items will be grayed out and can only be changed by staff at SASD. Please report any needed changes to SASD, in a note, if you see incorrect information concerning name, SSN, DOB.



5. Enter as much additional data that you have for this client and change any incorrect information. Any required fields are marked with a red asterisk

Be sure to check for correct Gender, & Street Address (A COMPLETE address is required for Claims Submission.)

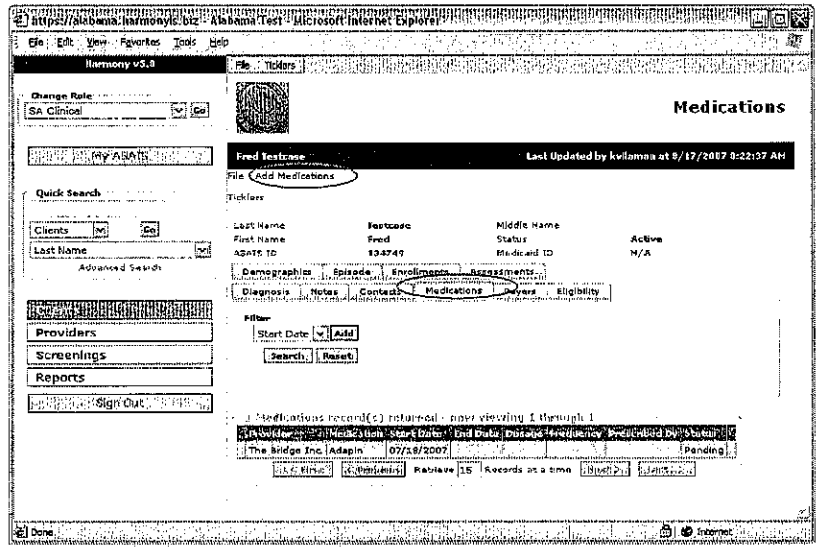
6. Click *Save and Close Demographics* when finished



Medications

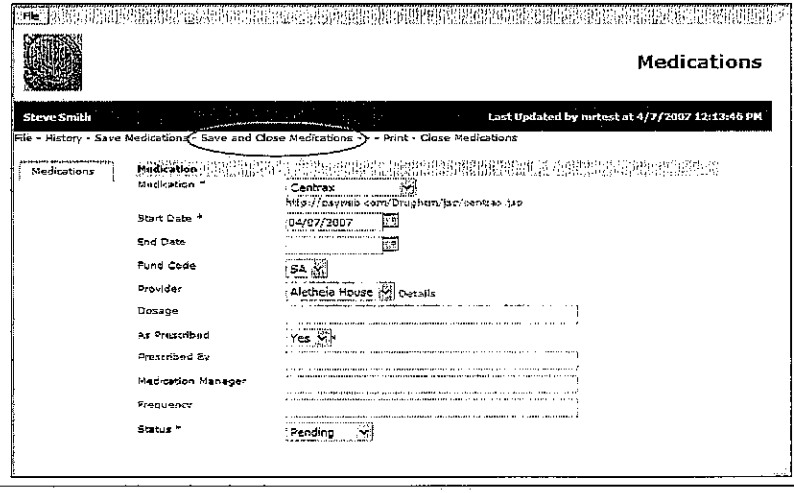
Using the Medications tab, you can capture the information about any medications that this client may be taking. This is not a pharmacy system, so it will not perform drug interactions, but will capture the information as a reference. This information can be very important when referring to residential programs.

1. On the client's record, click on the *Medications* tab.



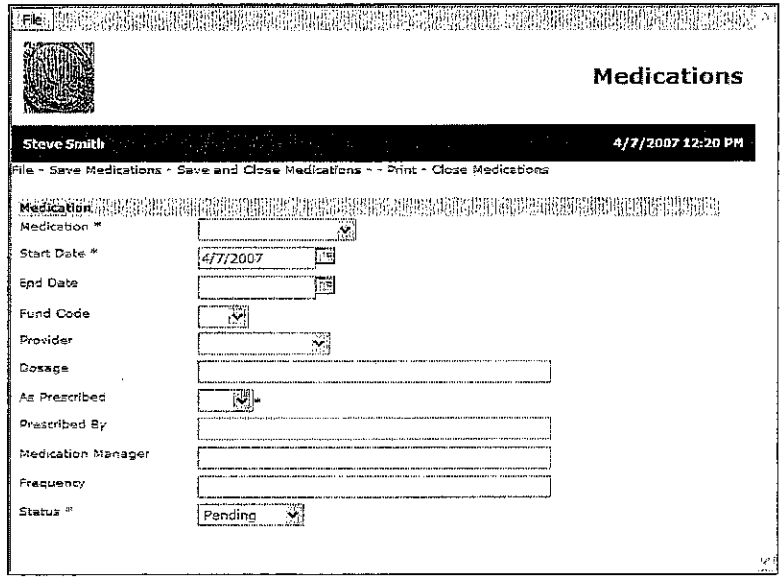
2. Edit or view an existing *Medications* record by clicking on it in the list.

3. If any changes are made, remember to select *Save and Close Medications* from the *File* menu. If no changes are made, select *Close Medications* from the *File* menu.



4. If you would like to add a new medication, select *Add Medications* from the *File* menu.

5. The *Medications* screen will appear.

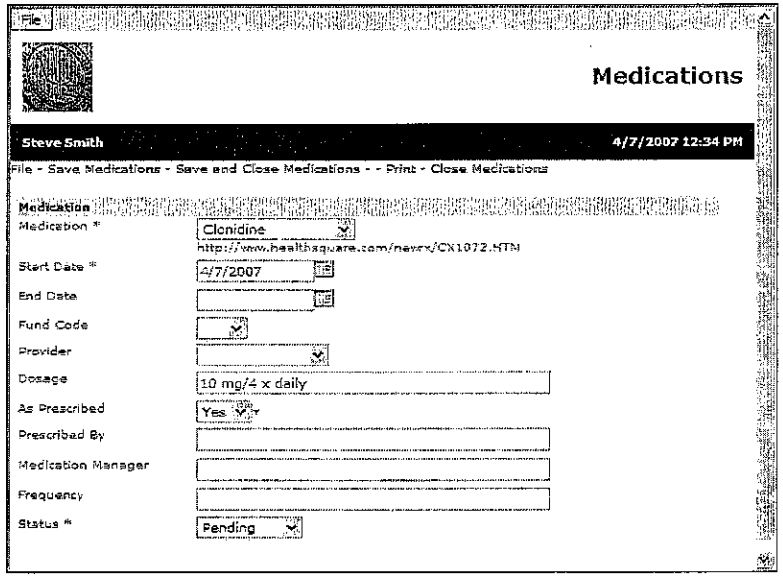


6. Using the drop down box, select the *Medication* for this client.

Note
Once you select a medication, a hyperlink may appear that will take you an external website when clicked. This website will provide information about the medication.

7. Complete any other information you have for this medication.

8. Select *Save and Close Medications* from the *File* menu.



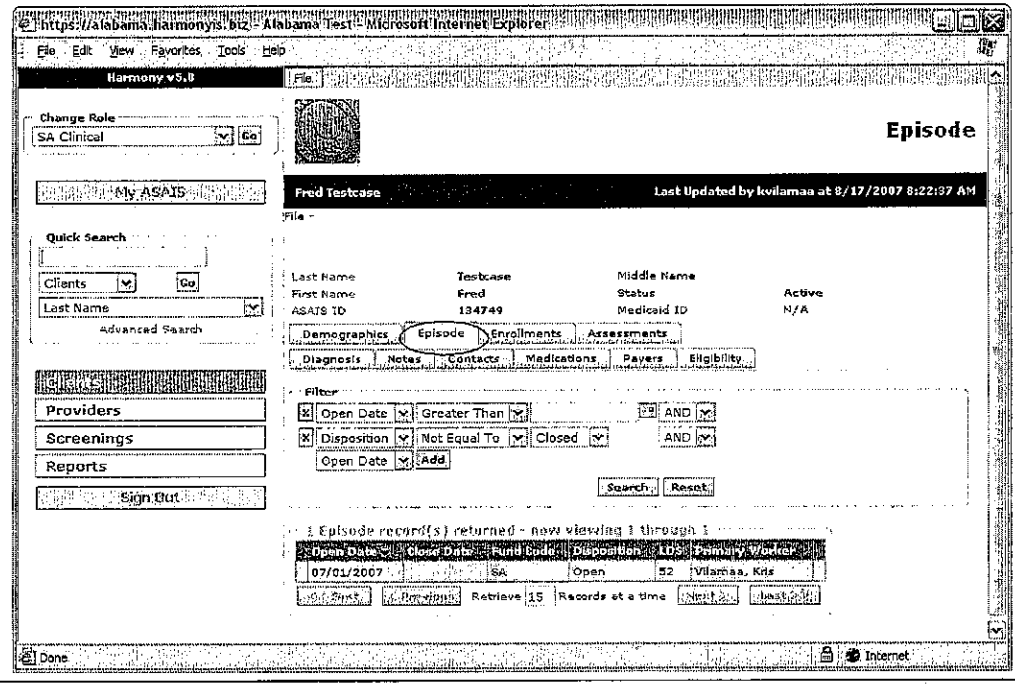
Episodes

Viewing an Episode

The Episode tab refers to an episode of care and is used to keep an historical record of when clients are opened and closed to ASAIS. Every client must have a record in the Episode tab with an Open disposition. This record is opened and edited by staff at SASD.

The assigned worker (Primary Worker) in the record will show as either the SUDS legacy worker (converted data from SUDS) or as the SASD/Central Office worker who created the episode.

NOTE: The date on this record is important. If services need to be billed prior to the date that appears here, please contact the ASAIS enrollment specialists to correct.

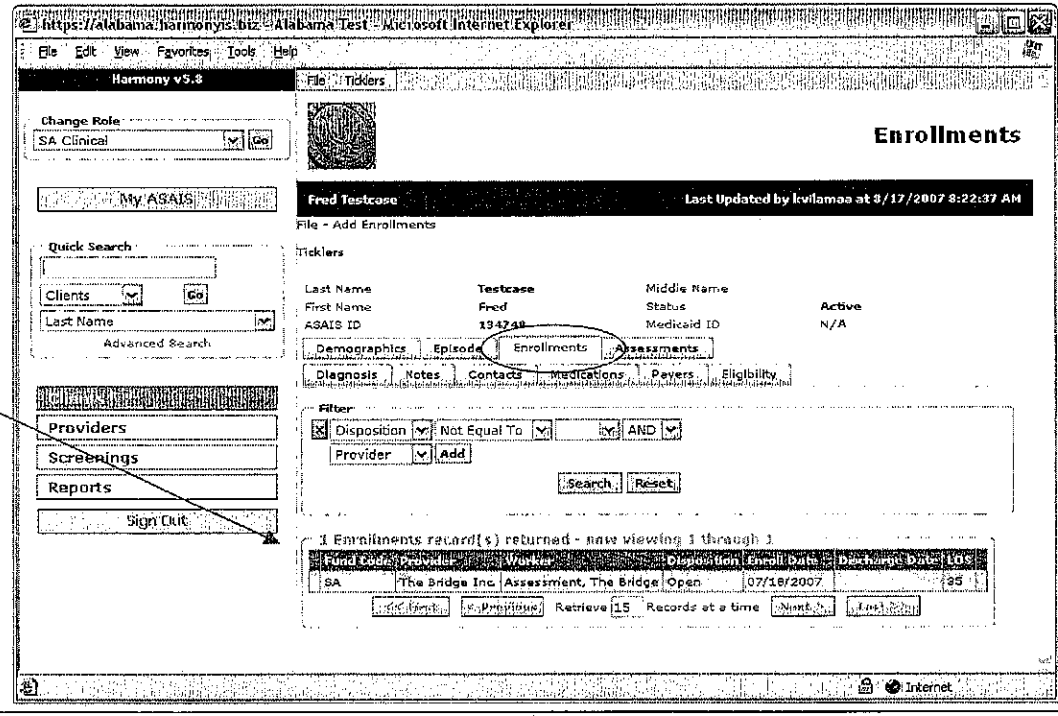


Program Enrollments

As new clients are entered via a Screening, the SASD staff will establish the first Enrollment record for Assessment with your agency. The worker for this first assessment will be a generic assessment worker with your agency (e.g. Assessment, The Bridge). This will allow one or more staff at your agency to have access to assessment records. When you decide to enroll the client into your program, you will update this enrollment record to Open instead of Assessment.

Updating an Enrollment for an Existing Client

1. Navigate to the desired client record by using the *Search* features or selecting it from *Current Active Cases* under *My Management* on the *My ASAIS* page.
2. Click the *Enrollments* tab.
3. Select the Enrollment record for your agency in the Enrollment grid.



4. Update the *Program* (Facility/Level of Care) and *Disposition* as appropriate.

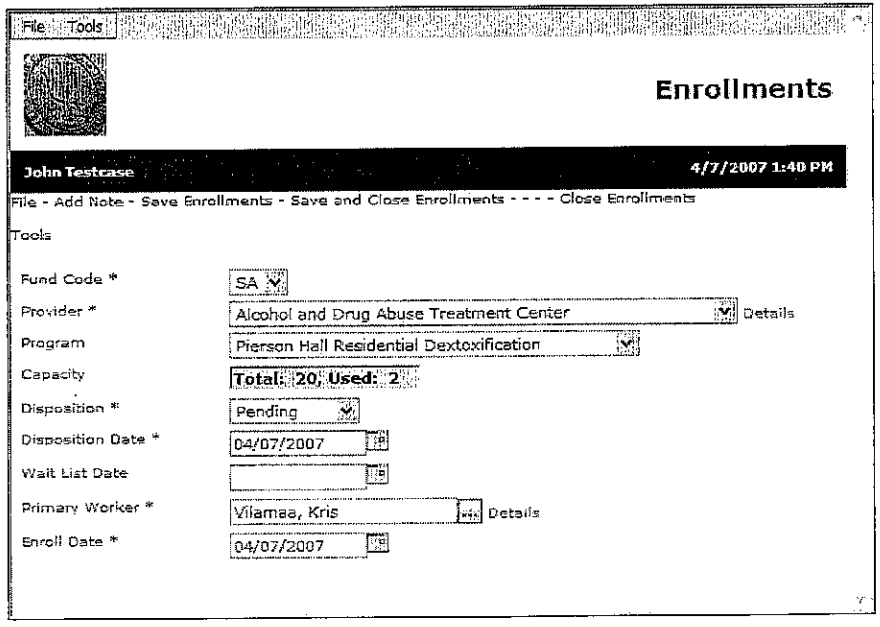
If a client is moving from one Facility/LOC to another, Add Facility to this record. Do not change the existing facility record to the new LOC as you will lose history and may create claims denials as the client will no longer be eligible for services in the previous LOC.

In the existing LOC record, change the disposition to Transferred then Add Facility for the new LOC that will have the Open disposition.

5. The dates will default to the current date, but can be changed if desired.

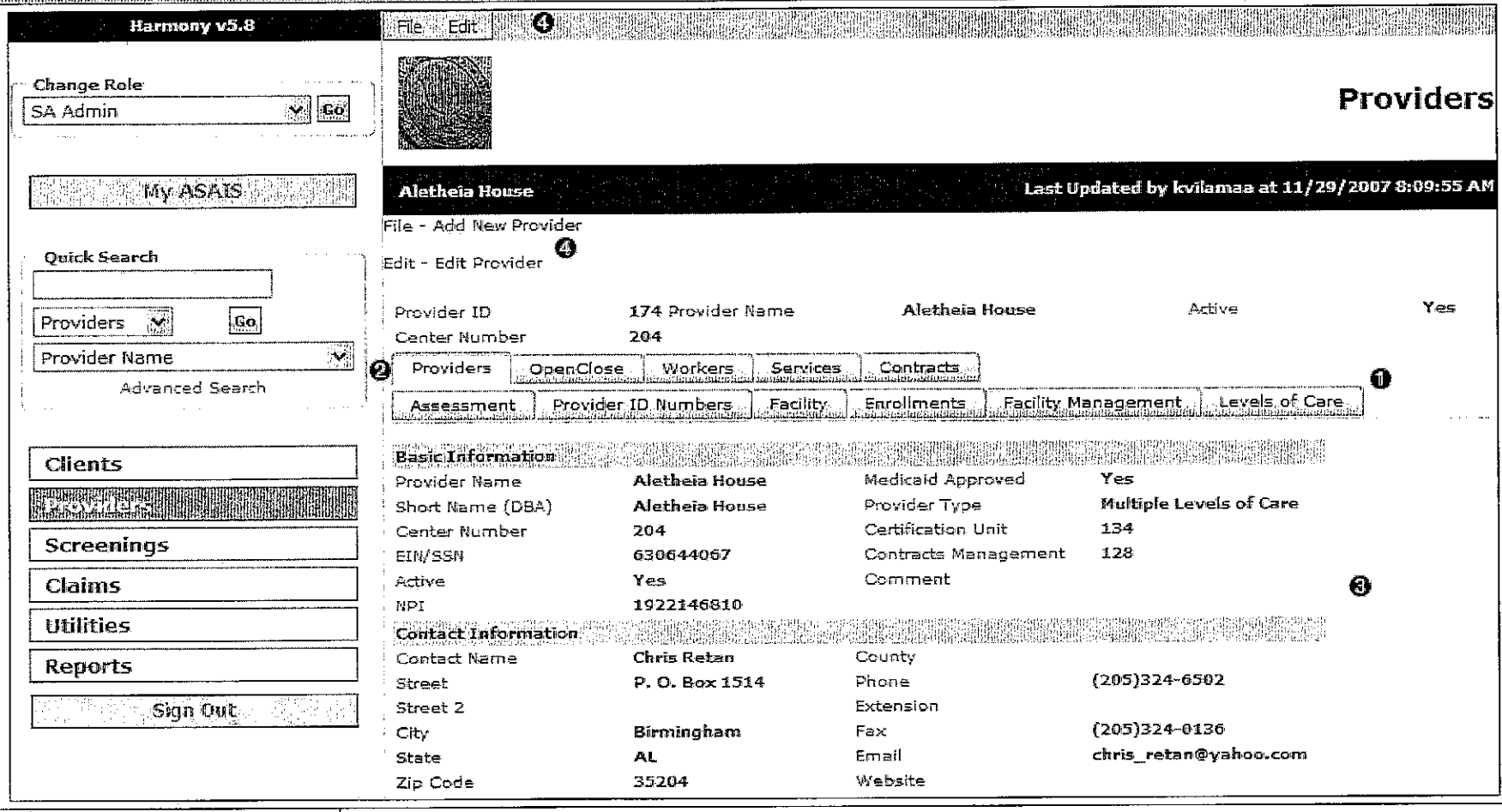
6. Select the appropriate *Primary Worker* for this *Program* enrollment.

7. Select *Save and Close Program* from the *File* menu.



Provider Record Review

Navigating a Provider's Record



1. Tabs	A Provider's record is broken up into different categories of data. These categories called Tabs (or sometimes pages) are displayed horizontally across the screen. Several sets of tabs may exist – to navigate to the next (or previous) set, click on the arrows at the end of the currently displayed set.

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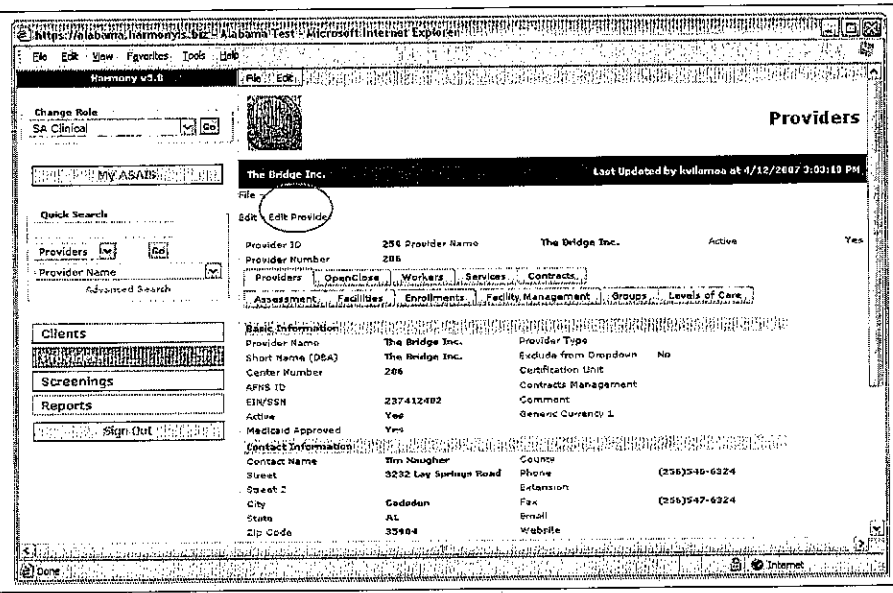
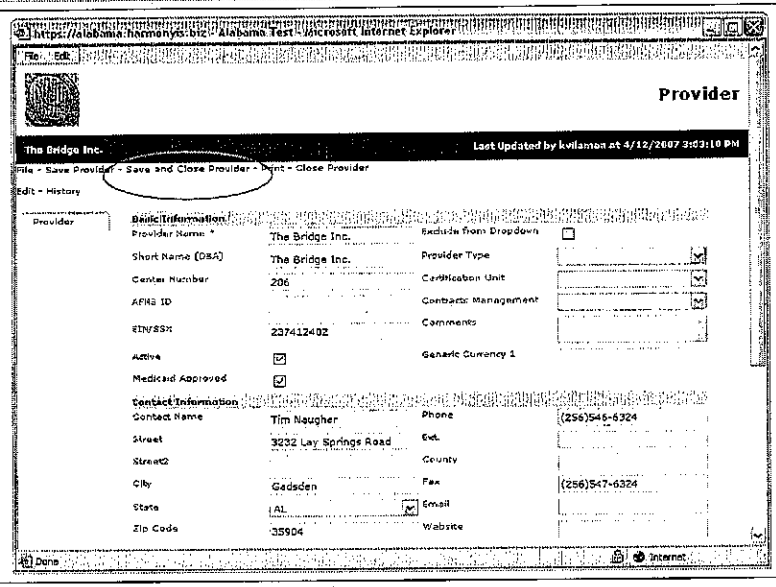
• Enrollments	Navigating to the Enrollments tab and clicking on it reveals a list of clients currently enrolled with the Provider. Users may click on a record to open it, but you can not edit enrollments here.
• Facilities	The Facilities tab will give you a grid of all facilities identified for this provider. There is a facility record for each one with location address and capacity identified.
• Facility Management	Facility Management tab provides a way to manage the enrollments in all facilities by disposition or by facility or a combination by using the filter. Clients dispositions may be managed via this tab.
• Levels of Care	Levels of care lists all levels of care that are provided by this provider.
2. Active Tab	The currently active Tab is highlighted. The ASAIS menu bar and the information displayed below the tabs correalates to the active Tab.
3. Data/List View	The information displayed below the tabs that correlates to the active Tab. Information may be displayed in a list. To open an item in the list, simply click on it. (Provider information can be edited by selecting Edit Providers from the Edit menu in the ASAIS menu bar.)
4. ASAIS Menu Bar	The Menu Bar contains a set of menus that allow the User to access different functions related to the Provider's record. Alternatively, the same menu items are displayed as links that show all available options for any particular screen.

Editing Providers

1. Navigate to the Provider record.
2. Click *Edit Provider*

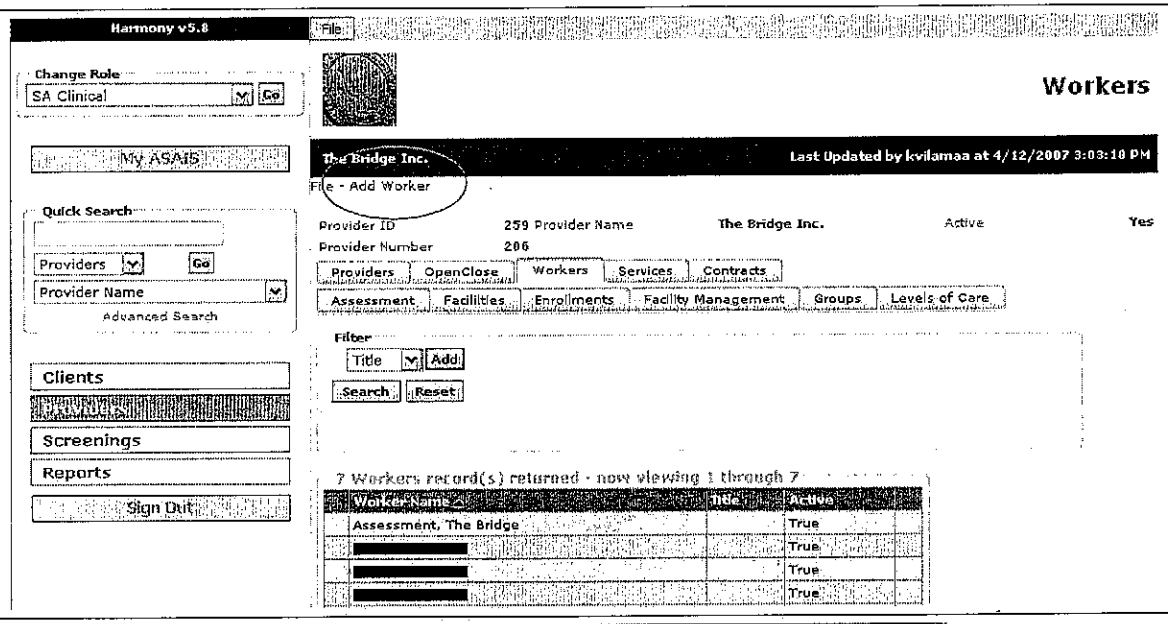


3. Edit address or other information as needed.
4. Click *Save and Close Provider* when finished.

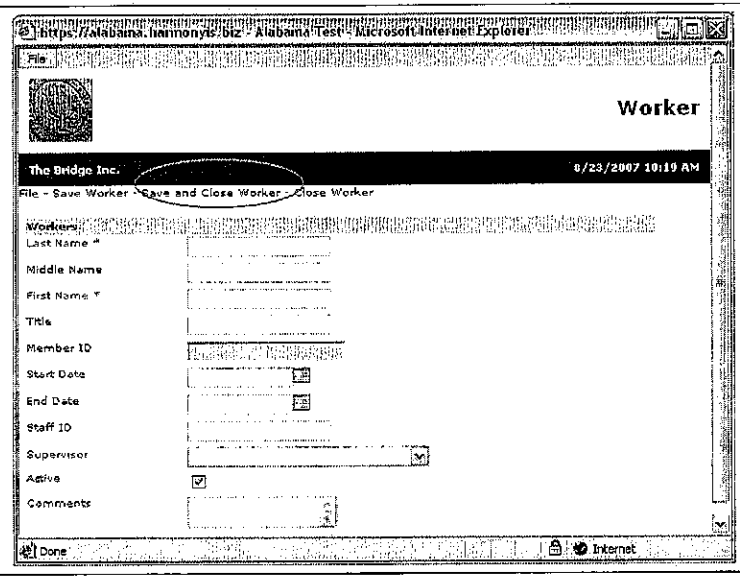


Adding Workers

1. Click on the *Workers* tab.
2. Click *Add Worker*.

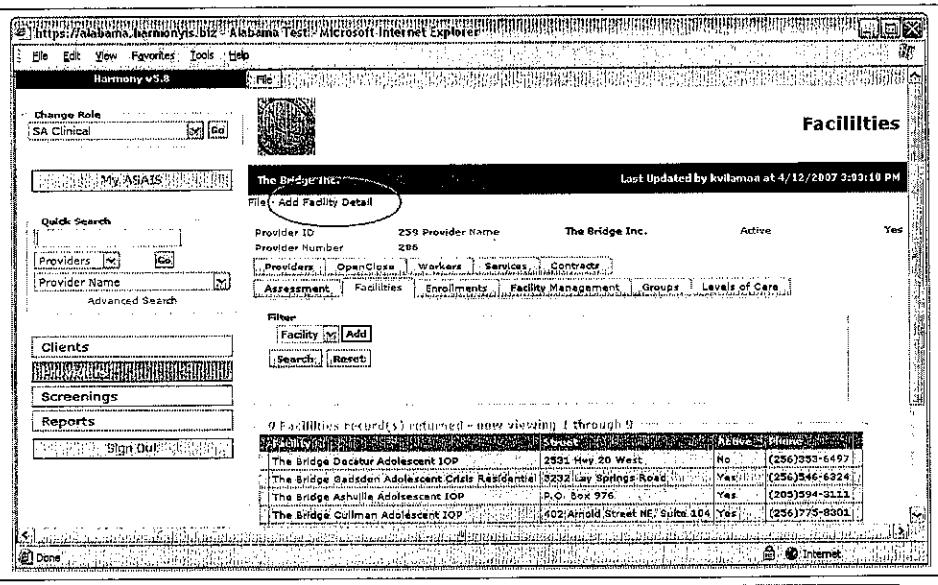


3. The *Add Worker* page will open
4. Fill out the required information for the Worker.
5. Select *Save and Close Worker* from the *File* menu when finished.
6. Repeat steps 2 through 5 if you have additional workers to enter.

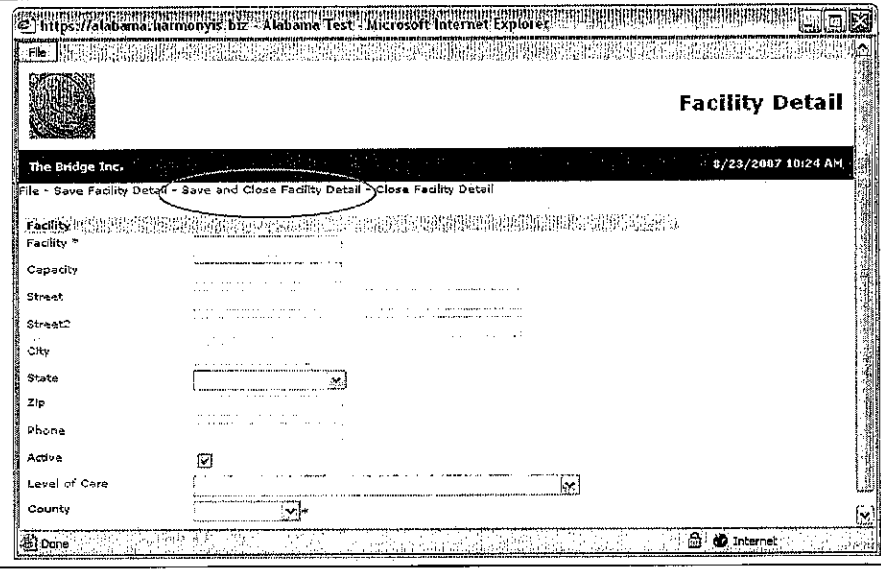


Adding Facilities

1. Click on the *Facilities* tab.
2. Click *Add Facility Detail.*



3. The *Add Facility* page will open
4. Fill out the required information. Be sure to select the **Level of Care**, as well as capacity, address, and County as this information feeds the SA Wait List.
5. Select *Save and Close Facility Detail* from the *File* menu when finished.
6. Repeat steps 2 through 5 if you have additional facilities to enter.



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Goal #9
Attachment #2

Alabama
department of mental health & mental retardation

Management Information Systems

Provider Claims/Finance Training Manual
ASAIS

1/27/2009

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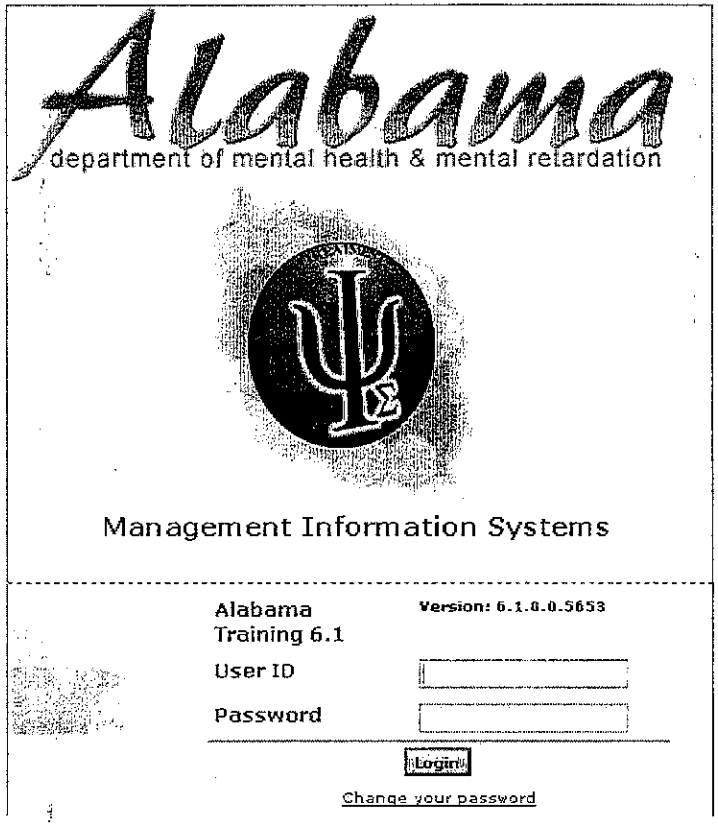
ASAIS Basics

DMHMR staff, along with Harmony Information Systems, has specially configured the system to map your business processes in application.

The ASAIS application only works using Internet Explorer. Your PC may need to be configured by your IT department to allow ASAIS and all its functionality to work properly.

The ASAIS application knows who you are based upon your assigned User ID. What you can see and do in ASAIS is determined by a pre-determined security level: your view of ASAIS screens may differ from those shown in this manual.

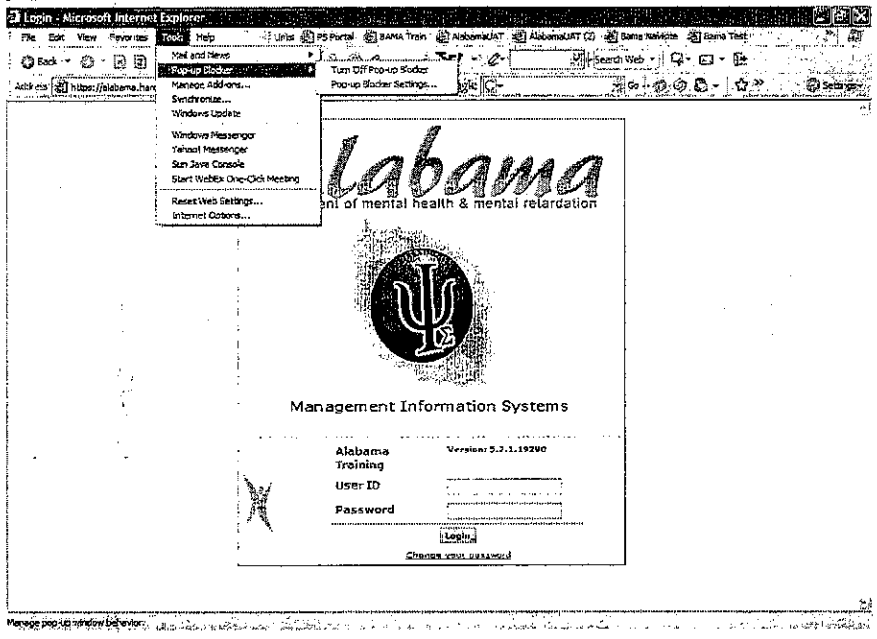
Any issues that you encounter during your use of ASAIS should be reported to your group's system administrator or IT department.



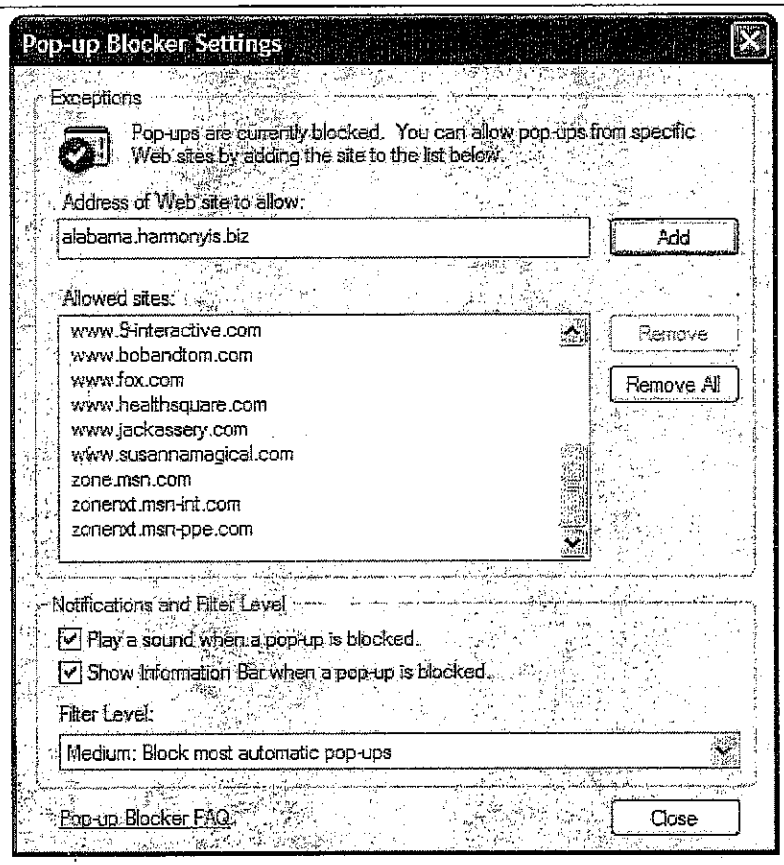
Pop-Up Blockers

The ASAIS application uses pop-up windows to present information to users. It is important to set up your Internet Explorer to allow these.

1. Go to the Tools menu in Internet Explorer
2. Mouse over "Pop-up Blocker"
3. Select "Pop-up Blocker Settings"



4. In the *Address of Web site to allow* field, type alabama.harmonyis.biz
5. Click the *Add* button.
6. Click the *Close* button.



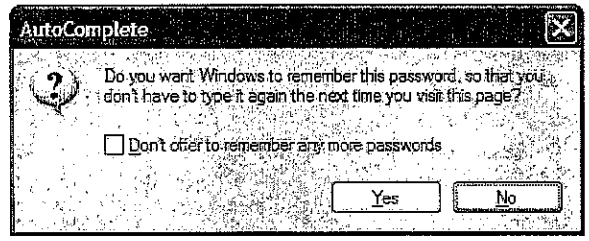
If you use any other type of pop-up blocker (Yahoo, Google, etc.), follow their instructions to permit the alabama.harmonyis.biz site to use pop-up windows.

The ASAIS Sign In Page

Signing In To ASAIS

CAUTION

The first time you log in to *ASAIS*, you may receive the following message:

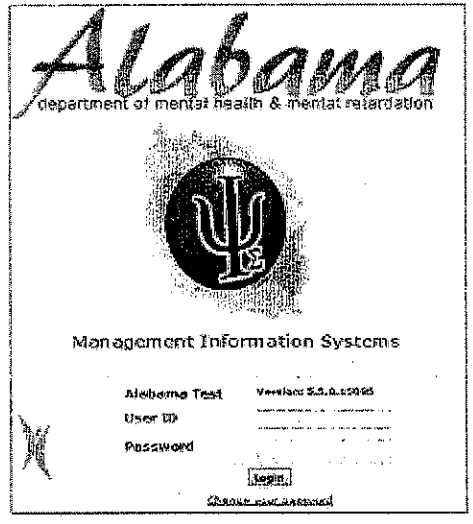


It is important that you respond "No" to this message. Otherwise, it is possible that an unauthorized person could access *ASAIS* and view confidential client information by simply guessing your User ID.

1. Open your Internet Explorer
2. Type the address to the right to navigate to ASASIS.
3. Sign on with *Username* and *Password* (password is same as username). (Passwords are case sensitive, User ID's are not.)
4. Click on the *Login* button (or press Enter).
5. Press F11 on keyboard to clear Explorer menus

For Training: https://demo.harmonyis.biz/AlabamaTraining/

For Live: https://alabama.harmonyis.biz/AlabamaLive



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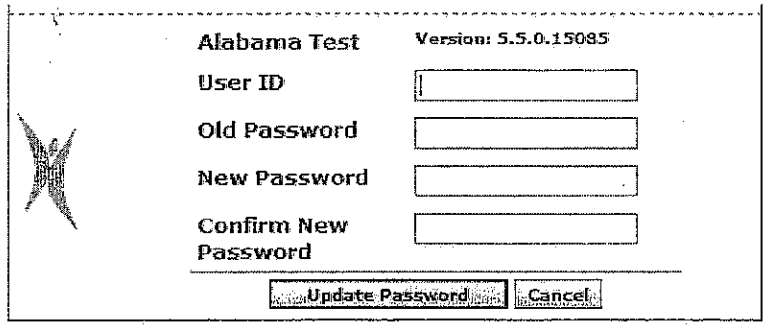
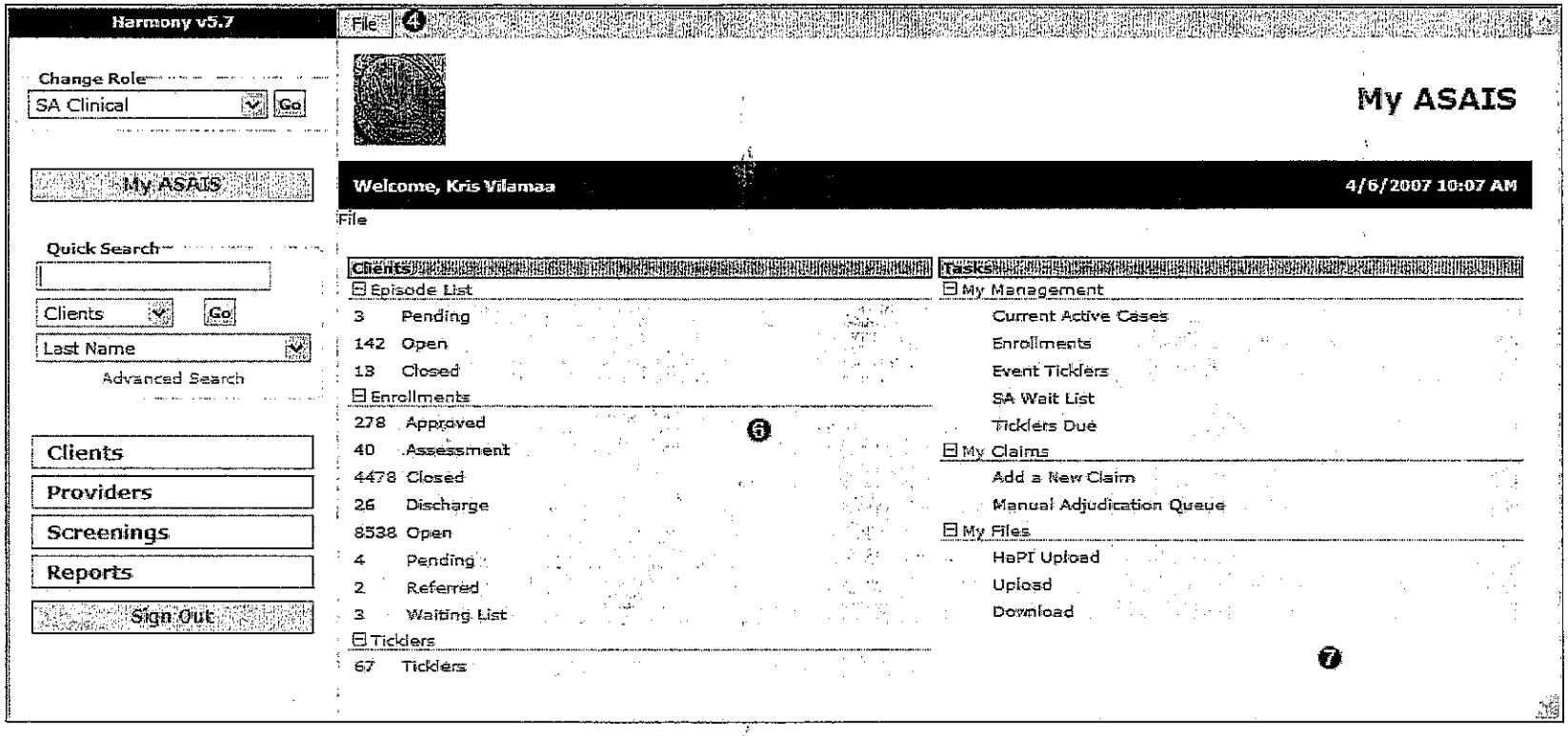
Changing Your Password

1. Click on the *Change Your Password* link.
2. Enter your *User Name* (User ID), *Old Password,* and *New Password.*
3. Click on the *Update Password* button. ASAIS will tell you that your password has been changed.
4. Click *OK.*
5. Sign in with your new password.



My ASAIS Page

Navigating the My ASAIS Page



The Main Menu screen in *ASAIS* is called **My ASAIS**. The My ASAIS screen presents the user with up-to-the-minute links to all-important elements of their personal *ASAIS* usage. The *My ASAIS* link located at the top of the left-hand menu is always available, allowing the user to quickly return to the My ASAIS screen. Your screen may look slightly different depending on your access level.

1. Role	Displays the role under which you are currently viewing ASAIS.

2. My ASAIS	Clicking on **My ASAIS** at any time will bring you back to this page. If you check the box, clicking on will also refresh the data listed on the page.
3. Search	Use the **Quick Search** to find a Clients, Providers or Claims.
	• Clients can be searched for by ASAIS ID, Last Name, SSN, DOB, or Medicaid ID.
	• Providers can be searched for by Provider Name or Number (you only have access to your provider record).
	• Screenings can be searched for by Provider Number, Agency or Consumer Name (Last Name, First Name format).
	• ASAIS will return a list of all possible matches. Open the desired record by clicking on it in the list. If there is only one match, ASAIS will take you directly to that record.
	• You may also enter just the first few letters of a Client or Provider.
4. ASAIS Menu Bar	The **ASAIS Menu Bar** contains various tools that allow you to perform many tasks, such as adding new records, editing records, or printing a Report. The tools that are available depend upon which page the user is currently viewing.
5. Chapters	**Chapters** are links to different areas of ASAIS. The Chapters that a User may see and access are dependent upon their assigned security level.
6. Clients	The **Clients** section in My ASAIS provides quick links to information concerning clients and tasks assigned to the User. (Users assigned to the SA Finance role will not have assigned clients)
7. Tasks	The **Tasks** section provides quick links to tasks and reports. The sections are described below:
• My Management	**My Management** provides supervisors with access to information regarding the cases of their direct reports:
	• **Current Active Cases** – displays a list of all active (open) cases
	• **Enrollments** – displays a list of all active clients by program enrollment

	• **Event Ticklers** – provides a list of incomplete tasks or ticklers by event (SA Enrollments Assessment, Open Client Tasks, etc.); users can review each of the tasks in an event by clicking on the + sign to the left of the event; each task can then be reviewed or acted upon by clicking on it
	• **SA Wait List** – used to review and act on clients assigned to the SA Wait List
	• **Ticklers Due** – displays a list, by worker, of all incomplete ticklers
• My Claims	You may have access to **My Claims** if your role requires it.
	• **My claims** – used for batch claims entry
	• **Add a New Claim** – used for direct claims entry of individual claims
• My Files	You may have access to **My Files** if your role requires it. My Files provides links to file import and export tools:
	• **HaPI Upload**
	• **Upload**
	• **Download**
Signing Out	
8. Sign Out	You may log out at any time by selecting **Sign Out.** It is important that you use the **Sign Out** link versus the Internet Explorer controls to ensure that information is probably saved before exiting.

List Views and Search Filters

List View Screens

In various areas of ASAIS, records may appear on a List View screen. The List View screens limit the number of records returned at one time.

List View screens allow a user to quickly review a list to retrieve the desired record. If the desired record does not appear on the initial list view, users can click on one of the following buttons to scroll through the records:

<< First – This button will call the list view containing the first record.

< Previous – This button will call the previous list view.

Next > – This button will call the next list view.

Last >> – This button will call the list view containing the last record.

Users can also modify the number of records returned in the list view by entering the desired number in the "Retrieve [ ] records at a time" field and clicking on one of the record search buttons (i.e., First, Previous, Next, Last).

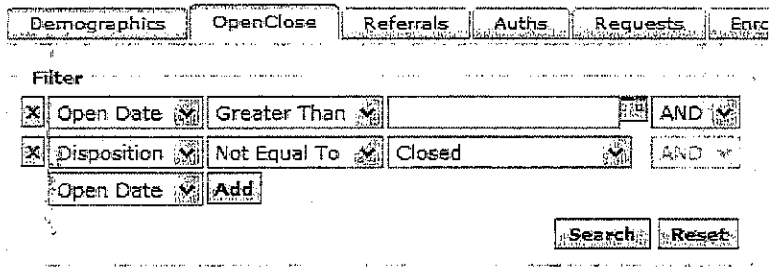
Tip

By clicking the column header in a list view, you can sort the records in ascending order. By clicking the column header a second time, you can sort the records in descending order.

Search Filters

Several List View screens allow users to search using multiple filters of their choosing.

Users can add additional filters by selecting the desired parameter from the bottom dropdown list and then clicking on the Add button.



Each of these filters allow the user to select from the following comparison search criteria:

- Equal To
- Begins With
- Ends With
- Not Equal To
- Greater Than
- Less Than

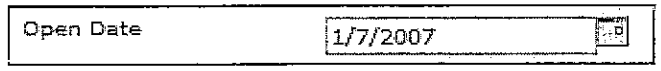
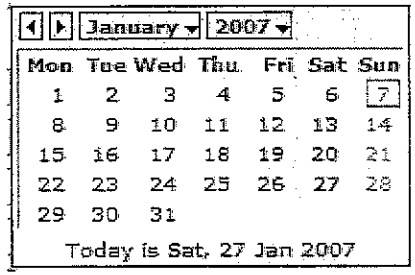
In addition, users can search on these filters using Boolean logic (AND or OR).

To remove a filter, click the  to the right of the filter criteria.

Misc. ASAIS Features

Date Fields

Wherever a date field appears in ASAIS, users have 2 options:

1. Click on the text box and enter the date (simply type the numbers – *mmddyyyy* - ASAIS will format the date with /'s)	
2. Click on the calendar icon. Use the arrows to navigate through the calendar. Then click on the desired date to select it. (The current date is highlighted in red.)	

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Claim Set-Up Requirements

Client Record

In the Client's records, the following must first be established before a claim can be successfully adjudicated:

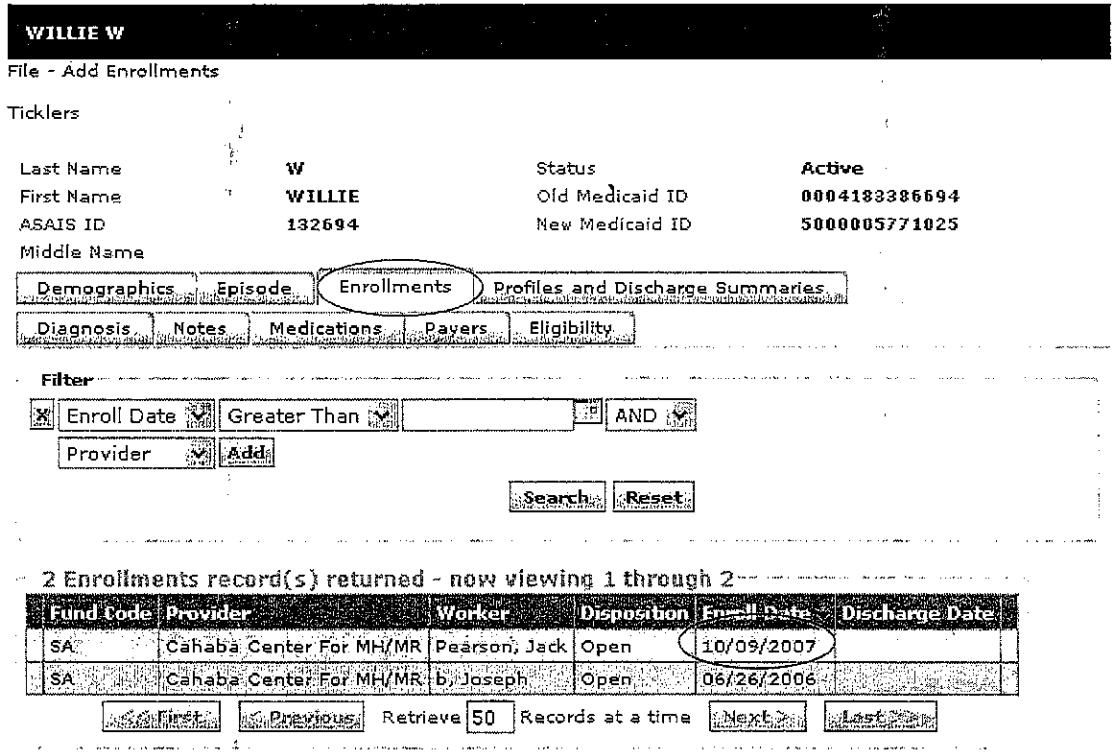
1. Provider Enrollment with Facility (LOC) Detail
2. SA Client Profile Completed
3. Diagnosis (this is not required in the client record, but if set up correctly will be used as a default for claims entry)
4. Eligibility

Enrollments

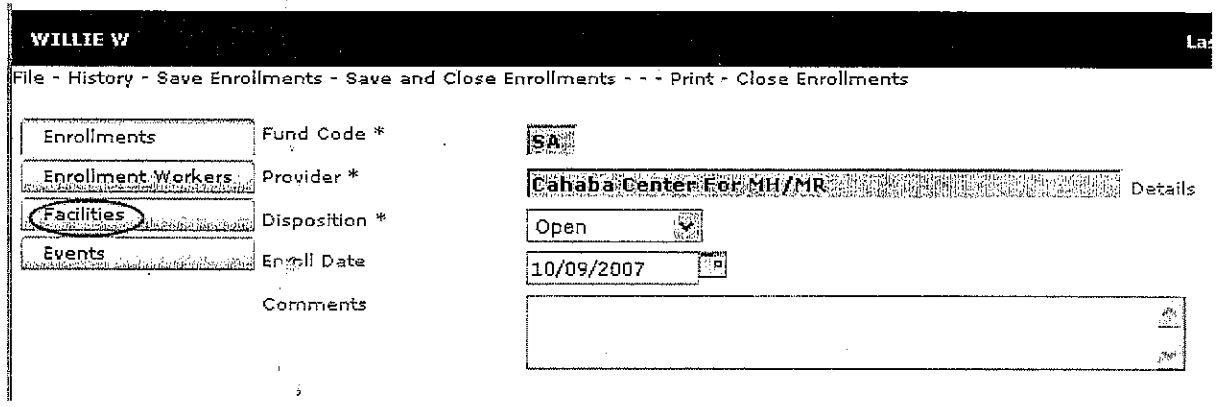
The *Enrollments* tab is used to capture information about client enrollments in specific providers within ASAIS.

Important: A claim will not be paid if the date of service on the claim is earlier than the enrollment date with the provider.

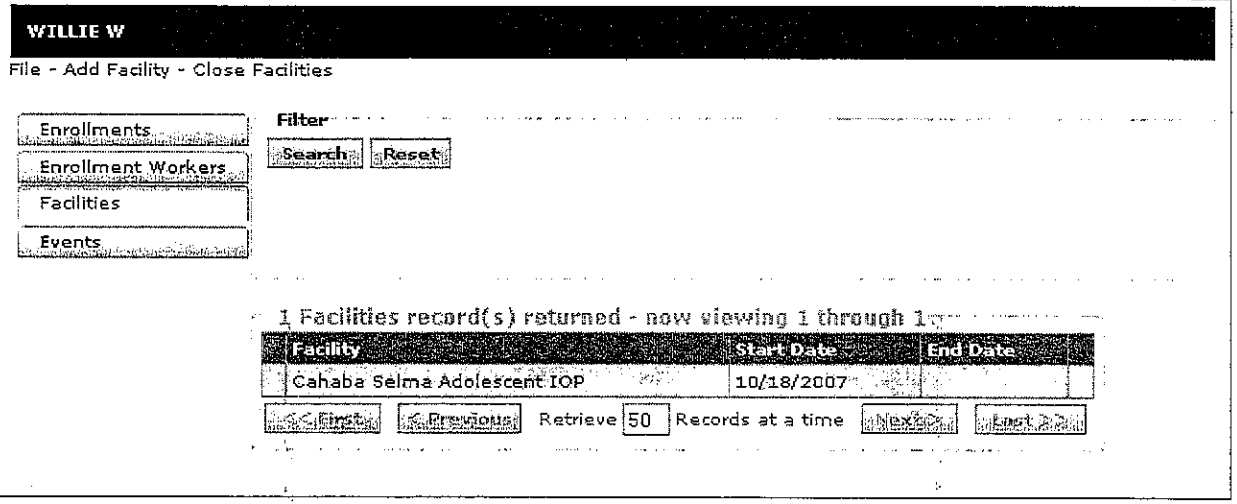
The client's enrollment record should remain open until services are discontinued with that provider, at which time the enrollment record can be closed.



To see the facility level detail, first select the enrollment record, then click on the facilities option.

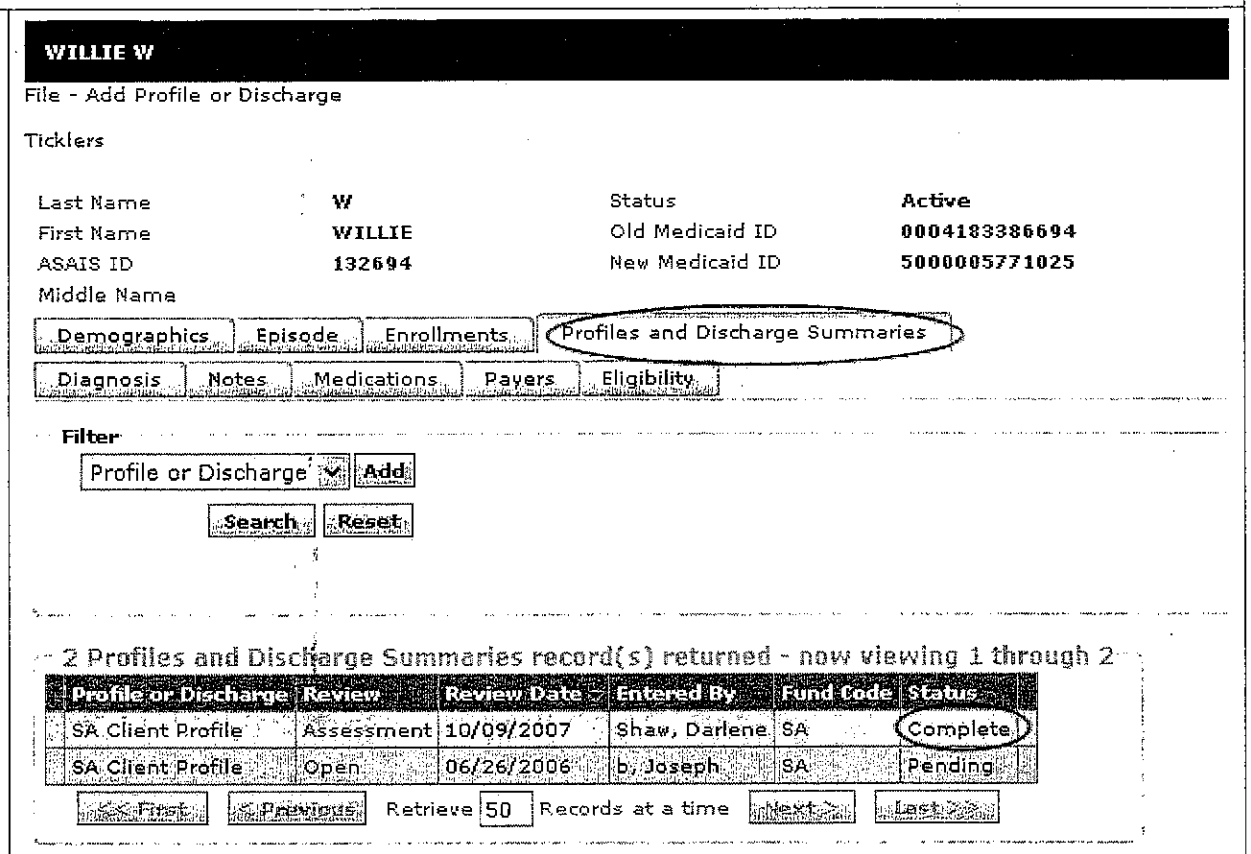


A client may have multiple facility enrollments if they are in multiple programs.



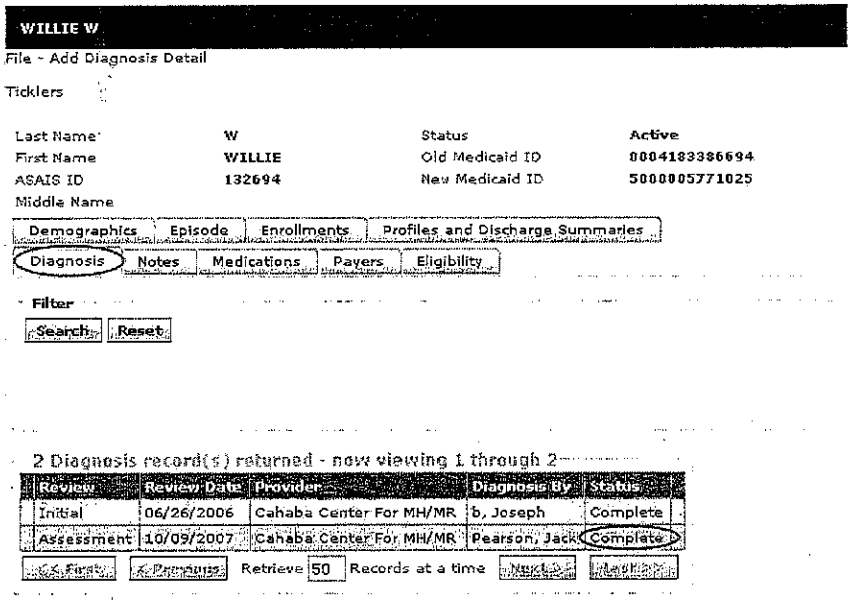
Profile

A client must have an SA Client Profile with a status of Complete.

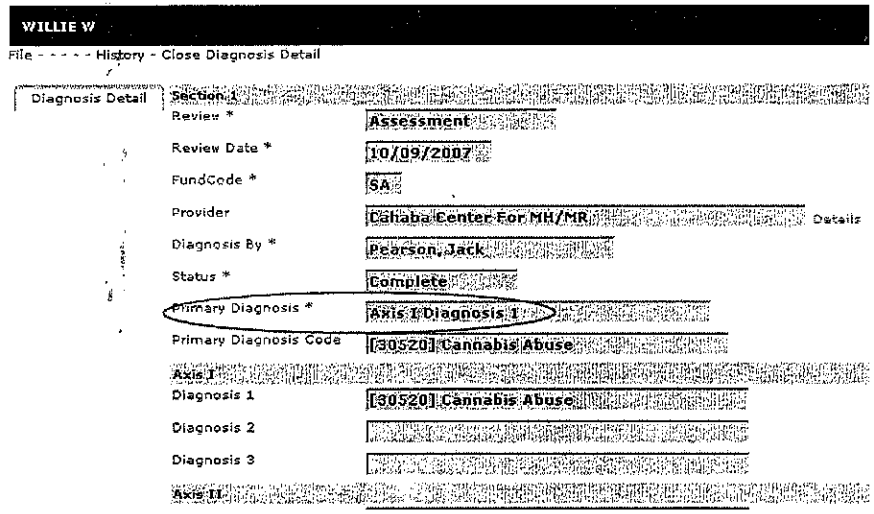


Diagnosis

In order for the Diagnosis to default correctly for claims processing, there must be a vaid diagnosis record set with a status of Complete .



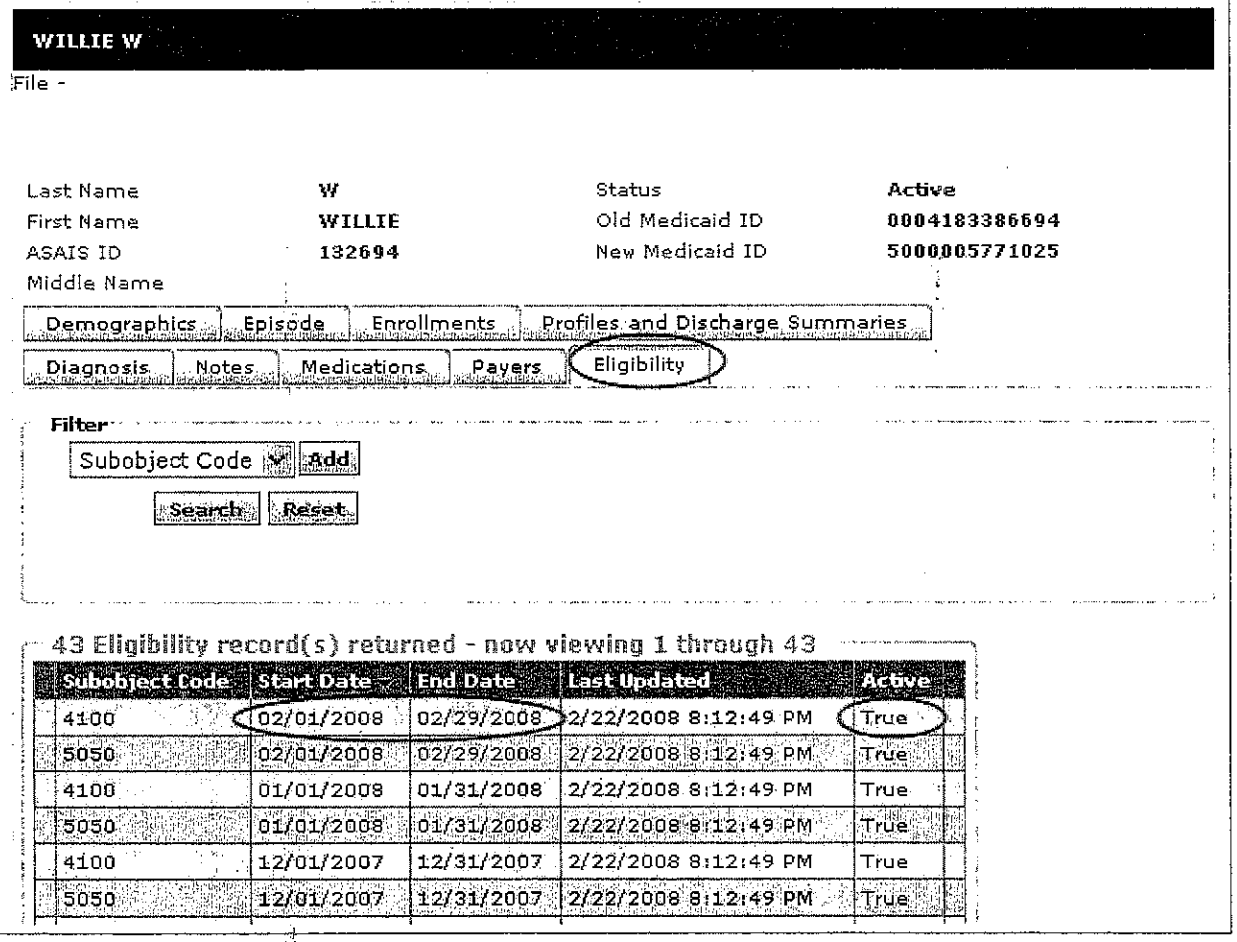
The Primary Diagnosis must also be set to Axis I Diagnosis I.



Eligibility

There must also be an active Eligibility record for the date of service on the claim.

Eligibility records are created when a client profile is completed and when the eligibility verification (270/271) is processed between ASAIS and EDS.



Provider Record

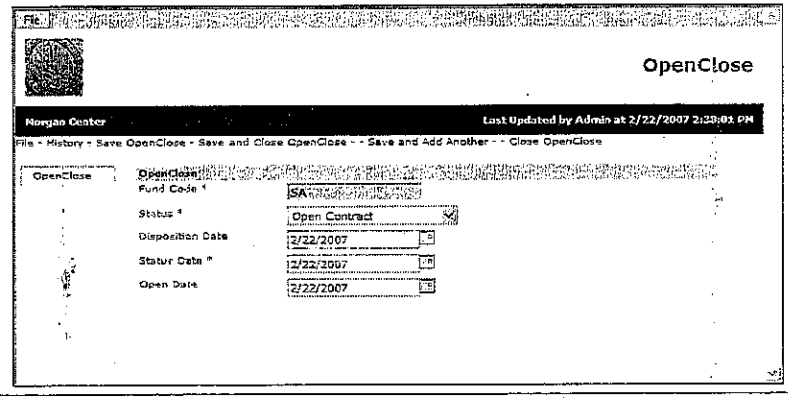
In the Provider's record, the following must first be established before a claim can be successfully adjudicated:

1. Open/Close
2. Provider Services
3. Provider ID Numbers
4. Workers

OpenClose

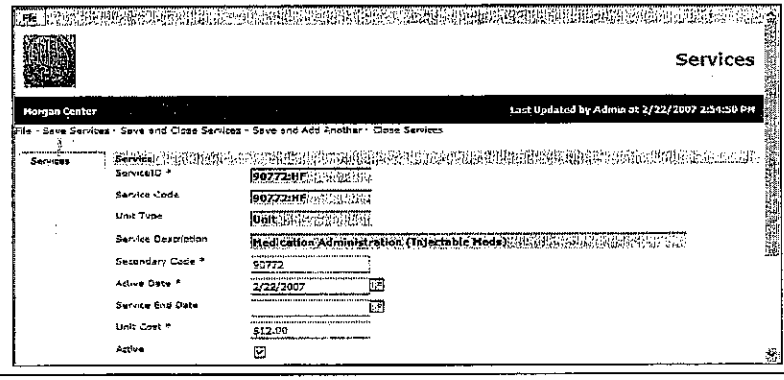
The OpenClose tab lists all existing fund codes under which the provider can provide services to clients.

A provider must have an OpenClose record with an Open disposition in order for Services to be added to their record.



Services

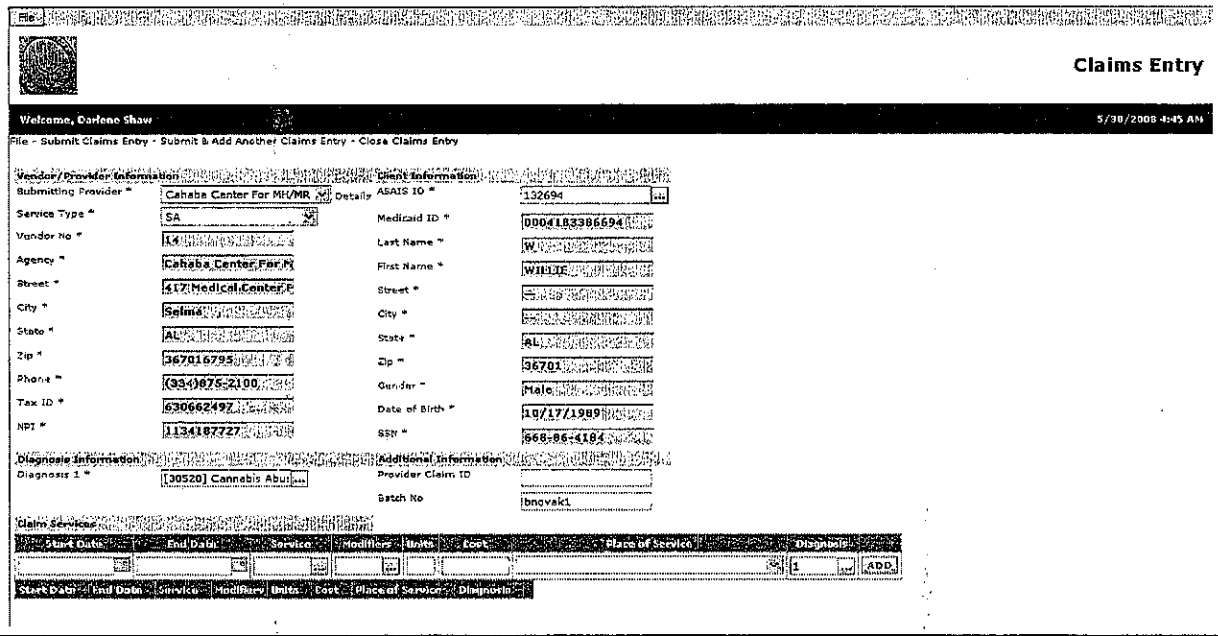
The Services tab lists all program services that the provider offers as established in *ASAIS*.



Entering Claims into ASAIS

Direct Entry of Claims by Client

1. Go to My ASAIS Screen.
2. Go to Tasks column, "My Claims."
3. Click on "Add a New Claim."



4. Populate Claims Entry Screen.
   a. Pick Submitting Provider.
   b. Pick Service Type (if more than one is available – should always use SA for ASAIS claims). Provider information will populate automatically.
   c. Select client.

5. Populate diagnosis code(s).
   a. If it is not pre-populated, click on ellipsis button to select diagnosis code.
   b. Select diagnosis from the drop-down list.
   c. Click on ellipsis button to add additional codes (up to 8).

6. Populate Additional Information section
   a. Populate Provider Claim ID (optional)

b. Populate the Batch No field (optional)

7. Add service(s)
   a. Enter Start date
   b. Enter End date. (If the start date is the 1st of the month, this will automatically populate with the last day of the month. Adjust as necessary).
   c. Populate Service (modifiers will be automatically populated by the system)
   d. Enter units (Cost will be automatically calculated by the system)
   e. Populate the place of service from the dropdown.
   f. The diagnosis will be automatically populated with diagnosis 1 from the diagnosis section. Click on the ellipsis to modify, change, or add additional diagnoses to the service line.
   g. Click the Add button to record the service line.

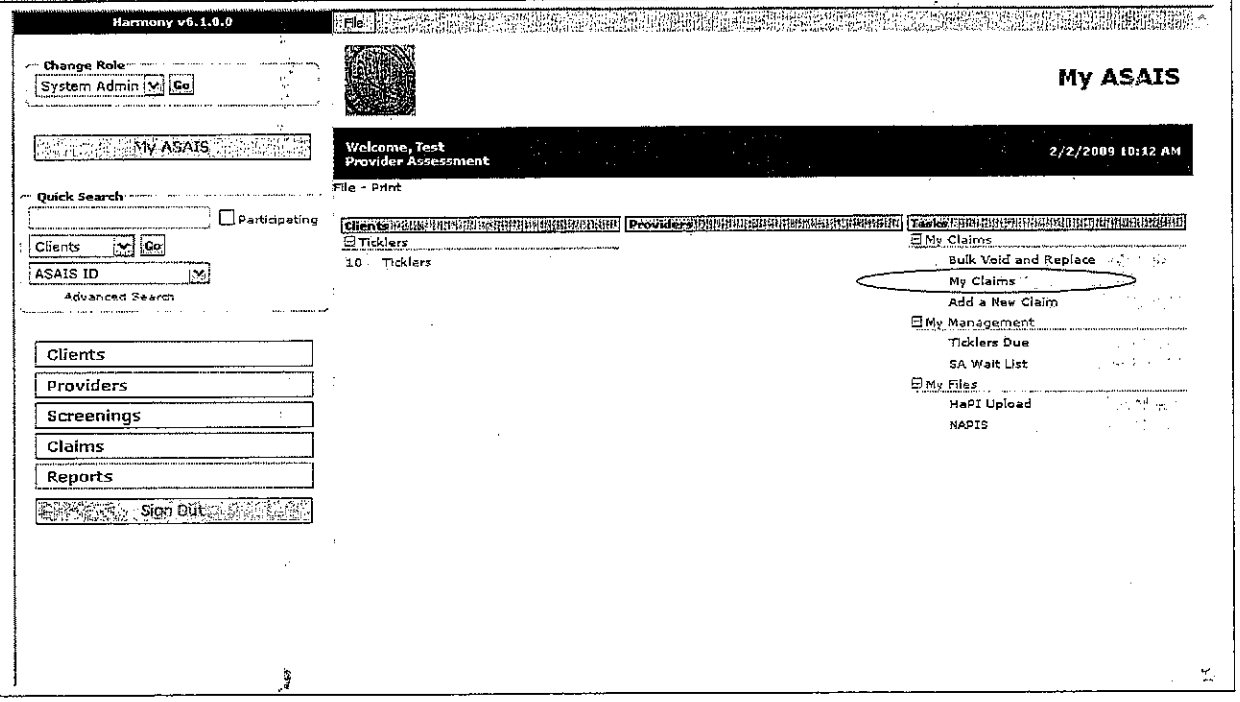
8. Repeat 7 a-g until all services for this client have been entered. Note: Each service will be saved as a separate claim in the claims grid.

9. Click "Submit Claims Entry" to submit claim. If message box appears stating that specified required fields are not populated, populate the fields and resubmit.

Direct Entry of Claims By Batch (Multiple Clients)

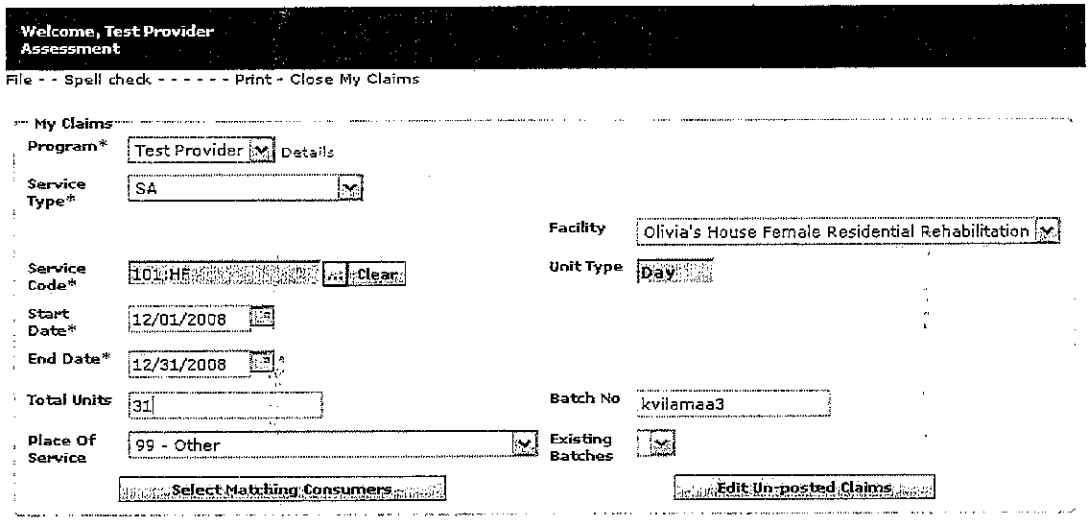
1. From the *My ASAIS* page, click on *My Claims* to access the Claims Batch Billing screen, which allows you to enter claims by service, instead of by client.

NOTE: It could be advantageous for some providers to use this claims entry instead of the entry screen that works by client, but it depends on the business process and nature of the provider.



2. A new window will appear that shows much of the same information as is required on the single client entry screen:

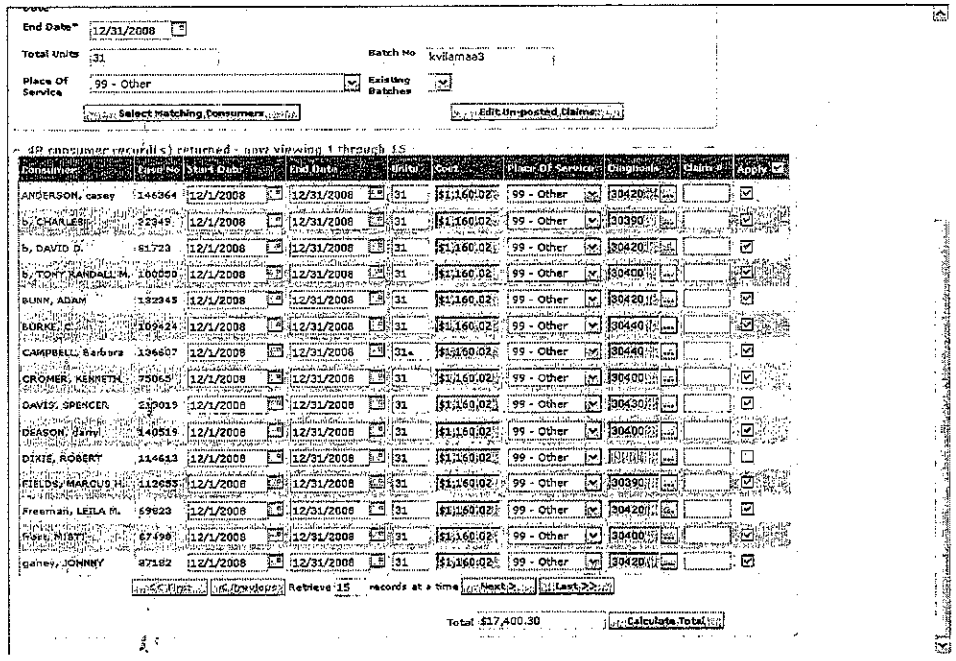
   - **Program** = Your Agency
   - **Service Type = SA**
   - **Facility** – Can be used to select only clients from a particular facility
   - **Service Code** – Click on the ellipsis to select an appropriate service
   - **Start Date**
   - **End Date**
   - **Total Units**
   - **Place of Service**



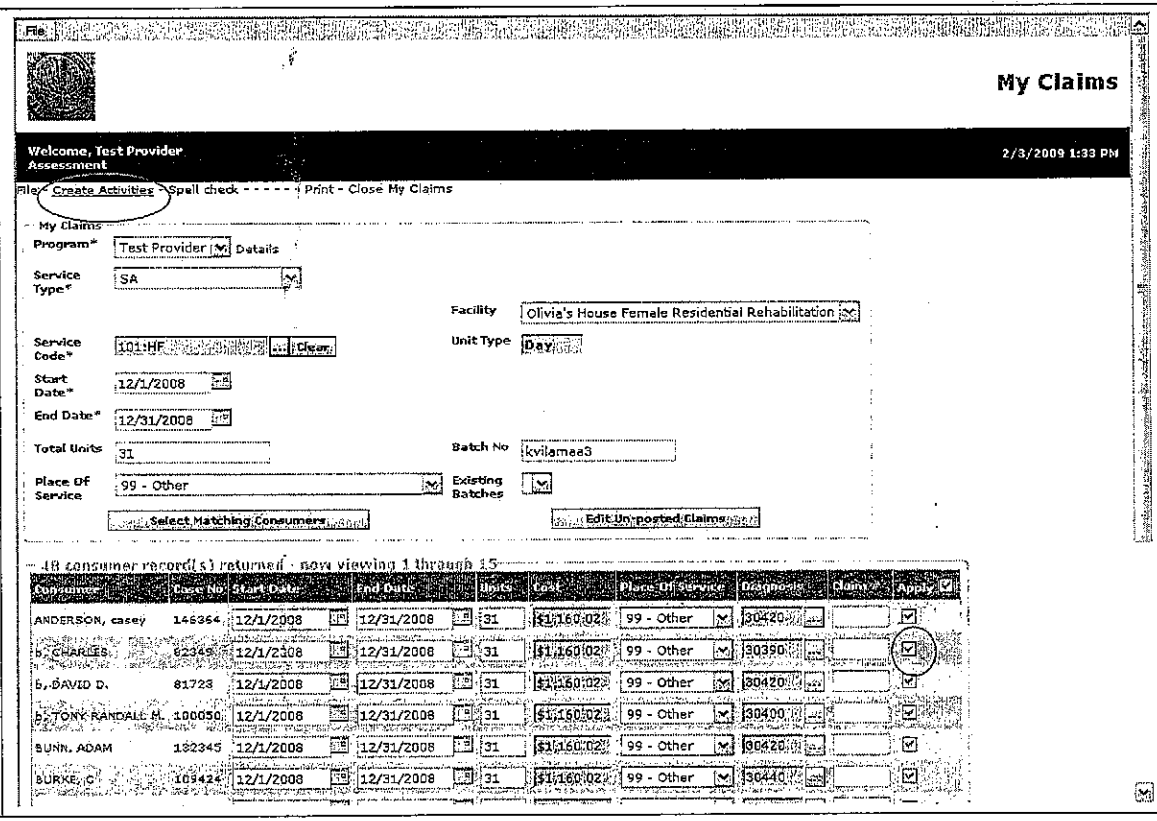
3. Once you complete the information you would like populated for the clients, click "Select Matching Consumers". The screen will refresh and show all clients who have a facility record that was open during the span indicated.

4. Now, you should decide which clients to include in your activity creation.

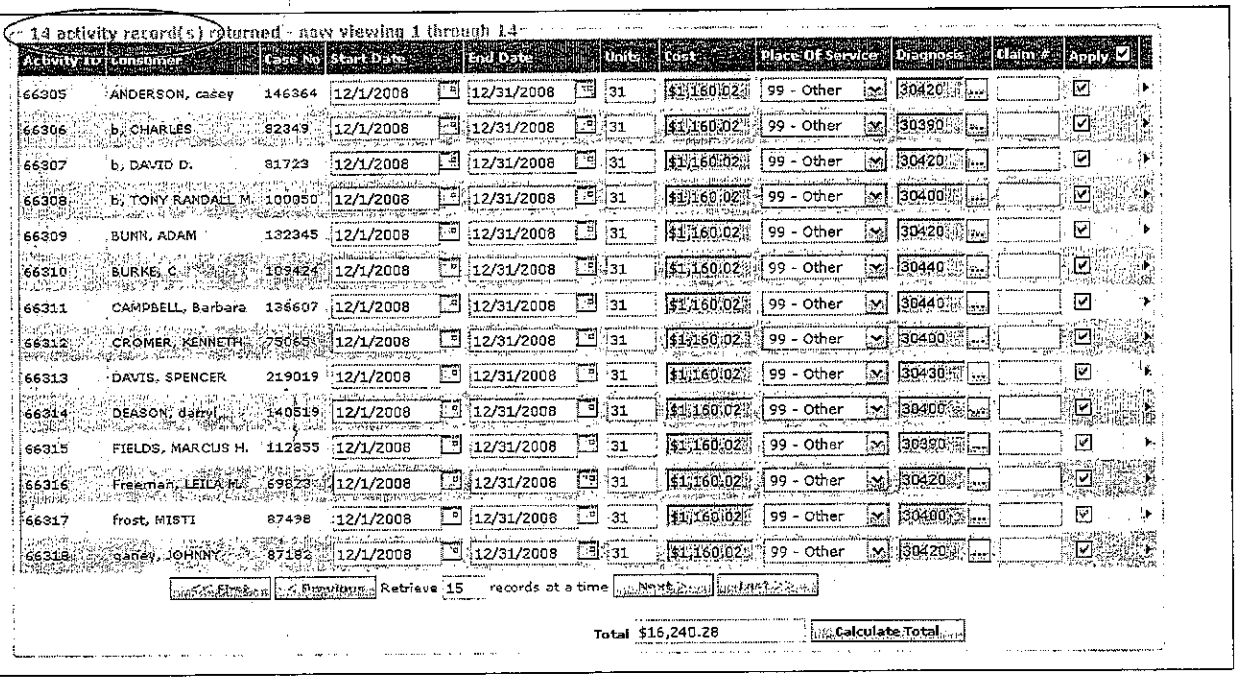
NOTE: If a client is showing and is no longer participating in your program, encourage clinical staff to discharge the client, so their record no longer shows in your claim entry.



5. Once you have selected the clients you wish to include for submission by checking the box at the end of that client's line. Then click "Create Activities"

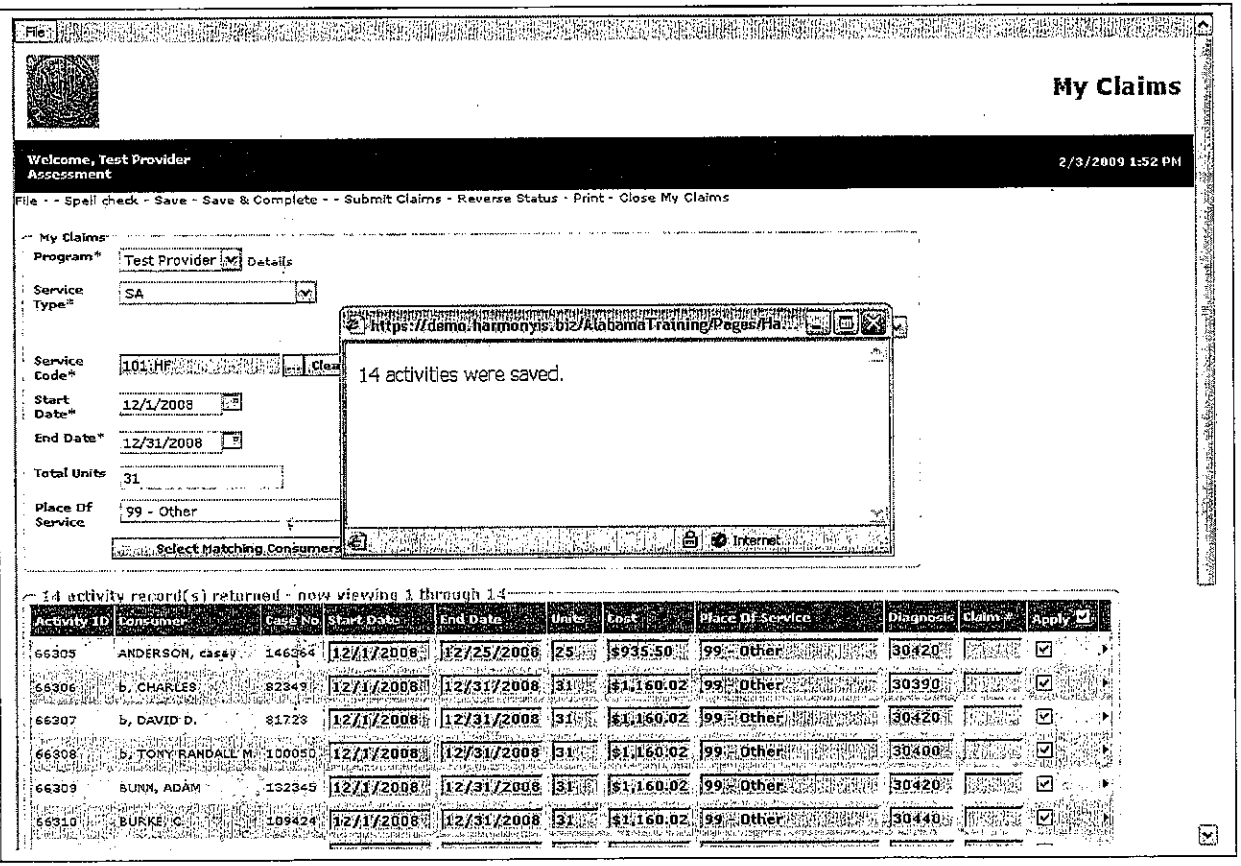


6. A pop-up will confirm whether or not activities were created and the screen will refresh to show any clients who met the criteria, but were not included in activity creation.
7. Click on "Edit Un-Posted Claims" to access the activities you created. Notice the display now refers to **activity** records.
8. You can now edit the start/end dates, units and place of service for each individual client. Click "Calculate Total"

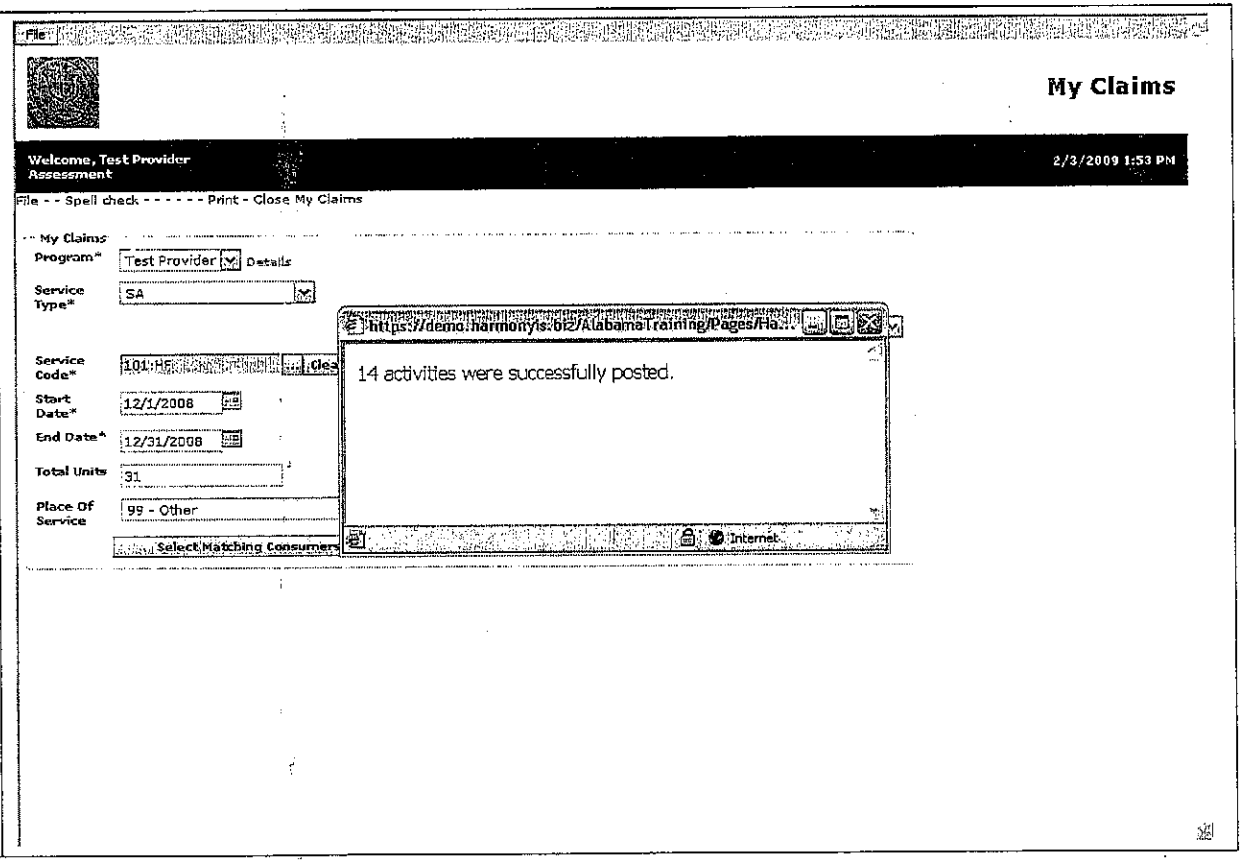


9. When you have completed your edits, click "Save and Complete"
10. You will get a pop-up that confirms the activities have been saved, and the grid will now be read only. Your activities are now ready to be submitted as claims.

NOTE: If you need to make changes to what you saved, before submission, you can click "Reverse Status". You will then need to click "Save and Complete" again when you're finished.



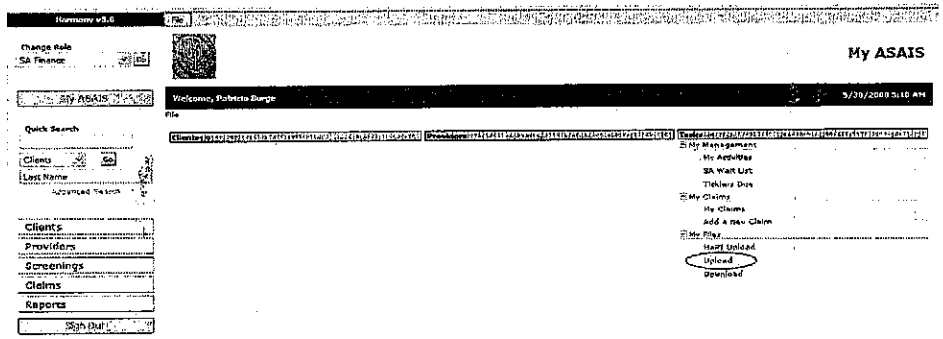
11. Click "Submit Claims" and you will get a confirmation pop-up that the activities were successfully posted as claims and the grid will disappear.
12. From this point forward, each service line is treated just as it would be from the "Add A New Claim" screen.



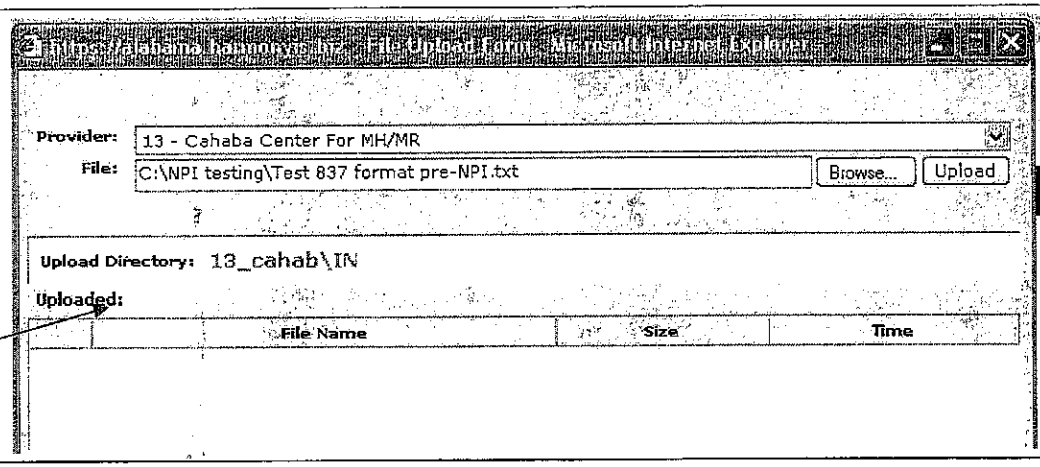
837 Claim Submission

My Files - Upload

13. From the My ASAIS page, select the Upload option to open the File Upload Form.



14. Use Browse to locate the 837 file to be uploaded for processing.
15. Confirm that the file has a txt extension.
16. Click on Upload
17. Once the file has been successfully uploaded, it will show in the uploaded section of the file upload form

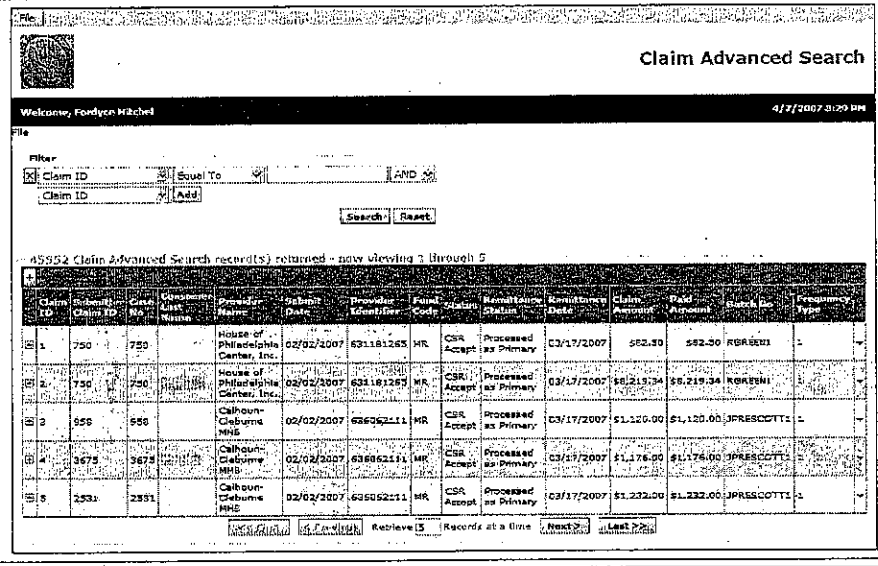


Reviewing Claims

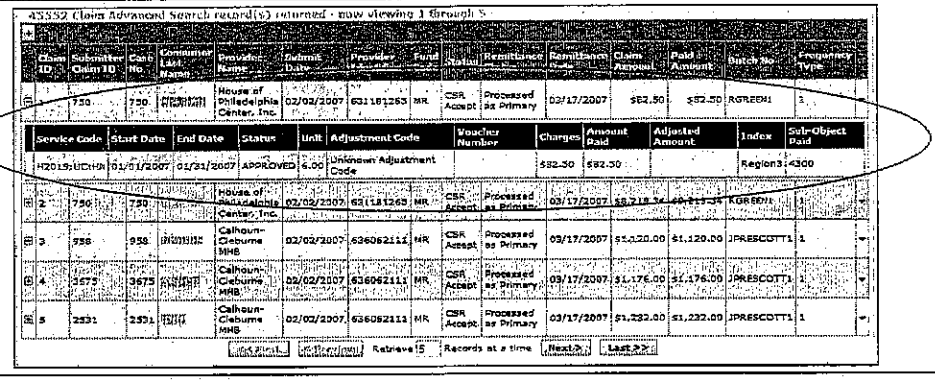
Claims Chapter

Users with the proper permissions, can access the Claims Chapter to review claims previously entered into the system and their current status

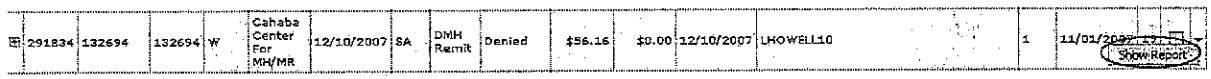
1. Click on the *Claims* chapter link in the left hand menu.
2. The *Claims Advanced Search* screen will open.
3. Select the desired search filter(s) and then click on the Search button.
4. A list of Claims matching the search filter criteria will appear.



5. Clicking on the + sign to the left of a claim will reveal additional details.

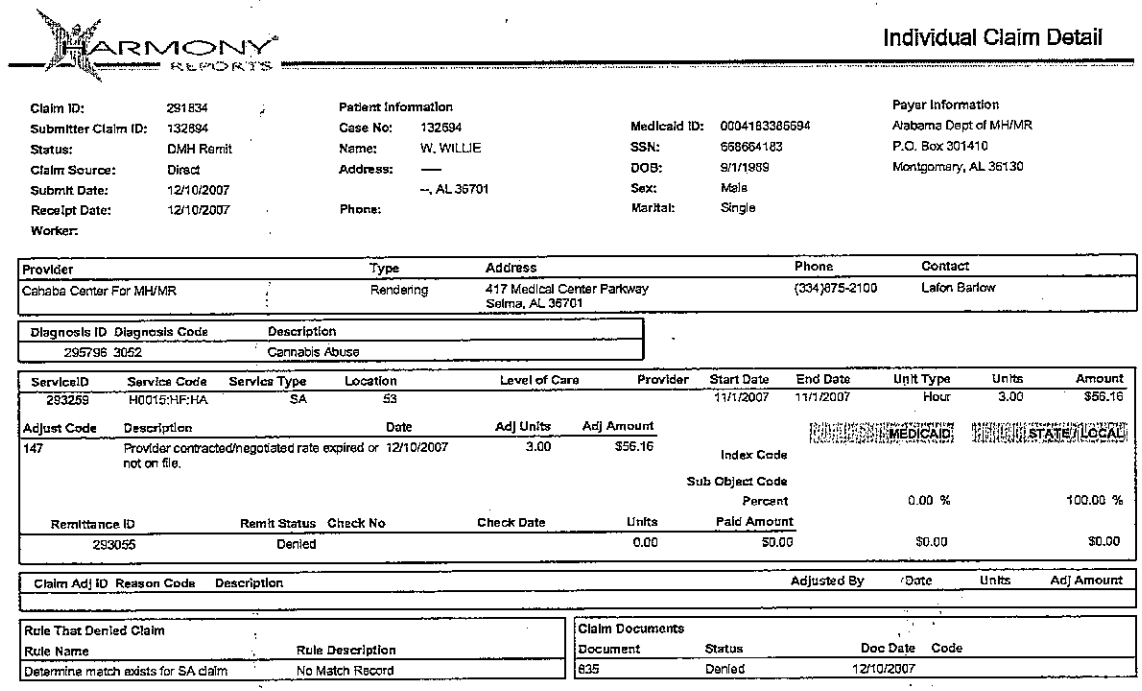


6. The easiest way to get a concise summary of the claim details is to select the Show Report option which appears if you hover over the arrow at the far right side of the grid.



⊞	291834	132694	132694	W	Cahaba Center For MH/MR	12/10/2007	SA	DMH Remit	Denied	$56.16	$0.00	12/10/2007	LHOWELL10		1	11/01/2007 12:... Show Report

7. This will bring up the Individual Claim Detail report, which contains detailed information on the claim, including any denial reasons if the claim was denied.



HARMONY REPORTS

Individual Claim Detail

Claim ID:	291834	Patient Information				Payer Information	
Submitter Claim ID:	132694	Case No:	132694	Medicaid ID:	0004183386594	Alabama Dept of MH/MR	
Status:	DMH Remit	Name:	W, WILLIE	SSN:	658664183	P.O. Box 301410	
Claim Source:	Direct	Address:	—	DOB:	9/1/1989	Montgomery, AL 36130	
Submit Date:	12/10/2007		-, AL 36701	Sex:	Male		
Receipt Date:	12/10/2007	Phone:		Marital:	Single		
Worker:							

Provider	Type	Address	Phone	Contact
Cahaba Center For MH/MR	Rendering	417 Medical Center Parkway Selma, AL 36701	(334)875-2100	Lafon Barlow

Diagnosis ID	Diagnosis Code	Description
295796	3052	Cannabis Abuse

ServiceID	Service Code	Service Type	Location	Level of Care	Provider	Start Date	End Date	Unit Type	Units	Amount
293259	H0015:HF:HA	SA	53			11/1/2007	11/1/2007	Hour	3.00	$56.16

Adjust Code	Description	Date	Adj Units	Adj Amount
147	Provider contracted/negotiated rate expired or not on file.	12/10/2007	3.00	$56.16

	MEDICAID	STATE/LOCAL
Index Code		
Sub Object Code		
Percent	0.00 %	100.00 %

Remittance ID	Remit Status	Check No	Check Date	Units	Paid Amount
293055	Denied			0.00	$0.00

$0.00	$0.00					

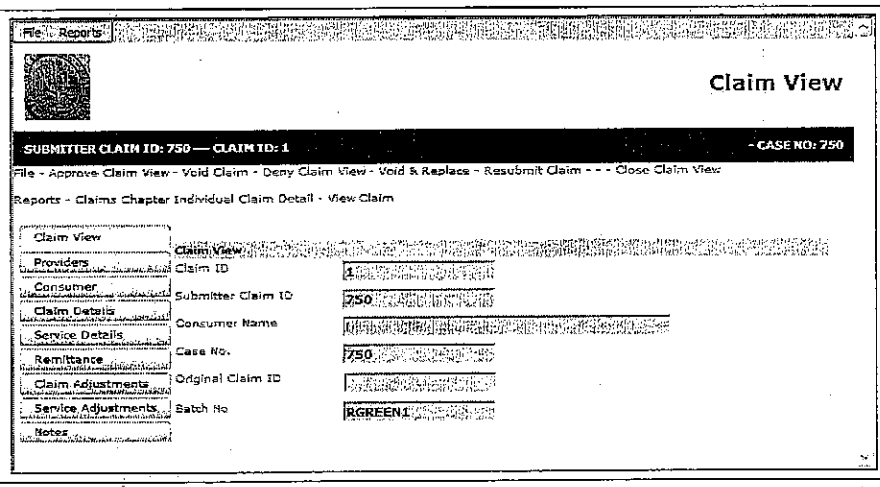
Claim Adj ID	Reason Code	Description	Adjusted By	Date	Units	Adj Amount

Rule That Denied Claim	
Rule Name	Rule Description
Determine match exists for SA claim	No Match Record

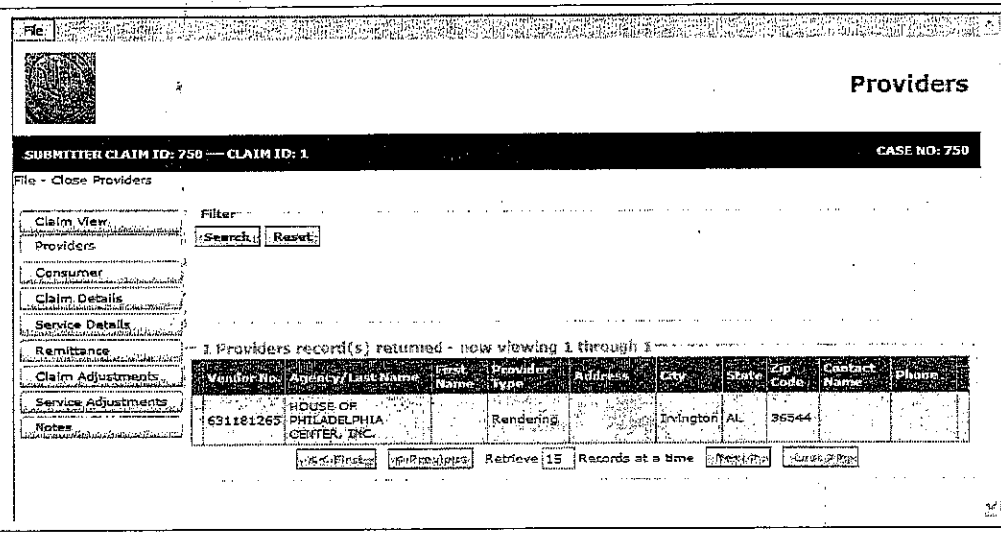
Claim Documents			
Document	Status	Doc Date	Code
835	Denied	12/10/2007	

8. Clicking on a claim in the list will open the Claim View window.

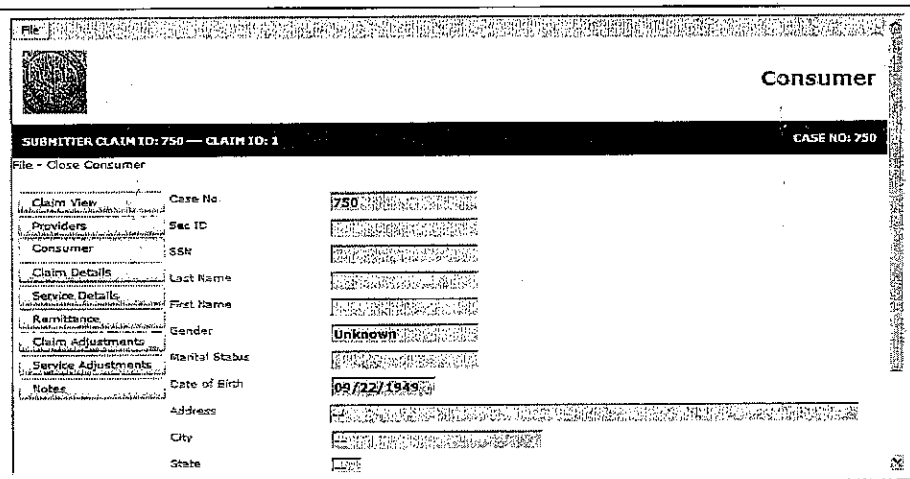
9. The sub-page links on the left will provide additional information about the claim:



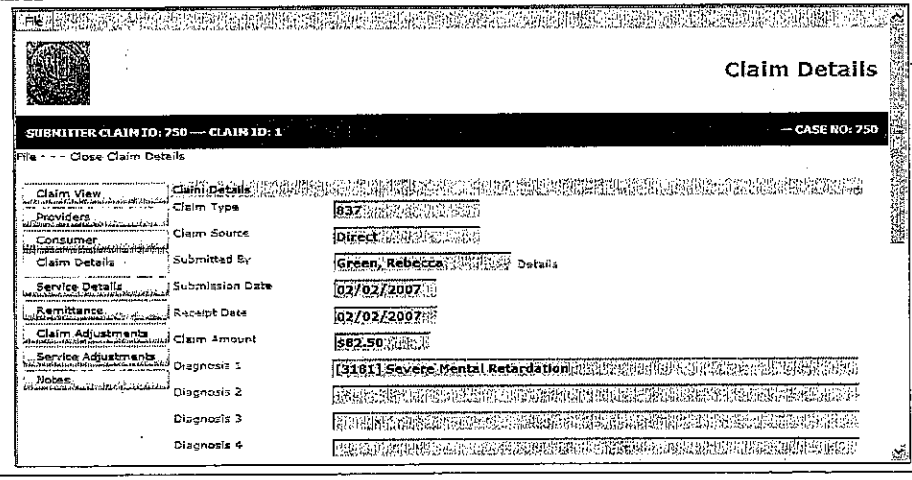
a. ***Providers*** – information about the agency submitting the claim

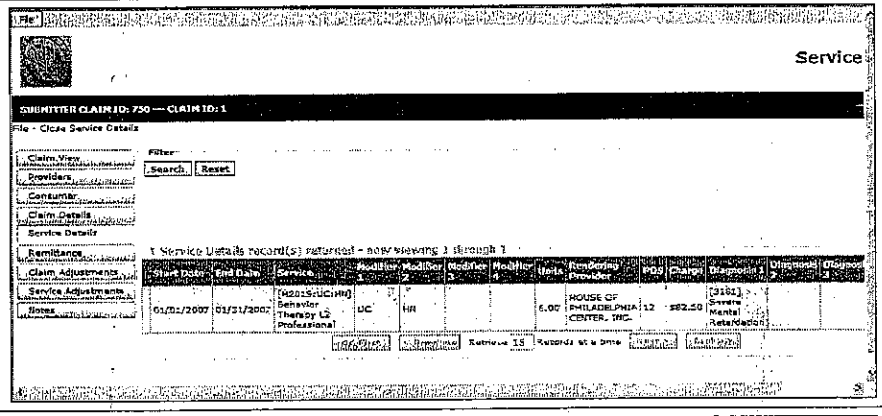
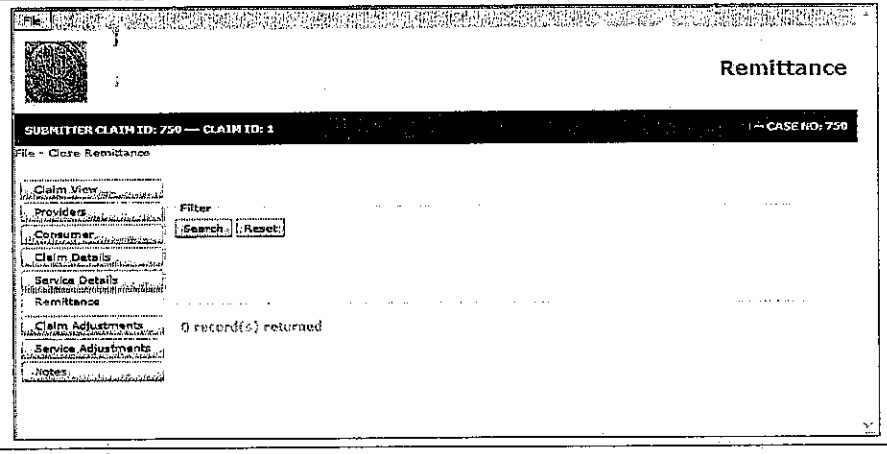


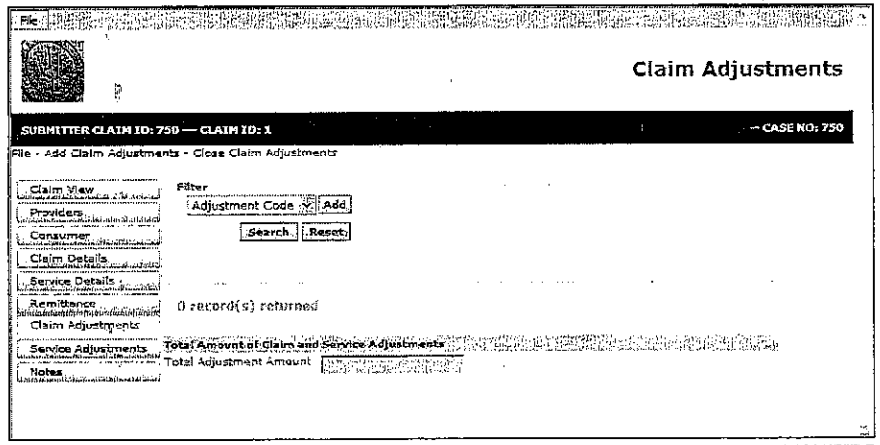
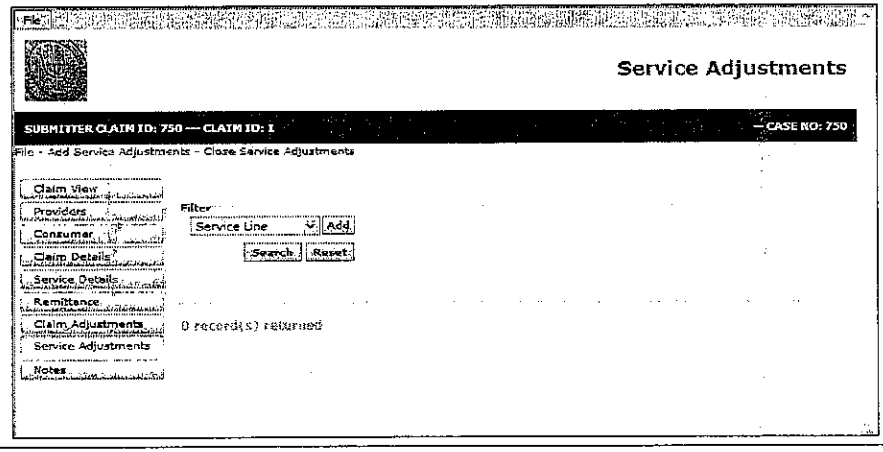
b. ***Consumer*** – information about the client



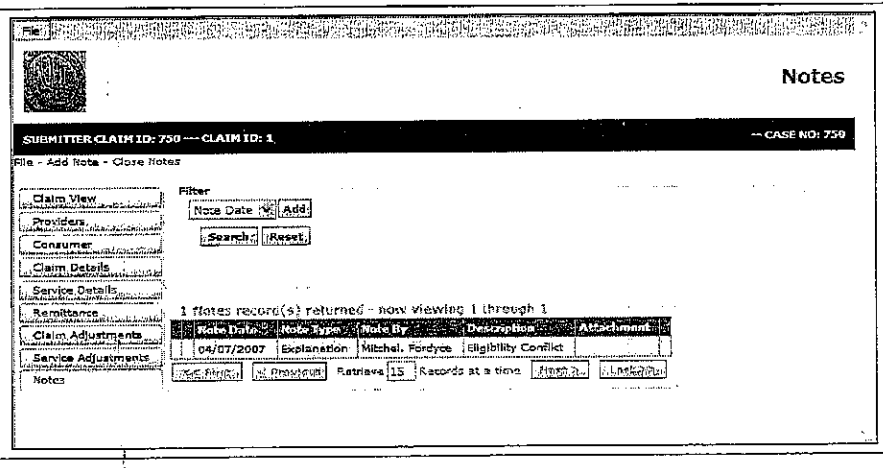
c. ***Claim Details*** – additional claim details including diagnoses



d. ***Service Details*** – information about the activity or activities on the claim	
e. ***Remittance*** – any remittance applied to the claim	

f. ***Claim Adjustments*** – adjustments made at the claim level	
g. ***Service Adjustments*** - adjustments made at the service level	

h. ***Notes*** – list of notes attached to the claim – users may add additional notes by selecting *Add Notes* from the *File* menu



Correcting Claims

Resubmit

If a claim has been denied, a new claim can be entered through normal claims entry (Add Claim or 837) or the claim can be resubmitted through the claims chapter.

The resubmission option is an alternative to typing the entire claim again. The original claim is not altered, but a copy of the original claim is made, which can then be edited and resubmitted through the ASAIS adjudication workflow.

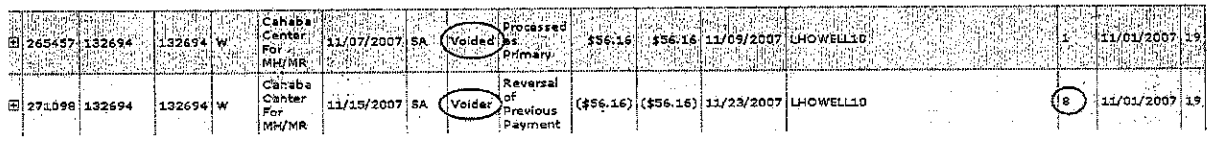
1. Select the claim to be resubmitted from the claims grid
2. Use the arrow on the right to select the option to Resubmit
3. Modify the claim to reflect any necessary changes
4. Submit claim and verify the "submit successful" message is returned

Void and Void/Resubmit

If a claim has been paid that was submitted incorrectly, it needs to be voided through the claims chapter in ASAIS. This will create a reversal claim in ASAIS to offset the original paid claim.

There is also a Void/Resubmit option which both creates the reversal claim and makes a copy of the original claim which can be edited and resubmitted through the ASAIS adjudication workflow.

1. The original claim will continue to show with the paid amount that was initially paid on the original EOP date, but the status will be changed to Voided.



⊞	265457	132694	132694	W	Cahaba Center For MH/MR	11/07/2007	SA	Voided	Processed as Primary	$56.16	$56.16	11/09/2007	LHOWELL10	1	11/01/2007	19
⊞	271098	132694	132694	W	Cahaba Center For MH/MR	11/15/2007	SA	Voider	Reversal of Previous Payment	($56.16)	($56.16)	11/23/2007	LHOWELL10	8	11/01/2007	19

2. The reversal claim will show with a status of Voider and a Frequency Type of 8. The reversal claim will also have an EOP date for when the reversal was processed.	

Financial Reporting and Reconciliation

Overview of Key Processing Dates

- **Submit Date** – the date the claim processed through the Harmony workflow. The ASAIS adjudication rules are applied and the claim shows in the claims chapter.
- **Remit Date** – the date the adjudication decision is made. For state/block grant funded claims it is normally the same as the submit date. For Medicaid claims, it is the EOP date set by Medicaid as the check-write date at EDS.
- **EOP Date** – the date associated with a specific warrant.

Claims Reports – Based on EOP Date

The following reports are most commonly used to balance the check received against the specific claims that were paid and to identify denied claims:

- Alabama Remittance Advice – PV Number
- Alabama Claim Reconciliation by EOP Date
- Remitted Claims by EOP with All Denials

harmony INFORMATION SYSTEMS, INC.

DRAFT Attachment #3

SA Wait List

Welcome, Kris Vilamaa

7/29/2009 1:36 PM

Filter

Level Of Care Equal To Clinically Managed High Intensity Residential (Crisis Res) OR
Level Of Care Equal To Clinically Managed Low Intensity Residential (Res Rehab) OR
Level Of Care Equal To Medically Monitored Inpatient Detoxification (Detox) OR
Level Of Care Equal To Clinically Managed Residential Detoxification AND
County

47 SA Wait List record(s) returned - now viewing 1 through 47

Facility	County	Capacity	Enrolled	Availability	Referred to Waiting List	On Waiting List ▾		
B'ham Fellowship House Male Res Rehab	Jefferson	25	71	-46	70	226	No	
B'ham Fellowship House Female Res Rehab	Jefferson	11	32	-21	30	97	No	
B'ham Fellowship House Co-Occurring Male Res Rehab	Jefferson	7	39	-32	10	40	No	
Cedar Lodge Guntersville Male Crisis Res	Marshall	16	77	-61	3	37	No	
Caradale Lodge Sylacauga Male Crisis Residential	Talladega	16	13	3	0	33	No	
Cedar Lodge Guntersville Female Crisis Res	Marshall	12	68	-56	4	19	No	
B'ham Fellowship House Co-Occur. Female Res Rehab	Jefferson	7	6	1	2	17	No	
Caradale Lodge Sylacauga Female Crisis Residential	Talladega	8	5	3	0	11	No	
B'ham Fellowship House Drug Court Male Res Rehab	Jefferson	9	6	3	0	6	No	
Pearson Hall Male Crisis Residential	Jefferson	32	20	12	18	4	No	
CED Fellowship House Gadsden Adult Male Res Rehab	Etowah	20	18	2	1	4	No	
Caradale Lodge Sylacauga Adult Residential Detox	Talladega	16	10	6	0	4	No	
Aletheia House Special Women's IOP w/Residential	Jefferson	32	71	-39	0	4	No	
Anniston Fellowship House Male Res Rehab	Calhoun	19	18	1	9	3	No	
Aletheia House Male IOP with Residential Component	Jefferson	66	56	10	1	3	No	
Pearson Hall Female Crisis Residential	Jefferson	16	8	8	9	2	No	
A Woman's Place Female Crisis Residential	Tuscaloosa	16	13	3	23	2	No	
C.A.P. Capitol Recovery Center Adult Male Crisis R	Montgomery	24	37	-13	23	2	No	
B'ham Fellowship House Drug Court Female Res Rehab	Jefferson	4	3	1	1	2	No	
The Bridge Mobile Adolescent Crisis Residential	Mobile	22	26	-4	1	1	No	

	Haven Male Crisis Residential	Houston	26	222	-196	2	1	No
	Pearson Hall Residential Dextoxification	Jefferson	12	63	-51	1	0	No
	Olivia's House Female Residential Rehabilitation	Jefferson	27	107	-80	8	0	No
	Olivia's House Special Women's Services	Jefferson	5	29	-24	1	0	No
	The Bridge Gadsden Adolescent Crisis Res	Etowah	20	34	-14	0	0	No
	The Bridge Mobile GEMS Adolescent Crisis Residenti	Mobile	4	0	4	1	0	No
	Haven Female Crisis Residential	Houston	10	73	-63	2	0	No
	Northwest MHC START Adolescent Female Crisis Resid	Walker	16	88	-72	1	0	No
	Riverbend Sunrise Lodge Male Crisis Residential	Franklin	12	13	-1	3	0	No
	Emma's Harvest Home Mobile Co-Occurring Residentia	Mobile	8	12	-4	4	0	No
	The Shoulder Daphne Res Rehab	Baldwin	48	22	26	5	0	No
	Dauphin Way Lodge Mobile Male Crisis Res	Mobile	25	187	-162	1	0	No
	Dauphin Way Lodge Mobile Male Res Rehab	Mobile	25	18	7	8	0	No
	St. Anne's Home Birmingham Female Residential Reha	Jefferson	18	106	-88	5	0	No
	First Step Andalusia Male Crisis Resi	Conecuh	18	175	-157	7	0	No
	Second Choice Co-Occurring Residential Rehab	Mobile	14	59	-45	4	0	No
	Rapha Ministries Attalla Male Res Rehab	Etowah	54	64	-10	1	0	No
	Phoenix House Tuscaloosa Male Residential Rehab	Tuscaloosa	24	23	1	27	0	No
	Phoenix House Tuscaloosa Female Residential Rehab	Tuscaloosa	16	17	-1	16	0	No
	The Pathfinder Huntsville Male Residential Rehab	Madison	15	13	2	50	0	No
	The Pathfinder Huntsville Female Residential Rehab	Madison	15	22	-7	13	0	No
	New Life for Women Gadsden Female Crisis Res	Etowah	12	12	0	0	0	No
	Lighthouse Cullman Male Res Rehab	Cullman	12	18	-6	23	0	No
	Lighthouse of Tallapoosa Alex City Male Res Rehab	Tallapoosa	15	61	-46	22	0	No
	Freedom House Rogersville Female Adult Res Rehab	Lauderdale	22	93	-71	5	0	No
	New Life for Women Residential Rehab	Etowah	8	14	-6	0	0	No
	Emma's Home Mobile Female Res Rehab	Mobile	4	1	3	0	0	No

Retrieve 47 Records at a time

518

DRAFT

Goal # 17
Attachment # 1

September 18, 2009

RAPHA Ministries
New Centurions
The Shoulder

Dear :

The attached information describes "Charitable Choice Requirements" which apply to all faith-based contracting substance abuse programs. I am fulfilling a Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Prevention and Treatment Block Grant (SAPT BG) requirement by distributing this information and informing you of the stated protections for the provider organization and the service recipient. Please review the information and implement the following practices in your program.

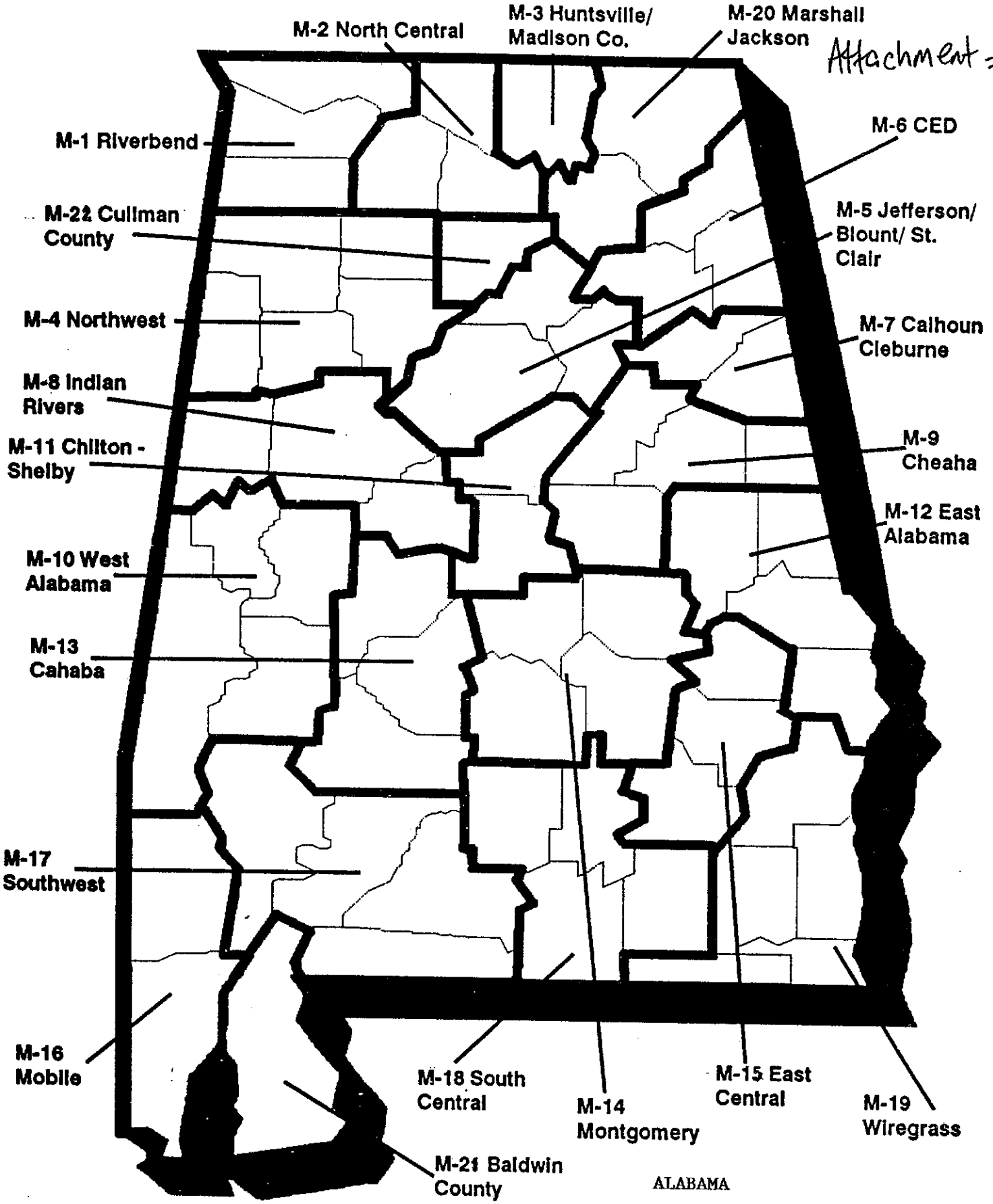
1. Incorporate "Attachment A" in your client rights procedure.
2. Notify the SASD within thirty days when you are unable to refer clients to another provider if they object to the religious nature of your program.
3. Annually report, to the SASD, the number of service recipients requesting referrals to an alternative provider.

If you should have any questions, please let me know.

Sincerely,

J. Kent Hunt
Associate Commissioner for Substance Abuse Services

Attachment #1

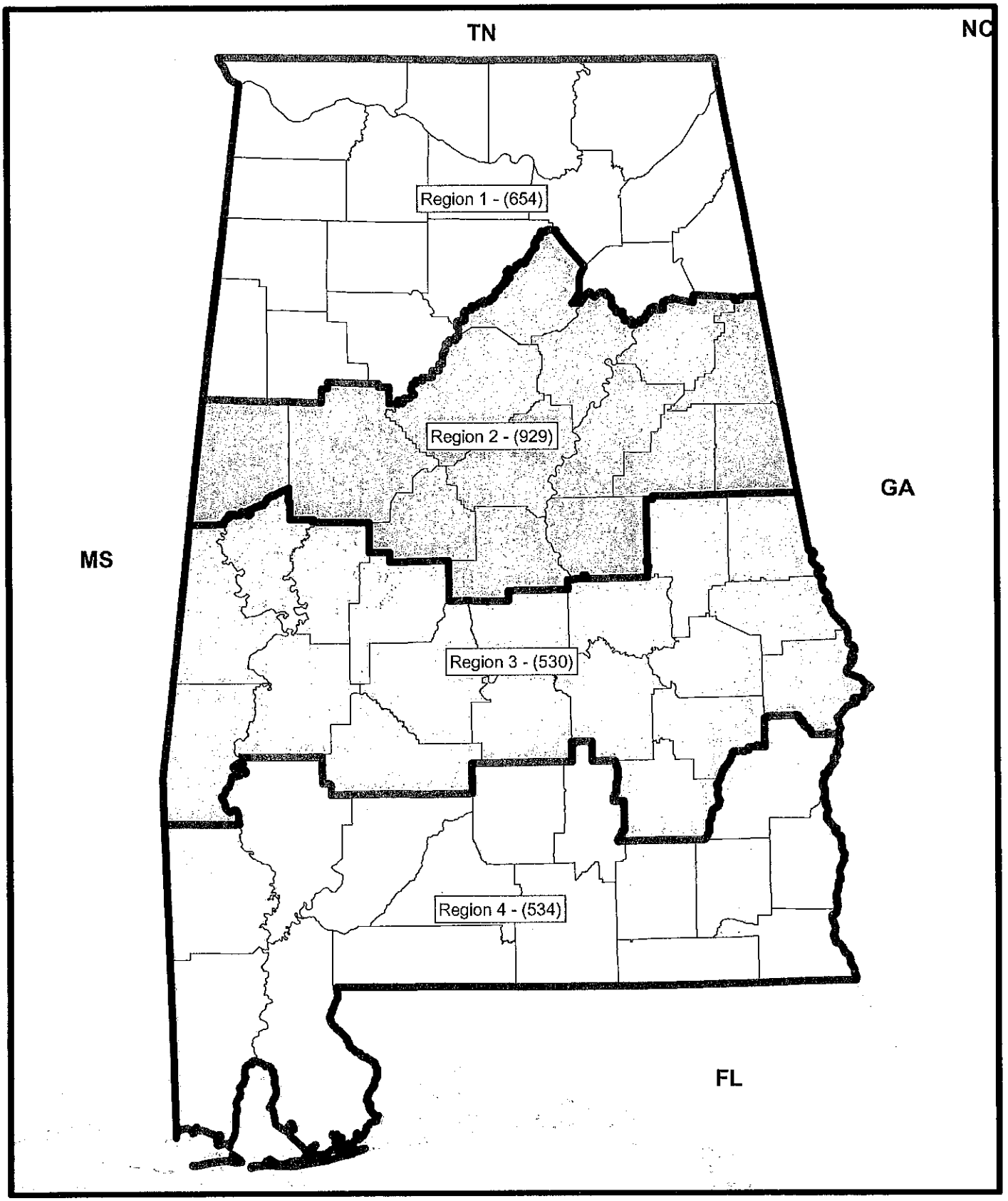


310 BOARD CATCHMENT AREAS

Attachment #2

Attachment A

Definitions and 1999-2001 NSDUH Sample Sizes for Sub-state Areas: Alabama



Attachment B

ALABAMA – Counties by Planning Regions			
Region 1	**Region 2**	**Region 3**	**Region 4**
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
DeKalb	Chilton	Choctaw	Clarke
Etowah	Clay	Dallas	Coffee
Fayette	Cleburne	Elmore	Conecuh
Franklin	Coosa	Greene	Covington
Jackson	Jefferson	Hale	Crenshaw
Lamar	Pickens	Lee	Dale
Lauderdale	Randolph	Lowndes	Escambia
Lawrence	Shelby	Macon	Geneva
Limestone	St. Clair	Marengo	Henry
Madison	Talladega	Montgomery	Houston
Marion	Tuscaloosa	Perry	Mobile
Marshall		Pike	Monroe
Morgan		Russell	Washington
Walker		Sumter	
Winston		Tallapoosa	
		Wilcox	