Alabama

UNIFORM APPLICATION
FY2011

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

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

OMB - Approved 07/20/2010 - Expires 07/31/2013

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

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 454 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.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at http://bgas.samhsa.gov.

Form 1

DUNS Number: 929956324-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

I. 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

II. 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	

III. State Expenditure Period:

From: 10/1/2008 To: 9/30/2009

IV. Date Submitted:

Date: 10/1/2010 7:09:28 PM Original: ◉ Revision: ○

V. Contact Person Responsible for Application Submission:

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

Form 2 (Table of Contents)

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

c ***Title XIX, Part B, Subpart II and Subpart III 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 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications

As required by Title XIX , Part B, Subpart II and Subpart III 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 C.F.R. 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 C.F.R. 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 C.F.R. 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 C.F.R. 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 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.	By signing the certification, the undersigned certifies 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

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT:
PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following 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.

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five 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 (SPA).
- 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.
- Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its 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 and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

- 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 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)
Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development
Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels —processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System
Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes
Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

The Alabama Department of Mental Health (DMH) must provide for a systematic long range and operational planning process that recognizes the statutory authority of both the DMH, 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. In efforts to meet both obligations, Alabama created planning regions and implemented a planning structure.

Alabama is divided into twenty-two mental health catchment areas (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 are responsible for the planning and coordination of mental health, intellectual disability, 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 DMH sub-divided Alabama into four regions (Planning-Attachment #2) for the purposes of planning substance use disorder prevention and treatment services and allocating resources since it was not practical to expect that a full continuum of services could be provided in every catchment area. Population, proximity of catchment areas, major metropolitan areas and the location of residential programs were all taken into consideration when creating the planning regions.

In 1993 efforts to provide structure for the planning process resulted in the creation of the Management Steering Committee. 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 DMH, the 310 Boards, family members of consumers, primary consumers and advocates. 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:

- Position Vacant, Mental Health Consumer, Montgomery
- Ms. Gwen Thomas-LaBlanc, Advocate, Jasper
- Ms. Susie Kingry, Provider, Dothan
- Mr. Jim Counts, Certification Board Representative, Birmingham
- 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
- Mr. Brian Davis, 310 Board Representative, Huntsville

- 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
- Ms. Kathy Goodwin, 310 Board Representative, Decatur

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 prevention and treatment 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. These efforts have been continued as described in Planning-Attachment #3. The expanded local planning/needs assessment process requires pre-publicized, open meetings that are chaired by the local 310 Board Director. The meetings are designed to identify local mental health, intellectual disabilities and substance abuse needs. The identified needs are then rolled up to the regional planning level. These needs are considered and prioritized in regional meetings by consumer, family, advocate and provider representatives that are elected from the local meetings to represent the local groups at the regional meetings. The prioritized needs are then passed along the respective Coordinating Subcommittees for consideration, prioritization and inclusion in the DMH's budget request.

The prioritized need identified through the local process provides the basis for DMH budget requests which are presented to the Governor each November. As a result of the local need identification process, the SASD requested $18 million (FY 2009-2010) and $19 million (FY 2010-2011) new State funds to address the locally identified needs. Unfortunately, State budget restraints prohibited any increases. However, the local planning/needs assessment process continues. Planning-Attachment #4 includes the substance abuse goals which were developed through the local planning process and included in the FY 2010-2011 Operational Plan for substance abuse services. Plans are already being implemented for the generation of the FY 2011-2012 budget request which will include new State funding designed to meet the locally identified needs.

In addition to the previously described local needs assessment process, the DMH, Substance Abuse Services Division (SASD) estimates incidence, prevalence and need by utilizing data collected through the

Alabama Pride Survey, Alabama Department of Education Reports (Adequate Yearly Progress, Free/Reduced Lunch, School Incident Reports, In School Suspension Reports, Truancy Reports), Juvenile Court Arrest Reports, Alabama Alcoholic Beverage Control Board Compliance Rates, Alcohol Density Reports (Licensees, Violations), Alcohol Tax Reports, Nuisance and Abatement Ordinances (Enforcements), Alabama AIDS Cases, Alabama Hepatitis B Cases, DUI Arrest Report, Other Drug Arrest Report, the original treatment Needs Assessment Study, Social Indicator Study, the National Survey on Drug Use and Health, and Alabama Waiting List data. Data sources are detailed in Planning-Attachment #5 – Planning, Data Sources.

In addition to estimating local need, data from these sources are used to compare resource allocation with estimated prevalence/need. Using several key data sources, the Planning Regions are ranked (1= most needy to 4=least needy) based on estimated need and compared to regional per capita distribution of funding.

Regional Rankings

	Region #1	Region #2	Region #3	Region #4
#s Served	2	1	4	3
# of DUI Arrests	1	4	3	2
# of Other Drug Arrests	3	1	4	2
# of Hepatitis B Cases	2	1	3	4
# of AIDS Cases	4	3	1	2
# of TB Cases	1	2	4	3
PRIDE Survey	3	2	4	1
Waiting List	2	1	4	3
NSDUH	4	2	1	3
2003 County Profiles	3	4	2	1
Overall Score	25	21	30	24

Overall Ranking 3 1 4 2
SFY 09-10 Per Capita
Funding (Ranking) 4 1 3 2

When this analysis was conducted in 2009, the Planning Region rankings aligned with the regional distribution of funding. According to this analysis, Regions #1 and #3 switched rankings. Therefore, the regional distribution of funding for SFY 2009 - 2010 is not aligned with regional rankings based on estimated need. Realignment of future funding will be evaluated.

Monitoring

It is important to the SASD that community resources produce positive outcomes. Several processes are utilized to assure the effective and efficient use of very limited community prevention and treatment resources.

The SASD conducts an on-site monitoring process, as described in Goal #5-Attachments #1-4 which is designed to enhance the current contractual and data monitoring processes.

The Alabama Substance Abuse Information System is an integral part of the SASD's monitoring process. ASAIS is the collection point for screening, assessment, enrollment, referral, waiting list, priority population management, capacity, utilization, individual services, claims processing, Medicaid utilization, etc. ASAIS also allows for voluminous management report generation which allows the SASD and providers to monitor all phases of Alabama's substance use disorder prevention and treatment system.

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 on-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.

Independent peer reviews are organized by the SASD which are designed to enhance efficiency and effectiveness of local programming by allowing sharing of professional expertise in a non-threatening manner.

All contracting community programs are required to submit to the DMH annual financial audit reports which include contract compliance letters. These audits also serve as an essential part of the SASD monitoring process.

Alabama Epidemiological Outcomes Workgroup

The Alabama Epidemiological Outcomes Workgroup (AEOW) operates in accordance with thecharter, which is included as Goal #13-Attachment #1. The mission of the AEOW is "…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".

The AEOW collects data from national, state, and local levels which are related to substance abuse such as National Survey on Drug Use and Health, Youth Risk Behavior Surveillance System, Behavioral Risk Factor Surveillance System, and Pride Surveys. For example, alcohol and other drug arrest data, fatal crash data and Pride student survey data are indicators included in the Alabama Epidemiological Outcomes Workgroup (AEOW) profiles. The profiles provide community providers and coalitions with needs assessments which are used to develop prevention strategies. Other data sources such as juvenile arrest and school incident

reports are also suggested as tools to assist in determining local needs. The needs assessment indicators are utilized to rank the priority populations for targeted evidence-based strategies.

Prevention resources are available to community providers to assist with workshops and trainings which are components of Alabama's Systems Improvement Initiative. Also, the AEOW continues to recruit new members to the workgroup which will expand data resources available for community providers and coalitions.

Community providers are required to submit related data to support their proposed education, alternative and environmental strategies. The providers also are required to identify the evidence-based programs that will be used to address their target populations as referenced in their needs assessment data. Progress and outcomes are monitored through compliance checks, student surveys, reports and on-site visits. The reports will be used to analyze the target populations and monitor resource utilization. The analyses will be used in the AEOW profiles for future planning and implementation.

Public Comment

Initially, the SASD conducted regional meetings to elicit public comments on the DMH plans for substance abuse prevention, treatment and the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) Application. After three years of receiving practically no responses, the SASD decided that these meetings were not yielding the desired results so they were discontinued.

Continued efforts to elicit public comments included running notices in the major metropolitan newspapers (cost of approximately $800 annually) in the state inviting comments on the SAPT BG Application. During FFY 2000 a total of six responses were received and incorporated into the planning process. Due to the high cost and very poor results this effort was dropped.

In Alabama, the public comment process has evolved to the point that the Alabama substance abuse prevention and treatment system, including the SAPT BG Application, goals, objectives, priority populations, priority services, budget requests, resource allocation, etc., are the result of continuous public comment. Public participation is available through the local needs assessment process, the Substance Abuse Coordinating Subcommittee, the Management Steering Committee, the Mental Health Board of Directors and the Commissioner's budget presentation (which includes prevention and treatment) to the Alabama Legislature each year. In addition, the SAPT BG Application is available for public comment on the DMH website at www.mh.alabama.gov .

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 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

1 Problem levels as estimated by alcohol/drug-related crime statistics

1 Problem levels as estimated by alcohol/drug-related health statistics

1 Problem levels as estimated by social indicator data

4 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specify method)

Planning Region Needs Ranking

1 Size of gaps between resources (as measured by)

320,000 need treatment but not getting treatment

and needs (as estimated by)

National Survey on Drug Use and Health

1 Other (specify method)

Alabama Epidemiological Outcomes Workgroup Profile

Form 4 (formerly 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: 2009 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:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 1	1,308,958	81,874	12,281	1,637	246	24,563	3,684	5,223	4,578	0	2.22	2.60	4.13

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: 2009 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:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 2	1,521,436	98,410	14,762	1,968	295	25,558	3,834	3,899	6,558	0	2.50	2.63	4.08

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: 2009 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:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 3	831,215	71,165	10,675	1,423	234	21,350	3,202	2,259	1,998	0	1.56	6.02	2.17

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: 2009 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:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Region 4	1,047,099	71,583	10,737	1,431	215	21,475	3,221	3,850	4,022	0	0.86	4.78	3.25

1. Substate	2. Total Population						Calendar Year:	

Substate Planning Area	Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		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:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	4,708,708	323,032	48,455	6,459	990	92,946	13,941	15,231	17,156	0	1.89	3.72	3.57

Form 5 (formerly Form 9)

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	0	0	0	0	0	0	0	0	0	0	10,049	4,307	0	0
18 - 24 Years Old	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25 - 44 Years Old	308,676	178,318	70,758	41,719	17,881	0	0	0	0	0	0	0	0	0	0	220,037	88,639	0	0
45 - 64 Years Old	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly 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 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

The data in Form 4 (columns 3,4 and 5) and Form 5 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 include the required level of detail.

Alabama has established a State Epidemiological Outcomes Workgroup (AEOW) which update the prevention and treatment needs assessment and increase the volume, reliability and usefulness of Alabama needs assessment in management of prevention and treatment resources.

Data reported in Form 4 (columns 6 and 7) is collected from the relevant State agency maintained databases. The data included reflect calendar year 2009. DUI and other drug related arrest data is provided by the Alabama Criminal Justice Information Center. Hepatitis B, AIDS and TB data is provided by the Alabama Department of Public Health.

Data in Form 5 (columns D,E,F,G and H) is not available since the 1999 Needs Assessment Study did not provide this level of race/ethnicity data.

Form 6 (formerly 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 2011 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	$ 17,887,506	$ 5,840,006	$ 92,258	$ 24,372,552	$	$ 6,709,628
Primary Prevention	$ 4,770,002		$	$	$	$
Tuberculosis Services	$	$	$	$	$	$
HIV Early Intervention Services	$	$	$	$	$	$
Administration: (Excluding Program/Provider Lvl)	$ 1,192,500		$	$ 2,104,708	$	$
Column Total	**$23,850,008**	**$5,840,006**	**$92,258**	**$26,477,260**	**$0**	**$6,709,628**

***Prevention other than Primary Prevention**

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$	$	$ 433,520	$	$
Education	$ 1,240,201	$	$	$	$
Alternatives	$ 906,300	$	$	$	$
Problem Identification & Referral	$ 72,592	$	$	$	$
Community Based Process	$	$	$	$	$
Environmental	$ 2,550,909	$	$	$	$
Other	$	$	$ 201,090	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$4,770,002**	**$0**	**$634,610**	**$0**	**$0**

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 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**

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 2011 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: %

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: 10 %
Percent of Expenditures: 10 %

☐ 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: 80 %
Percent of Expenditures: 80 %

Unit: Individual	Rate: $ 48.11
Unit: Group	Rate: $ 15.77
Unit: Case Management	Rate: $ 38.52

☑ Per capita allocation (Formula:)

Percent of Clients Served: 20 %
Percent of Expenditures: 20 %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:

Reference Attachment #1 and Attachment #3, Billing Manual and Rate Sheet.

Program Performance Monitoring

- [x] On-site inspections

  Frequency for treatment: ANNUALLY

  Frequency for prevention: ANNUALLY

- [x] Activity Reports

  Frequency for treatment: ANNUALLY

  Frequency for prevention: ANNUALLY

- [x] Management Information System

- [ ] Patient/participant data reporting system

  Frequency for treatment: NONE SELECTED

  Frequency for prevention: NONE SELECTED

- [ ] Performance Contracts

- [ ] Cost reports

- [x] Independent Peer Review

- [x] Licensure standards - programs and facilities

  Frequency for treatment: EVERY TWO YEARS

  Frequency for prevention: EVERY TWO YEARS

- [x] Licensure standards - personnel

  Frequency for treatment: NOT APPLICABLE

  Frequency for prevention: NOT APPLICABLE

Other:

- [ ] Specify:

Form 7

State Priorities

	State Priorities
1	By 2015, a continuum of outcome supported prevention, treatment and recovery support services for adults will be available in all 67 counties.
2	By 2015, a continuum of outcome supported prevention, treatment and recovery support services for children and adolescents will be available in all 67 counties.
3	By 2015, prevention and treatment outcomes will be measured using the ten national outcome measures for substance abuse and utilized in performance monitoring and resource allocation.
4	By 2015, substance abuse advocacy efforts will be active in all 67 counties.
5	By 2012, a uniform substance abuse screening/assessment and placement process will be utilized in Alabama.
6	By 2012, American Society of Addiction Medicine (ASAM) levels of care will be provided by all Department of Mental Health certified substance abuse programs.
7	By 2015, the number of Department of Mental Health certified residential beds for women suffering with substance use disorders will be increased by 100% over the 2008 baseline.
8	By 2015, publicly supported residential and outpatient detoxification services will be available in Alabama's four planning regions.
9	By 2015, Publicly supported child and adolescent, non-residential services will be available in Alabama's four planning regions.
10	By 2015, publicly supported outpatient substance use disorder services will be available to support adult drug courts, adolescent drug courts and family dependency drug courts.

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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 during SFY 2011.

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

This goal was met during the SAPT BG 2008 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 implemented fifty-five contracts to purchase prevention and treatment services from sixty-three community organizations (refer to Form 8). 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 systems in operation in 2008 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 2008 SAPT BG were tracked to the individual client level through the Stand-Alone Uniform Data Reporting System (SUDS) from October 1, 2007 through June 30, 2008 and the Alabama Substance Abuse Information System (ASAIS) July through September 2008. Reports regarding expenditures and service information for the SAPT BG Application are generated from the SUDS and ASAIS data systems.

How the SAPT BG funds were used to meet the goals, objectives and activities of the FY 2008 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
Auburn University (SIG Evaluation)	Lee	3
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
City of Selma (SIG)	Dallas	3
Council on SA	Montgomery	3
Cullman MHC	Cullman	1
Drug Education Council	Mobile	4
East Alabama MHC	Lee	3
East Central MHC	Pike	3
Elmore County Partnership (SIG)	Elmore	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
Marshall County Commission (SIG)	Marshall	1
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
Tuscaloosa County BOE (SIG)	Tuscaloosa	2
Tuskegee University (SIG)	Macon	3
Sylacauga Alliance (SIG)	Talladega	2
UAB	Jefferson	2
West Alabama MHC	Marengo	4
Wilcox County Commission (SIG)	Wilcox	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 Attachment #3) 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 2008 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 (69.5%)
  - Female 6,395 (30.5%)

- Race:
  - White 12,216 (58.2%)
  - Black or African American 8,501 (40.5%)
  - 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 (98.9%)
  - Hispanic of Latino 221 (1%>)

- Age:
  - 17 and under 1,512 (7.2%)
  - 18 – 24 4,074 (19.4%)
  - 25 – 44 11,313 (53.9%)
  - 45 – 64 3,978 (18.9%)
  - 65 and over 88 (1%>)

- Pregnant (of total females):
  - Yes 216 (3.0%)

  - White 144 (67.0%)
  - Black 66 (31.0%)

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 and Attachment #3), through contracts with certified community providers. During the 2008 SAPT BG expenditure period the SASD implemented contracts covering sixty-three 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.

The SASD data system, the Alabama Substance Abuse Information System (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 and Attachment #3). 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 2010.

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
Dothan/Houston City Drug Treatment	Houston	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
Hamilton Economic Development		
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
The Right Turn	Montgomery	3
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
Elmore County Partnership	Elmore	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

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify 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)).

Primary Prevention: Six (6) Strategies

• **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

• **Education** –This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

• **Alternatives** –This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.

• **Problem Identification and Referral** –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. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

• **Community-based Process** –This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

• **Environmental** –This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

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

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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
2009-2010

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

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: Mental Health centers, SASD funded prevention programs, after school and other agencies, and middle schools
How: Contract that was extended through FFY2008
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 strategies 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 2008
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 2008
Where: Statewide
How: ADECA collaboration and competitive grants to health and human service contractors

D. Problem Identification and Referral

No community contract providers reported or billed for any PIDR activities. Technical Assistance & Training was available to all interested providers and reinforced by the Prevention Consultants to the local provider community. In addition, technical assistance was 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. 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”. 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.

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 2008
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 2008
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: FFY2008
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, prevention Block Grant funds maintain statewide support services designed to enhance the State's service delivery system.

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

By September 30. 2010, an ordinance will be passed to limit the number of new business licenses with the intent to sale alcohol to 3 within a 5 mile radius in the West Anniston area. Collaborate with SAPAC and the Faith-Based Community to obtain Memorandum of Understandings supporting the Ordinance, by March 1, 2011. Educate our local Coalition (SAPAC) concerning the problems associated with high density of alcohol vendors in our community and secure their support and a signed Memorandum of Understanding. Educate residents in the target area concerning the problems associated with high density of alcohol vendors in a community. Media campaigns encourage strong attendance to the City Council Meeting when the Ordinance comes up for a vote.

Provider Strategy Domain Evidence-based Program Program Location # of Service Hours Timeframe (During School, After School, Weekends, Summer, Spring Break) Target Population
Cullman Environmental Enforce current random room inspections at designated intervals in Wallace State Community College dormitories as Student Code of Conduct and Residence Hall General Policies as a deterrent to possession & availability of alcohol by March 30, 2011. Implement actual schedule of random dorm room inspections by September 30, 2010. Information dissemination of information regarding alcohol abuse/binge drinking to dorm residents. Power point presentation to new student orientation classes and dissemination of information on alcohol abuse consequences. Utilize banners, articles, announcements, signs and publications regarding alcohol awareness & standards of conduct. Alcohol usage surveys given to students once per semester (18-24). Coordinate with Clearing House to provide needed material for awareness & information dissemination. Utilize a media campaign to educate students on legal & health consequences of alcohol abuse/binge drinking. Create a new campus protocol of developing a centralized database for recording alcohol related incidences on campus as an indicator of alcohol use and as a means to develop new alcohol policies by December 31, 2010. Meet with Campus Security to establish protocol for reporting incidents to database.

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

Alabama / SAPT FY2011 /

To reduce the availability and accessibility of alcohol to underage youth living in the Weed & Seed Community by working with the local State of Alabama Alcoholic Beverage Control (ABC) Board-Enforcement Division on the regulation of alcohol sales by implementing compliance checks of retail vendors. And reduce the non-compliance rate by the 14 vendors in the Weed & Seed community by 3% no later then September 30, 2011. Recruit volunteers from Weed & Seed churches and community to become active coalition members in the battle against youth access to alcohol. Distribute flyers and information to churches in the Weed & Seed Area highlighting the need for adult involvement in the battle against underage alcohol use. Distribute informational packets to adults containing laws and penalties for adults contributing to the sale or use of alcohol to youth in Montgomery County, especially the Weed & Seed community. Educate vendors on the importance of compliance of underage sales of alcohol to minors and the penalty of non-compliance. Host a Town Hall Meeting to raise awareness and encourage action in preventing underage drinking for Alcohol Awareness month in April. Host a Town Hall Meeting to raise awareness and encourage action in preventing DUIs in the weed & seed area. Organize coalition/workgroup members in the Weed & Seed area that will assist in increasing awareness of the importance of sobriety checks in the area and the risks of drunk driving.

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 To reduce access and availability of alcohol to minors in City Council Districts 1 and 2 by increasing the number of retail compliance checks and by decreasing the non-compliant rate by September 2012; and by monitoring environmental factors which have been identified through the environmental scan/community mapping process.

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
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 Goal 1: By September 2012, partner with the Clanton Police Department to implement the use of a tip-line for the community to report any alcohol related incidents concerning minors.
Goal 2: By September 2011, with the Clanton Police Department, Chilton Shelby Mental Health Center will create two new community practices that will address identified risk factors in the community that facilitate

underage drinking.

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 By September 30, 2011 an indoor clean air ordinance shall be passed by the Jasper City Council affecting the number of minors who smoke. Conduct meetings to educate the public about the problem of underage tobacco use, and the dangers of secondhand smoke. Conduct a media campaign to alert/educate the public.

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

Collaborate with the City of Birmingham and the Ensley Community stakeholders to create, submit and get approved by September 2011, an city/county wide ordinance to have vendors remove open iced coolers, also known as portable coolers from “conspicuously accessible, available, quickly and easily seen areas in the stores”; especially areas where consumers pay and underage youth frequent, in the Ensley community. Develop flyers, posters, power point presentation and church bulletin inserts to address/disseminate information to the community as it relates to reducing and the prevalence of underage drinking with the assistance of the youth advisory council which includes the girl scouts and Oakmont All-Stars. Reward the youth participants with positive rewards, incentives and recognition for their participation.

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

To implement a 24-hour tip line (a new practice for this area) allowing anonymous callers to report underage alcohol use in Escambia County, Alabama for fiscal year 2010-2011. As tip line use increases (e.g., tips regarding parties with underage drinking, parental hosting of underage drinkers, stores allowing alcohol purchases without proper identification, field/creek parties, etc.), access and availability will decrease as parents/other adults and store/property owners become aware that they are at risk for being reported for condoning and/or illegally serving/supplying alcohol to Escambia County's youth. Develop a website about underage drinking to advertise tip line, educate visitors regarding the dangers of adolescent alcohol consumption, provide useful links, and allow the opportunity for community members to provide input/feedback via an online survey on the website by October 31, 2010. Finalize advertising plan/media campaign by November 30, 2010.

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 4th – 6th grades
Environmental
Decrease the non-compliance rate of alcohol sales to minors in Montgomery County (excluding the Weed & Seed area) by 2% by September 30, 2012. Contract with the ABC Board to complete 50 compliance checks on sale of alcohol by September 30, 2011. Provide community/parent education about the need for vendor compliance and additional compliance checks. Establish policies preventing underage youth from entering clubs that sell alcohol by September 30, 2014. Distribute 5,000 pieces of educational materials throughout the target area by September 30, 2010.

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
UAB Education Individual Too Good for Drugs Middle & High School, YMCA 92 DS, AS, S 5th – 12th graders
Alternative Individual Too Good for Drugs Middle & High School, YMCA 79 AS 5 – 12th graders
Environmental By September 2011, the Tarrant Coalition for a Safe and Drug Free Community and UAB/SAP will collaborate with the City of Tarrant to pass a City Ordinance prohibiting public display of portable coolers for alcohol beverages sold in local stores. Below are the measurable activities that will move us toward meeting our goal. By June 2011, the Tarrant Coalition for a Safe and Drug Free Community and UAB/SAP will present a formal request to the City Of Tarrant for an ordinance prohibiting portable coolers containing alcoholic beverages in the front of the store allowing for easy access and encouraging Underage Drinking.

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 5th – 9th graders
Alternative Individual/ Community Too Good for Drugs & Violence Community Center, Summer Camp, Church 30 S 10th – 12th graders
Environmental B September 30, 2011 the ABC Board will complete no less than 8 compliance checks at the identified 'hotspots' location near the schools, community centers and low income housing in Pratt City and West End, and decrease the accessibility and/or availability of alcohol to African American youth in these communities. The ABC Board will administer at least 1 compliance check at each of the designated locations "hotspots" in Pratt City and West End, and 2 additional compliance checks at randomly selected "hotspots" in same area by September 30, 2011. Involve youth in creating slogans and making signs (related to underage drinking) to be posted in the identified stores and throughout the community. Involve youth in developing strategies (policies and practices) that store owners can use to deter access and availability to alcohol, including theft and adults who make purchases for youth. Involve coalition members and youth in educating vendors and monitoring practices of the store owners, and communicating community expectations to vendors in Pratt City and West End about accountability to the community, and responsible practices (posting ABC Board legal warning signs, placement of coolers, the display and pricing of alcohol, etc.). Strengthen the community coalitions (in Pratt City and West End) by building membership and motivating members to actively participate in prevention efforts and identifying community needs and solutions via an annual needs assessment, and by sustaining organizational structure and function (policies/procedures, records, etc).

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 September 2011, to create a protocol in the City of Geneva to deal with minor youth caught using alcohol. By December 2010, review current practices of the city police department regarding youth who are caught using alcohol. By February 2011, to obtain a petition with at least 300 signatures for changing current practices related to underage alcohol issues. By September 2011, to develop a density ordinance in the City of Geneva limiting the number of alcohol vendors to no more than 5 within a five mile radius.

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 the University of North Alabama to implement practices in Residence Halls that will deter the access and availability of alcohol by September 30, 2011.

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, 2011. 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. 2011. 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

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 By May 15, 2011, the Birmingham City Council will pass an ordinance to limit the number of alcohol retailers in neighborhoods. To develop coalitions in the South East Lake and Arlington-West End that will address the issues of underage drinking and access/availability of alcohol by December 15, 2010. At least 20% of coalition members will be young people under the age of 21. To work with coalition members in each neighborhood to conduct at least 20 community meetings in churches, schools, community centers, neighborhood association meetings, tenant council meetings, etc. to inform the community about issues related to alcohol access and to promote support for the ordinance by February 15, 2011. To work with the youth members of the Coalitions and with older participants in the summer camps, to develop a media campaign designed by youth that will include social media such as Facebook by April 15, 2011. To work with Coalition members to advocate for the ordinance's passage. At least 40 individuals will attend the meeting where the Council votes on the ordinance.

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 6th – 8th graders

Alternative Individual/

Community Too Good for Drugs Boys and Girls' Club 240 W, S 6th – 8th graders

Environmental

By March 2011, an ordinance will be passed restricting the amount of Alcohol advertisement in West Gadsden/Attalla as well as restricting the placement of this advertisement. Conduct three town hall meetings to educate the local citizens about the problem of widespread alcohol advertising that appeals to youth in our small area. Facilitate education and training sessions for our local parent groups, local government, local law enforcement and merchants. Facilitate a motivational media assembly for the public to view to bring more awareness on the effects of alcohol and youth use and the importance of keeping these advertisements out of our youths view. The Etowah County Substance Abuse Prevention Advisory Coalition will partner with SADD youth to provide an alcohol free advertisement in our local movie theater.

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 Continue a fact gathering Safety Line (Called the Safety Line) so that the public can report any activities concerning underage drinking (This would include, but not be limited to the following: Field Parties, House Parties, Sales of Alcohol to Minors and Social Hosting Parties). This Underage Drinking Safety Line carried out through the Cheaha Mental Health Prevention Coalition and a partnership with The Lake Martin Area United Way 2-1-1 other tip line will remain in force from October 1, 2010 through September 30, 2011. Having developed a Data Gathering Form that will be used by 2-1-1, we will develop a protocol on how to develop the data that will be gathered by 2-1-1 calls. The Protocol will be in place by December 30 2010. The data, as sent from 2-1-1 will be sent to Richard Bonds, Prevention Specialist, and such data will be reviewed and tabulated so that Cheaha can develop a strong data base of information on Underage Drinking in the Sylacauga area.

Using our Coalition we will expand our media efforts by having a layered approach to publicize the 2-1-1 Safety Line. Also using our coalition we will mobilize the Community with quarterly Town Hall Meetings and other unspecified events to educate the public to the presence of the tip line and educate the community to issues of underage drinking and therefore mobilize the community's use of the Safety Line. Continue a heavy saturation Media Campaign that will advertise the dangers of Underage Drinking in our Community. Educate the local governing bodies (City Councils and Mayors) concerning high rates of non-compliance and the dangers of such high rates through Town Hall Meetings in each Councilman's District in which the Council Person is invited to take an active part in the Town Hall Meeting.

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

By September 2011, an ordinance will be passed to have vendors remove iced coolers, also known as portable coolers, from "conspicuously" accessible, available, quickly and easily seen areas in stores; especially areas where customers pay for items and underage youth frequent. Coordinate up to three coalition meetings to educate and seek support from the communities. Utilize youth focus groups to help educate peers, parents, and community members about underage drinking and access/availability to youth. Contact Public Safety Commission to verify needs assessment.

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 To increase the number of calls to the 24-hour anonymous underage drinking tip line by 10%. To increase the number of calls to the 24-hour anonymous underage drinking tip line through collaborations with law enforcement, media campaigns, parent and teen awareness. (The 24-hour underage drinking tip line will be monitored through local law enforcement to decrease access and availability of alcohol.) The 24-hour anonymous tip line will be advertised through media outlets and will be advertised as a tag on commercials, radio PSAs, and bill boards for maximum exposure. Measurable by the percentage of increase in the number of calls that are received compared to the number of calls from the previous year. Host 30-second commercial contest in middle and high school were students use their creative skills to compose a commercial that focuses on decreasing access and availability of alcohol. School winners will be selected from participating schools. There will be four overall winners selected from school winners. The four overall winners will have the opportunity to appear in their commercial that will be produced in their community by a local television station. Overall winning commercials will air for a minimum of one year. These commercial will be converted into radio spots when possible. School and overall winners will receive prize packs from media representatives. Photos along with an article outlining the contest will be submitted to local newspapers. Photos of commercial winners will appear on school website and on Planning Committee website.

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

Alabama / SAPT FY2011 /

Environmental Establish random dorm inspections in all on-campus dormitories at Alabama A&M University under the student affairs policies to deter access and availability of alcohol to students by September 30, 2011. Develop an advisory committee of students, local residents, university staff and other community stakeholders by Mary 1, 2011. Educate male and female residential coordinators, hall directors and assistant hall directors about the use of alcohol on college campuses. Develop a presentation for staff and students in the dorms on the dangers of alcohol use and the consequences of consuming alcohol on campus. Work with the student affairs office to educate incoming freshman living on campus about the rules and regulations of alcohol use on campus. Coordinate a public service announcement with the campus radio station (WJAB 90.9) 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
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 7th – 8th graders

Education Individual Too Good for Drugs Schools, Churches 40 DS, AS, S K – 5th 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 Cahaba Center for Mental Health will work with the Children's Policy Council (CPC) and Selma-Dallas Prevention Collaborative (SDPC) toward the passing of referendum by March 2011 which will ban the licensure of new vendors with the intent to sell alcohol within 500 yards of any Selma City School. Monitor ABC Board monthly for alcohol compliance reports to look for changes in numbers. Educate our local Coalition (SDPC) concerning the problems associated with high density of alcohol vendors in our community. Work with SDPC and their youth representatives to support a petition for referendum with 500 community stake holders/member signatures by September 30, 2010. Educate residents in the target area concerning the problems associated with high density of alcohol vendors in a community. Educate students in the 6th grade at the School of Discovery and middle school Selma (CHAT) Academy about dangers of drinking with evidence based program. Do media campaign about the referendum (radio PSA's, newspaper editorials, newsletter, "ASAP Bulletin").

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 To decrease the non-compliance rate of alcohol sales to minors to 12% or lower in the City of Decatur by September 30, 2011. Educate vendors about the importance of compliance of underage sales to alcohol to minors. Conduct at least one activity in Morgan County for each of the following alcohol awareness campaigns: National Red Ribbon Wee, Safe Spring Brea, Alcohol-free Weekend on college campuses, Alcohol Awareness Month, Operation Prom/Grad, National Alcohol and Drug Addiction Recovery Month, and National Collegiate Alcohol Awareness Week. Educate the community about the high non-compliance rate of alcohol sales to minors (community meetings, media campaigns – newspaper editorials, radio and television PSAs, billboards, etc. In conjuction with MCSAN, publish Handbooks to be distributed in the community that will contain facts and information about the prevention of underage drinking and support the amended ordinance. In conjunction with MCSAN, and as indicated by The Drug-Free Action Alliance regarding "Parents Who Host Lose the Most" campaign, purchase and utilize materials from kits that contain best practices for project ideas, fact sheets, sample media releases, newsletter articles, etc. to implement the campaign. Campaign material used will also include information about the ordinance amendment.

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

Decrease access/availability of alcohol to minors by securing an ordinance prohibiting conspicuous display (at the front of stores) of portable coolers containing alcoholic beverages in Brighton by June 2011. Collaborate with the Brighton Anti-Drug coalition members to assist with getting information out to the community (churches, homes, etc.). Representatives from the Brighton Anti-Drug coalition will assist Gateway in facilitating communication between community stakeholders and share information and resources. The students at the Gateway PROUD after school program will participate in a poster contest for alcohol awareness month in April. They will design posters that depict reasons youth should remain alcohol free. Educate the community on alcohol use and availability and its consequences on minors. (Event in April for alcohol awareness month, churches, etc). Students at Brighton Middle School will create public service announcements on underage alcohol use and will make the announcements during the school day at least three times this year. Use the Media to alert/educate the public (billboard, newspaper editorials). Three parent workshops will provide information on the dangers of alcohol use, youth access and social hosting parties. Develop (with assistance from youth at the PROUD program) power point presentations, posters and flyers designed by the youth.

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 2011 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 state epidemiological profile of substance use evaluates the consumption and consequences of alcohol, tobacco, and other drugs (ATOD) in Alabama. 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 per capita consumption of alcohol in Alabama is among the lowest in the country, ranking in the 9th decile.
- In 2008, 38% of Alabama adults reported consuming an alcoholic beverage within the past 30 days.
- More adults reported binge drinking (12%), defined as consuming 5 or more drinks on one occasion, than heavy drinking (4.5%), defined as more than 2 drinks per day for men or more than 1 drink per day for

women.

- Binge drinking and heavy drinking were more common among men than women.
- In 2006-2007, 221,000 adults in Alabama were estimated to be alcohol dependent or abuse alcohol and 209,000 were estimated to have needed but did not receive treatment for alcohol use.
- In 2005, 39.4% of Alabama youth in 9th-12th grades reported consuming an alcohol beverage within the past 30 days.
- Alabama youth reported alcohol use before age 13 (30.9%) and binge drinking (23.8%).
- In 2006-2007, 19,000 Alabama youth ages 12-17 were estimated to be alcohol dependent or abuse alcohol and 18,000 were estimated to have needed but did not receive treatment for alcohol use.

Tobacco

- Alabama ranks 46th out of all states and the District of Columbia for its tax rate on cigarettes.
- The rate of current smoking in Alabama ranks above the national median.
- In 2008, 22.1% of Alabama adults were current smokers.
- In 2005, 24.4% of youth in 9th-12th grades smoked on one or more days in the past 30 days.
- The use of chewing tobacco, snuff, or dip was higher in Alabama compared to national estimates.
- In 2005, 14.1% of 9th-12th graders in Alabama reported current use of chewing tobacco, snuff, or dip compared to 8.0% nationwide.
- The use of chewing tobacco, snuff, or dip was nearly 2-fold greater for Alabama boys (25.9%) than boys nationwide (13.6%).
- Also, more Alabama youth (21.2%) reported smoking their first whole cigarette before age 13 than youth nationwide (16%).

Other Drugs

- The use of other illicit drugs in Alabama is comparable to national averages.
- The leading other drugs used (lifetime, past year, and past month) in Alabama were marijuana and non-medical use of prescription pain relievers.
- In 2006-2007, 11.25% of Alabama adults ages 18-25 years and 3.25% ages 26 years and older reported using marijuana in the past month. Similarly, 13.8% of adults ages 18-25 years and 4.23% of adults ages 26 years and older reported non-medical use of prescription pain relievers in the past year.
- In 2006-2007, 99,000 Alabama adults were estimated to abuse or be dependent on illicit drugs and 79,000 were estimated to have needed but did not receive treatment for illicit drug use.
- Overall, current marijuana use declined among youth in 9th-12th grades in Alabama between 1999 and 2005.
- More boys (14.0%) reported trying marijuana before age 13 than girls (4.5%).
- In 2006-2007, 8.93% of youth ages 12-17 years reported non-medical use of prescription pain relievers.
- In 2006-2007, 16,000 Alabama youth ages 12-17 were estimated to abuse or be dependent on illicit drugs and 14,000 were estimated to have needed but did not receive treatment for illicit drug use.

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
(Attachment 1)

ADMINISTRATIVE: SECTION 1
(Answers should be listed under the stated question)

A. PROGRAM CAPACITY: Discuss the composition and credentials of your prevention personnel, both full-time, part-time and contract staff. Please provide the following general information:

A1. Staff member's name, prevention experience, educational credentials and designation (APS, CPS, CPM) and position title within the organization.

A2. Describe the training needs of the staff.

A3. What are your specific technical assistance needs?

A4. What tools and/or equipment are needed to facilitate prevention services in the catchment area?

B. PROGRAM PLANNING:

B1: Do you have a prevention planning committee?

Yes No

B2. If there is a planning committee, how many times has the committee met?

B3. How have the members of the planning committee been involved in the planning?

B4. What areas of concern have been discussed and reviewed by the prevention planning committee?

B5. If applicable, please attach a list of prevention planning committee members at the end of the completed document.

B6. Does your community have a coalition and/or active Children's Policy Council with whom you meet and collaborate?

Yes No

B7. Does your agency receive a portion of the Safe and Drug Free Schools (SDFS) funding? If so, explain how it affects your plan for prevention services. If you do not receive SDFS funding how are you collaborating with the community partners receiving the funding?

B8. 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.

B9. Do any of the counties you serve receive Drug Free Communities funding? If so, who is the recipient of the DFC funding?

C. PROGRAM EVALUATION:

C1. Who is responsible for data collection and program documentation?

C2. Describe how the data will be used for program monitoring, program improvement and outcome assessment.

FIRST EDUCATION STRATEGY-SECTION 2
NAME OF LOCATION
SITE:_____
City:_____
County:_____

CURRICULUM GRADE LEVEL RACE TIME OF SERVICE
(See guidelines) (check all that apply) (check all that apply) (check all that apply)
Curriculum 1: 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Curriculum 2:
(if applicable) 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Curriculum 1:
(if applicable) 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races

Other During School After-School
Summer Weekends
School holidays

1. List the assessment tool(s) and/or data sources utilized to identify needs below: (Provide actual data on data sheet)

2. What risk factor(s) does your data indicate? (See resource guide)

3. How does the collected data support your prevention plan?

4. Identify the vulnerable characteristics of this population. (See resource guide)

5. List community partners and the services they are providing to the same target population to implement a layered approach.
6. Are the youth receiving educational programs involved in alternative activities to implement a comprehensive plan?
Yes No

7. Is the target population being served universal, selected or indicated? If selected or indicated explain why.

FIRST EDUCATION STRATEGY
SUPPORTING DATA

SECOND EDUCATION STRATEGY-SECTION 2
NAME OF LOCATION
SITE:_____
City:_____
County:_____

CURRICULUM GRADE LEVEL RACE TIME OF SERVICE
(See guidelines) (check all that apply) (check all that apply) (check all that apply)
Curriculum 1: 5th 6th 7th 8th
9th 10th 11th 12th

College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Curriculum 2:
(if applicable) 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Curriculum 1:
(if applicable) 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays

1. List the assessment tool(s) and/or data sources utilized to identify needs below: (Provide actual data on data sheet)

2. What risk factor(s) does your data indicate? (See resource guide)

3. How does the collected data support your prevention plan?

4. Identify the vulnerable characteristics of this population. (See resource guide)

5. List community partners and the services they are providing to the same target population to implement a layered approach.

6. Are the youth receiving educational programs involved in alternative activities to implement a comprehensive plan?

Yes No

7. Is the target population being served universal, selected or indicated? If selected or indicated explain why.

SECOND EDUCATION STRATEGY
SUPPORTING DATA

ALTERNATIVE ACTIVITIES-SECTION 3
NAME OF LOCATION
SITE:_____
City:_____
County:_____

ACTIVITIES GRADE LEVEL RACE TIME OF SERVICE
(See guidelines) (check all that apply) (check all that apply) (check all that apply)
Activities: 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Activities
(if applicable): 5th 6th 7th 8th
9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays
Activities
(if applicable): 5th 6th 7th 8th

9th 10th 11th 12th
College/University White Black
Hispanic/Latino
2 or more races
Other During School After-School
Summer Weekends
School holidays

1. List any additional data sources that support alternative activities that are not listed in section 2.

2. What risk factor(s) does your data indicate? (See resource guide)

3. In what domain(s) are you serving the target populations with Alternative Activities?

4. Identify the vulnerable characteristics of this population. (See resource guide)

5. List community partners and the services they are providing to the same target population to implement a layered approach.
6. What percentage of youth involved in the Alternative Activities are involved in the Education Strategy to implement a comprehensive approach?

7. Is the target population being served universal, selected or indicated? If selected or indicated explain why.

FIRST ENVIRONMENTAL PLAN-SECTION 4

Use the following format:

Environmental data sheet

Goal Statement:

Objective:

Activities:

-
-
-
-
-

* See guidelines for examples.

Goal #3: Providing specialized services for pregnant women and women with dependent children

An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish and/or maintain new programs or expand and/or maintain 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, to make available child care while the women are receiving services (See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013, the Substance Abuse Services Division (SASD) of the Alabama Department of Mental Health (DMH) intends to spend no less than $2,960,087.00, annually, to procure specialized treatment services for pregnant women and women with dependent children. Specialized services will include access to prenatal care and child care for the women receiving such treatment. The specified funding is greater than the amount expended by the State of Alabama in 1994, will to be utilized to establish and/or maintain new programs, or expand and/or maintain the capacity of existing programs, and meet all other requirements of the SAPTBG. To accomplish this goal, SASD intends to attain the following objectives:

Objective 1: The SASD will continue to contract with qualified substance abuse treatment agencies for the provision of specialized treatment programs for pregnant women and women with dependent children.

Activities:

A. During FY 2011-2013, the SASD Women's Services Coordinator will work in conjunction with the DMH contracts office to ensure that all contracts issued by DMH for the provision of specialized treatment services for pregnant women and women with dependent children incorporate, at a minimum, the following stipulations:

1. The Contractor and its Subcontractor(s) shall 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:

a. Primary medical care for women, including referral for prenatal care and, child care while the women are receiving such services;

b. Primary pediatric care, including immunizations, for their children;

c. Gender specific substance abuse treatment and other therapeutic interventions for women which will address issues of relationships, sexual and physical abuse, parenting, and child care while the women are receiving these services;

d. Therapeutic interventions for children in custody of women in treatment which may, among other things, address developmental needs, issues of sexual and physical abuse, and neglect; and

e. Sufficient case management and transportation to ensure that the women and children have access to services for which a need has been established.

2. The Contractor and its Subcontractor(s) shall 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.

3. The Contractor and its Subcontractor(s) shall agree that treatment services will be provided or arranged for both women and their dependent children, whenever appropriate.

4. The Contractor and its Subcontractor(s) shall agree to provide interim services for pregnant women awaiting admission to a substance abuse treatment program that include, at a minimum:

a. Counseling and education about HIV and tuberculosis, about the risks of needle sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to prevent HIV and tuberculosis transmission;

b. Counseling on the effects of alcohol and drug use on the fetus; and
c. Referral for prenatal care, if needed.
5. The Contractor and its Subcontractor(s) shall agree to comply with all standards and guidelines established and promulgated by the SASD/DMH in regard to the provision of care for pregnant women, women with dependent children, and the children of these two populations.
6. The Contractor and its Subcontractor(s) shall agree to adhere to all SASD/DMH capacity management requirements, including notifications to SASD when the program cannot accommodate the admission of a pregnant woman.
7. The Contractor and its Subcontractor(s) shall agree to conduct outreach activities and publicize the availability of services for pregnant women and women with dependent children in compliance with guidelines promulgated by SASD/DMH.
8. The Contractor and its Subcontractor(s) shall agree to fully participate in all SASD compliance monitoring activities, including but not limited to document requests, on-site visits, surveys, meetings, technical assistance, and training.

B. The Women's Services Coordinator will meet with the DMH Medical Director as needed, during FY 2011-2013, but no less than on a semi-annual basis, to review and assess the quality and appropriateness of SASD's policies, procedures, guidelines, and standards relative to the provision of care for pregnant women, women with dependent children, and the children of these two populations.

Objective 2: Specialized residential treatment programs for pregnant women and women with dependent children, currently available in SASD/DMH Substate Planning Regions 1 and 2 only, will be available in each of the four (4) DMH/SA Substate Regions, by September 30, 2013.

Activities:
A. From October 1, 2010 thru December 31, 2012, the Associate Commissioner of SASD will identify, secure, and obligate funding for expansion of specialized residential treatment programs for pregnant women and women with dependent children. Potential funding sources may include, but will not be limited to, state and local funding, federal and state grants, reallocation of existing SASD revenue, reassignment of unutilized contract dollars, and private funding opportunities. No later than June 30, 2011, the Associate Commissioner of the SASD will secure and obligate funding to support expansion of a specialized residential program for pregnant women and women with dependent children in at least one of Alabama's Substate Planning Regions currently without such services.
B. Requests for proposals for at least one (1) specialized residential programs services will be prepared by the SASD Women's Services Coordinator by June 30, 2011. This proposal will be inclusive of the SAPTBG requirements for pregnant women and women with dependent children and include requirements for the selected contractor to implement evidence-based practices, as well, as adhere to specified process, performance, and outcome standards.
C. As other funding is secured and obligated for expansion of residential women's programs by the SASD Associate Commissioner, requests for proposals for these programs will be prepared by the SASD Women's

Services Coordinator, from January 1, 2011 thru June 30, 2013. This proposal will be inclusive of the SAPTBG requirements for pregnant women and women with dependent children and include requirements for evidence-based practices, as well, as process, performance, and outcome standards.

D. Within sixty (60) days of receipt of proposals for the planned specialized residential treatment programs for pregnant women and women with dependent children, the SASD Women's Services Coordinator will work, in conjunction with the DMH Contracts Office, to provide for peer review of the proposals, to select the most appropriate proposal for implementation based upon the proposal review process, and to award the contract to the most qualified provider.

E. During the start-up and initial implementation period, technical assistance and training will be provided by SASD personnel, including the Women's Services Coordinator, Treatment Services Director, Training and Certification Director, Information Services Director, Prevention Services Director, and Epidemiologist, for each new specialized residential treatment program developed for pregnant women and women with dependent children. Training and technical assistance will include, but will not be limited to topics, as, SAPTBG requirements, SASD certification standards, National Outcome Measures, data reporting procedures and requirements, service billing and coding, and program implementation standards specified in the request for proposals..

Objective 3: As of September 30, 2013, an additional five hundred (500) women will be served, annually, in the SAPTBG funded specialized women's programs in comparison to the annual number served in FY 2010.

Activities:

A. From October 1, 2010 thru July 31, 2011, the SASD Women Services Coordinator and treatment services staff will conduct on-site visits of each SAPTBG funded specialized program for pregnant women and women with dependent children for review of admissions, discharge, continued stay, treatment, continuing care, and recovery support practices. The site-visits will function to identify program policies and procedures that impact operational efficiency, including the number of program admissions and discharges.

B. A report of site-visit findings and recommendations for operational efficiencies and process improvements in regard to "A" above will be developed and disseminated to each specialized women's services programs no later than September 30, 2011 under the guidance of the SASD Women's Services Coordinator.

C. Admissions to and discharges from the specialized women's programs will be monitored monthly by the SASD Women's Services Coordinator from January 1, 2012 thru September 30, 2013 to assess the impact of recommendations for program operational efficiencies and process improvements, and to identify technical assistance needs.

D. By January 1, 2012, the SASD Women's Services Task group will develop, publish, and begin implementation of new strategies for advertising and marketing service availability.

E. Between October 1, 2010 and September 30, 2013, the SASD's staff will increase participation in interagency collaborative efforts to support identification of women in need of treatment and to enhance service delivery for women with substance use disorders and their children. Such efforts shall include, but will not be limited to, development of Memorandums of Understanding, participation on commissions,

committee, and advisory groups, development of opportunities to share resources, development and dissemination of newsletters, manning exhibits at conference, etc.

Objective 4: By September 30, 2013, all programs providing specialized treatment services for pregnant women and women with dependent children will utilize evidence-based practices in the provision of care for the women and the children enrolled in these programs.

Activities:

A. During the period October 1, 2010 thru December 31, 2010, the SASD/DMH Women's Services Coordinator, working in conjunction with the SASD Women's Services Task Group, will assemble and review guidance documents that related to women's services and compare this information to baseline data obtained in a FY 2010 survey of SASD/DMH funded specialized programs for pregnant women and women with dependent children that assessed use of evidence-based practices.

B. By January 1, 2011, the SASD Women's Services Coordinator working in conjunction with the SASD/DMH Women's Services Task Group will identify specific training, technical assistance, and other strategies needed to support the organizational changes necessary for implementation of evidence-based practices by each of the specially funded specialized programs for pregnant women and women with dependent children.

C. A strategic plan for implementation of the identified technical assistance, training, and other strategies needed to support utilization of evidence-based practices for services provided for the women and the children receiving services in specialized programs will be developed and appropriately disseminated by the SASD/DMH Women's Services Coordinator, no later than July 1, 2011.

D. The evidence-based practices strategic plan will be implemented by October 1, 2012 and monitored by the SASD Women's Services Coordinator on a quarterly basis thru September 30, 2013.

Objective 5: Beginning October 1, 2012, a core set of gender responsive specialized services will be available for utilization by programs funded to provide specialized treatment services for pregnant women and women with dependent children, and for reimbursement through the SASD/DMH fee-for-service payment system.

Activities:

A. Under the guidance of the Director of Substance Abuse Community Programs, SASD will define, assign appropriate CPT/HCPC Codes and modifiers to distinguish services provided for special populations, and establish reimbursement rates for services appropriate for the delivery of specialized substance abuse treatment for pregnant women and women and their dependent children. Implementation of this activity will represent a significant expansion of the services currently available for reimbursement through the SASD fee for service payment system. The expanded services will be disseminated to all SASD contractors by January 1, 2011.

B. By March 31, 2011, the SASD Information Services Director will develop guidelines and initiate training

for the specialized women's programs to allow for enrollment of children, who receive services along with their mothers, in the Alabama Substance Abuse Information System (ASAIS). Enrollment of children as collaterals in the treatment process will provide a mechanism for SASD to monitor service delivery for this population.

C. By March 31, 2011, the SASD Information Services Director will develop a monthly report to monitor utilization of the expanded services array by providers under contract with SASD/DMH for the provision of specialized services for pregnant women and women with dependent children.

Activities planned for implementation by SASD/DMH in FY 2008 and the related annual compliance report is as follows:

Activity A: Identify $2,556,405 of the Block Grant for the provision of specific services to pregnant women and women with dependent children.

FY 2008 (Annual Report/Compliance):
In FY 2008, SASD expended $2,556,405.00 for the provision of specific services to pregnant women and women with dependent children as follows:

Program Name *Level of Care 2008 Funding
Alcohol and Drug Abuse Treatment Centers, Inc, d.b.a. Olivia's House RES/PREG/POST $763,931.00
Aletheia House, Inc. RES/PREG/POST $393,970.00
Bibb, Pickens, Tuscaloosa Mental Health Center, d.b.a. Insight Center IOP $121,184.00
Cahaba Mental Health Center IOP $151,027.00
East Alabama Mental Health Center IOP $137,116.00
Lighthouse Counseling Center IOP $134,948.00
Altapointe - Mobile Mental Health Center IOP $131,077.00
North Central Alabama Mental Health Center, d.b.a. Quest Recovery Center IOP $215,409.00
Southwest Alabama Mental Health Center IOP $95,332.00
Substance Abuse Council of Northwest Alabama, d.b.a Freedom
House RES/PREG/POST/IOP $99,756.00
Riverbend Mental Health Center subcontracting with Freedom House IOP $180,765.00
University of Alabama at Birmingham, d.b.a. UAB Drug Free IOP $131,890.00
*RES=RESIDENTIAL; PREG=PREGNANT; POST=POST PARTUM; IOP= INTENSIVE OUTPATIENT

Activity B: Identify the services that are to be purchased with the funding for special women's services.

FY 2008 (Annual Report/Compliance):
In FY 2008, the following services, as specified in the SASD Contract Billing Manual, were purchased for the provision of specialized treatment for pregnant women and women with dependent children.:

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. This is a 24-hour a day, seven days a week, full time living arrangement which offers child care, 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 an LPN or equivalent or higher credentialed individual, a peer group living arrangement emphasizing abstinence from alcohol /drugs, support group meetings, social and vocational rehabilitation. This is a 24-hour a day, seven days a week, full time living arrangement which offers child care, linkages with educational opportunities, job placement, and referral.

3. Intensive Outpatient Services – Specialized Women's Programs Only: Chemical dependency treatment services and intensive therapeutic activities provided for pregnant women and women with dependent children that are designed to initiate and promote a client's status as free of chemical abuse. The program must provide a standard psycho-social assessment, gender specific substance abuse education, gender specific substance abuse therapy, group, family, and individual therapy, 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 parenting, child care, and transportation as needed.

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

FY 2008 (Annual Report/Compliance):
In 2008, funding for specialized women's services was distinguished in the DMH accounting system by the assignment of an exclusive fund code, as follows: 0001-217-8061-1299-1108. Within this code "1299" specifies SAPTBG funding for specialized women's programs only. The last two digits of funding specifies the SAPTBG award year.

The following service codes were used in FY 2008 to specifically identify specialized women's services in the SASD management information system, ASAIS.

Service	Service Codes
Residential Treatment	5990/H2036 HD
Residential Rehabilitation	5330/H2034 HD
Intensive Outpatient	5410/HOO15
Ancillary Services	6000/T1009 HD

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

FY 2008 (Annual Report/Compliance):
In FY 2008, SASD/DMH developed and implemented contracts with the following agencies for the provision of specialized substance abuse treatment for pregnant women and women with dependent children:

Program Name	*Level of Care	2008 Funding
Alcohol and Drug Abuse Treatment Centers, Inc, d.b.a. Olivia's House	RES/PREG/POST	$763,931.00
Aletheia House, Inc.	RES/PREG/POST	$393,970.00

Bibb, Pickens, Tuscaloosa Mental Health Center, d.b.a. Insight Center IOP $121,184.00
Cahaba Mental Health Center IOP $151,027.00
East Alabama Mental Health Center IOP $137,116.00
Lighthouse Counseling Center IOP $134,948.00
Altapointe - Mobile Mental Health Center IOP $131,077.00
North Central Alabama Mental Health Center, d.b.a. Quest Recovery Center IOP $215,409.00
Southwest Alabama Mental Health Center IOP $95,332.00
Substance Abuse Council of Northwest Alabama, d.b.a Freedom
House RES/PREG/POST/IOP $99,756.00
Riverbend Mental Health Center for Freedom House IOP $180,765.00
University of Alabama at Birmingham, d.b.a. UAB Drug Free IOP $131,890.00
*RES=RESIDENTIAL; PREG=PREGNANT; POST=POST PARTUM; IOP= INTENSIVE OUTPATIENT

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

FY 2008 (Annual Report/Compliance):
In FY 2008, the “normal contracting and service reporting system” were generally disrupted by efforts to implement a new management information system. During this time, service provision was monitored primarily through on-site certification reviews which did not reveal any compliance issues for the special women’s programs that were reviewed in FY 2008: Quest Recovery Center , Southwest Alabama Mental Health Center, Lighthouse Counseling Center, and Freedom House.

In July 2008, SASD’s management information system, ASAIS, began live operations. This system was developed with functionality for monitoring service delivery and moved the SASD from an unsupported DOS-based information system to a Web-based system built on the most up-to-date technology platforms available. The July start-up, however, did not allow for the generation of significant monitoring data, but did illustrate the importance of timely data entry by the provider community in order to maximize the system’s monitoring functionality, and the need for additional technical assistance, in regard to such, for providers.

Also in FY 2008, SASD’s treatment services staff began to structure a monitoring process that would complement the monitoring done through program certification site visits and data that will be available through ASAIS. This effort resulted in draft monitoring guidelines and a draft monitoring tool on which work would continue in FY 2009.

Activity A: Treat more pregnant women and women with dependent children.

Progress:
During FY 2010, the SASD continued efforts to treat more pregnant women and women with dependent children than in prior years. The SASD SAPTBG Application for FY 2010 application indicated that two hundred fifty (250) pregnant women and women with dependent children would be treated in all of the programs across the state. As of September 22, 2010, three hundred seven (307) pregnant women, alone, had been admitted to treatment.

During FY 2010, SASD, also partnered with the Alabama Medicaid Agency to implement the Alabama Screening, Brief Intervention and Referral to Treatment Program (ASBIRT) for doctors participating in the Agency's Maternity Waiver Program. Still in its primary growth stages, ASBIRT's benefits are expected to be far reaching and promising for the future as a new mechanism to reach additional pregnant women who have substance use disorders.

Activity B: Expand the levels of care available.

Progress:
During FY 2010, efforts by the SASD staff continued relative to expansion of the levels of care available for pregnant women and women with dependent children. Service level expansion has proven to be a multi-faceted process that has required SASD personnel to:

1. Identify the American Society of Addiction Medicine's Patient Placement Criteria 2R (ASAM) levels of care to be utilized in Alabama's substance abuse service delivery system.
2. Disseminate information to internal personnel and the provider community about the American Society of Addiction Medicine's Patient Placement Criteria 2R.
3. Develop Alabama specific definitions for the ASAM levels of care to be implemented.
4. Develop an assessment and assessment process to guide admission to each ASAM levels of care.
5. Develop certification standards to support implementation of the levels of care and monitoring of the services provided within each level of care.
6. Develop and implement services, service descriptions, and billing codes to support implementation of the ASAM levels of care.
7. Develop and implement training for internal staff and providers relative to implementation of the ASAM levels of care.

In FY 2010 the SASD's efforts to implement new levels of care progressed, wherein, (1) draft certification standards were disseminated for unofficial provider review and comment; (2) service descriptions were established, relative funding codes identified, and the process of rate setting for these services was begun bolstered by technical assistance provided by the Center for Substance Abuse Treatment (CSAT); (3) an

assessment and assessment process was completed; and (4) development of provider training on the ASAM levels of care and the assessment process was finalized; and (5) provider training was initiated throughout the state of Alabama.

As the process of service level expansion continued, the SASD continued the provision of the following levels of care 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. This is a 24-hour a day, seven days a week, full time living arrangement which offers child care, 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 an LPN or equivalent or higher credentialed individual, a peer group living arrangement emphasizing abstinence from alcohol /drugs, support group meetings, social and vocational rehabilitation. This is a 24-hour a day, seven days a week, full time living arrangement which offers child care, linkages with educational opportunities, job placement, and referral.
3. Intensive Outpatient Services – Specialized Women's Programs Only: Chemical dependency treatment services and intensive therapeutic activities provided for pregnant women and women with dependent children that are designed to initiate and promote a client's status as free of chemical abuse. The program must provide a standard psycho-social assessment, gender specific substance abuse education, gender specific substance abuse therapy, group, family, and individual therapy, supportive counseling/education, and detoxification if needed.

These services were provided at the following locations:

Program Name *Level of Care FY 2010 Funding
Alcohol and Drug Abuse Treatment Centers, Inc, d.b.a. Olivia's House RES/PREG/POST $1,043,716.00
Aletheia House, Inc. RES/PREG/POST $421,201.00
Bibb, Pickens, Tuscaloosa Mental Health Center, d.b.a. Insight Center IOP $129,560.00
Cahaba Mental Health Center IOP $161,466.00
East Alabama Mental Health Center IOP $146,594.00
Lighthouse Counseling Center IOP $144,276.00
Altapointe - Mobile Mental Health Center IOP $140,137.00
North Central Alabama Mental Health Center, d.b.a. Quest Recovery Center IOP $230,298.00
Southwest Alabama Mental Health Center IOP $101,921.00
Substance Abuse Council of Northwest Alabama, d.b.a Freedom House RES/PREG/POST/IOP $299,911.00
University of Alabama at Birmingham, d.b.a. UAB Drug Free IOP $141,007.00

Alabama / SAPT FY2011 /

*RES=RESIDENTIAL; PREG=PREGNANT; POST=POST PARTUM; IOP= INTENSIVE OUTPATIENT $2,960,087.00

Activity C: Expend more than what was spent in FY 1994

Progress:
The SASD continued to expend more in FY 2010 to maintain the capacity of existing specialized treatment programs for pregnant women and women with dependent children than was expended by the state in 1994. A total of $2,960,087.00 was expended for the purpose stated in FY 2010. All funding agreements with special women's programs continued to require to adherence to all specifications within their contracts, within the SASD Contract Billing Manual, and the SASD Program Certification Standards.

In FY 2010, the following activities occurred to improve SASD's policies and procedures for monitoring provider compliance with SAPTBG and other contract requirements:

1. A monitoring toolkit was developed that included a policy on monitoring, an on-site monitoring survey, PowerPoint trainings on monitoring, capacity management notice form, a monitoring outcomes report, and templates for tracking and reporting waiting lists.
2. An implementation plan and timeline was developed to phase in the new process for monitoring.
3. An electronic survey was developed and piloted to assess the actual level of provider compliance with all SASD/DMH contractual requirements.
4. A pilot version of the new on-site monitoring process was started.

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(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 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

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 III.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 2008 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 2008 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?

1. In FY 2008, the SASD/DMH provided funding for eleven (11) programs for the provision of specialized substance abuse treatment services for pregnant women and women with dependent children. Each of these programs was contractually required to provide and provided the following services:

A. Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
B. Primary pediatric care, including immunization, for their children;
C. Gender specific substance abuse treatment and other therapeutic interventions for women which will address issues of relationships, sexual and physical abuse, and parenting, and child care while the women are receiving these services;
D. Therapeutic interventions for children in custody of women in treatment which may, among other things, address developmental needs, issues of sexual and physical abuse, and neglect; and
E. Sufficient case management and transportation to ensure that the women and children have access to services for which a need has been established.

Each of the eleven (11) programs is briefly described below:

A. Aletheia House, Inc. is located in Birmingham, Alabama in SASD/DMH Substate Region #2. In FY 2008, this program provided residential treatment services for pregnant women and women with dependent children. Onsite child care was provided. The program has the daily capacity to serve ten (10) women, along with their infant children.
B. Alcohol and Drug Abuse Treatment Centers, Inc. is located in Birmingham, Alabama in SASD/DMH Substate Region #2. In FY 2008, this agency provided specialized residential treatment services for pregnant women and women with dependent children at its all women's facility, Olivia's House. An onsite child care center was operated by the program. The program has the daily capacity to serve thirty (30) women, along with up three (3) children, aged 0-12, each for six to twelve months.
C. The Substance Abuse Council of Northwest Alabama is located in Rogersville, a rural area of north Alabama, in SASD Substate Planning Region #1. In FY 2008, this agency provided specialized residential treatment services for pregnant women and women and their dependent children at its facility, Freedom House. SAPTBG funded Specialized Intensive Outpatient treatment services were also provided at Freedom House through a subcontract agreement with Riverbend Mental Health Center. Freedom House has a residential capacity of thirteen (13), and an outpatient program capacity of fifty-five(55).
D. The Riverbend Mental Health Center is located in Florence, Alabama, which is in SASD Substate Planning Region #1. This agency, previously a direct provider of specialized services for women, in FY 2008 utilized those funds to purchase intensive outpatient services for pregnant women and women with dependent children from the Substance Abuse Council of Northwest Alabama at Freedom House in Rogersville.
E. The Bibb, Pickens, Tuscaloosa Mental Health Board is located in Tuscaloosa, Alabama which is in SASD Substate Planning Region #2. In FY 2008, the program provided intensive, gender specific outpatient

services for pregnant women and women with dependent children at its outpatient facility, the Insight Center. The program has the capacity for twenty (20) women.
F. The Cahaba Mental Health center is located in Selma, a rural area of Alabama located in SASD Substate Planning Region #3. In FY 2008, this program provided intensive, gender specific outpatient services for pregnant women and women with dependent children. The program has the capacity for twenty (20) women.
G. The East Alabama Mental Health Center is located in Opelika, Alabama which is in SASD Substate Planning Region #3. In FY 2008, this program provided intensive, gender specific outpatient services for pregnant women and women with dependent children. The program has the capacity for one hundred (100) women.
H. Altapointe, a program of the Greater Mobile Mental Health Board is located in Mobile, Alabama, which is in Substate Planning Region #4. In FY 2008, this program provided intensive, gender specific outpatient services for pregnant women and women with dependent children. The program has the capacity for seventy-five (75) women.
I. In FY 2008, the University of Alabama at Birmingham provided intensive, gender specific outpatient services for pregnant women and women with dependent children at its facility UAB Drug Free, also located in Birmingham and within SASD Substate Planning Region # 2. The program has the capacity for twenty (20) women.
J. The Lighthouse Counseling Center is located in Montgomery, Alabama , within SASD Substate Planning Region #2. In FY 2008, the agency provided intensive, gender specific outpatient services for pregnant women and women with dependent children. The program has the capacity for twenty (20) women.
K. The North Central Alabama Mental Health Board is located in Decatur, Alabama. In FY 2008, the agency provided intensive, gender specific outpatient services for pregnant women and women with dependent children at Quest Recovery Center, also located in Decatur and within SASD Substate Planning Region #1. The program has a static capacity of 15 women.
L. The Southwest Alabama Mental Health Center is located in Monroeville, a rural area of Alabama within SASD Substate Planning Region # 4. In FY 2008, the agency provided intensive, gender specific outpatient services for pregnant women and women with dependent children. The program has a static capacity of forty-five (45) women.

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 III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

RESPONSE:
Programs funded by SASD/DMH in FY 2008 to provide specialized treatment for pregnant women and

women with dependent children as follows:

I-SATS ID Program Name Location in Alabama Substate Planning Region Level of Care Capacity 2008 Funding
AL750405 Alcohol and Drug Abuse Treatment Centers, Inc, d.b.a. Olivia's House Birmingham 2 Residential 30 $763,931.00
AL300037 Aletheia House, Inc. Birmingham 2 Residential 10 $393,970.00
AL900091 Bibb, Pickens, Tuscaloosa Mental Health Center,d.b.a. Insight Center Tuscaloosa 2 IOP 20 $121,184.00
AL302108 Cahaba Mental Health Center Selma 3 IOP 30 $151,027.00
AL900612 East Alabama Mental Health Center Opelika 3 IOP 100 $137,116.00
AL301407 Lighthouse Counseling Center Montgomery 3 IOP 20 $134,948.00
AL901206 Altapointe - Mobile Mental Health Center Mobile 4 IOP 75 $131,077.00
AL900117 North Central Alabama Mental Health Center, d.b.a. Quest Recovery Center Decatur 1 IOP 15 $215,409.00
AL900513 Southwest Alabama Mental Health Center Monroeville 4 IOP 45 $95,332.00
AL100668 Substance Abuse Council of Northwest Alabama, d.b.a. Freedom House Rogersville 1 Residential 13 $99,756.00
AL900778 Riverbend Mental Health Center (Subcontracted to Freedom House) Florence 1 IOP 55 $180,765.00
AL100049 University of Alabama at Birmingham, d.b.a. UAB Drug Free Birmingham 2 IOP 20 $131,890.00

2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

RESPONSE:
The SASD/DMH entered into contracts with the agencies identified in the chart in Section "1" above for the provision of treatment services for pregnant women and women with dependent children. Contracts contained the following specifications requiring each agency to provide:

A. Primary medical care for women, including referral for prenatal care and, child care while the women are receiving such services;
B. Primary pediatric care, including immunization, for their children;
C. Gender specific substance abuse treatment and other therapeutic interventions for women which will address issues of relationships, sexual and physical abuse, parenting, and child care while the women are receiving these services;
D. Therapeutic interventions for children in custody of women in treatment which may, among other things, address developmental needs, issues of sexual and physical abuse, and neglect; and

E. Sufficient case management and transportation to ensure that the women and children have access to services for which a need has been established.

Agencies were also contractually required to:

A. Utilize the SASD/DMH management information system for submission of service encounter data for each woman served;
B. Submit to SASD an annual audit in accordance with DMH audit guidelines; and
C. Maintain service documentation in a form that would facilitate establishment of an audit trail for a minimum of three (3) fiscal years.

Funds spent in FY 2008 by SASD/DMH for specialized services for pregnant women and women with dependent children, $2,556,405.00, greatly exceeded the amount expended by the State of Alabama in 1994.

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?

RESPONSE:
In FY 2008, the primary methodology used by SASD/DMH to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children was the on-site certification review conducted under the supervision of the SASD Director of Certification and Training.

All programs funded by SASD/DMH are required by Alabama Act 881 to meet physical plant, safety, and clinical standards established by DMH and published in the Alabama Administrative Code. On-site visits, scheduled to assess compliance with these standards, are conducted annually for all Opioid Treatment Programs and programs demonstrating less than optimum performance during its last scheduled site-visit, and bi-annually for all other programs.

Four of the eleven (11) programs providing specialized services for pregnant women and women with dependent children, Quest Recovery Center in Decatur, Alabama, Southwest Alabama Mental Health Center, Lighthouse Counseling Center in Montgomery, and Freedom House in Rogersville, were provided on-site certification review in FY 2008. During each of the site-visits conducted in FY 2008, program descriptions were reviewed to ensure the inclusion of service elements defined in the contract, policies and procedures were reviewed to ensure operationalization of the program description, compliance with standards was assessed, and clients were interviewed to assess the extent to which the program was meeting the needs of the woman and her family and the degree of client satisfaction with the program.

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

RESPONSE:
In FY 2008, treatment capacity of the programs providing services for pregnant women and women with dependent children was determined by two data gathering processes, dependent upon the level of care provided. For agencies that provided intensive outpatient services, data estimating treatment capacity was based upon each program's self-report. SASD/DMH asked the programs to asses the number of staff assigned to the program, evaluate useable facility space, and determine the availability of other essential resources to determine the maximum number of active clients that could be accommodated at one time. For agencies that provided residential services, program capacity was formally established by the DMH's facility (physical plant) certification staff based upon regulations published in the Alabama Administrative Code.

5. What did the State do with FY 2008 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?

RESPONSE:
FY 2008, SASD/DMH did not establish or expand the capacity of any programs for pregnant women or women with dependent children. Block Grant and State funds were utilized to maintain the capacity of existing programs. Each of the programs under contract with SASD/DMH for the provision of special services for pregnant women and women with dependent children received a 4% cost of living rate adjustment in FY 2008.

Goal #4: Services to intravenous drug abusers

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013, the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) will 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. To accomplish this goal, SASD/DMH intends to attain the following objectives:

Objective 1: By September 30, 2013 establish documented improvements in SASD/DMH's service delivery system for intravenous drug users.

Activities:

A. By January 1, 2011, the SASD/DMH staff, under the guidance of the Treatment Services Director, will develop and disseminate to all treatment providers a clearly articulated operational definition of intravenous/injecting drug use.

B. Contract language of all SASD/DMH funded treatment providers will be modified by the Contract Services Coordinator to incorporate the established definition of intravenous/injecting drug, and to clearly delineate the responsibilities of all providers in regard to addressing the needs of individuals with intravenous/injecting drug use disorders, by June 30, 2011.

C. By July 1, 2011 under the guidance of the Director of Treatment Services, the SASD will develop and disseminate a guidance document in regard to clinical and administrative performance requirements of programs that provide services for services for intravenous drug users. This document will incorporate requirements and guidelines for implementation of the 90% capacity reporting and 14-120 day admission regulations.

D. Under the guidance of the Training and Certification Director, the SASD/DMH will provide required participation training for all of its contract treatment providers in regard to the content of the disseminated guidance document, during the period from August 1, 2011 through September 30, 2011.

E. Beginning October 1, 2010, the SASD will provide continuous access to online training reflective of the guidance document for treatment of intravenous/injecting drug use disorders. This activity will be under the supervision of the Director of Training and Certification and will be operationalized through the use of existing DMH resources for development of on-line training.

F. The SASD will establish at least one (1) formalized Outreach Program for intravenous/injecting drug users in each Substate Region and establish Interim Services at all treatment program serving intravenous/injecting drug users by September 30, 2012. The SASD Associate Commissioner will identify secure and obligate funding to support this activity. The Director of Substance Abuse Community Programs will develop standards for certification of these services and establish service descriptions and codes to

allow for proper billing and reimbursement.

G. On at least a bi-annual basis, all treatment programs will be monitored on-site to assess the quality and appropriateness of service delivery for intravenous/injecting drug users as well as compliance with administrative reporting requirements. The process will take place under the leadership and supervision of the Treatment Services Director, and will utilize the SASD prepared guidance document as the bench mark for performance, along with established SAPTBG monitoring guidelines.

Objective 2: By September 30, 2013, increase the availability of treatment services for intravenous drug users.

Activities:
A. The SASD, under the guidance of the Director of Substance Abuse Community Programs, will promulgate program certification standards that will prohibit SASD/DMH funded programs from denying admission to an individual solely on the basis of intravenous drug use or current maintenance on Methadone or other Opioid treatment medications by January 1, 2011.
B. The SASD will provide access to publicly funded medication assisted treatment and maintenance programs for Opioid addicted individuals in each of the SASD Substate Regions, by September 30, 2013. The SASD Associate Commissioner will secure and obligate funding for this purpose by September 30, 2012. Services will be acquired through development and issuance of a Request for Proposals under the guidance of the Director of Substance Abuse Community Programs.

Activities planned for implementation by SASD/DMH in FY 2008 and the related annual compliance report is as follows:

1. Activity:
The Treatment Access Project (T.A.P.), as described in Narrative #9 of this application, will be continued. Access to treatment through the T.A.P. is driven by the priorities set by the Block Grant. The major components of T.A.P. include capacity management and waiting list management.

FY 2008 Annual Report/Compliance:
The Treatment Access Project (T.A.P) was not utilized in FY 2008. Beginning in 2005, the SASD/DMH worked in conjunction with the Robert Wood Johnson Foundation to develop a state-of-the art management information that would automate capacity management and waiting list functions as required by the SAPTBG. This system, the Alabama Substance Abuse Information System (ASAIS), began live operations in July, 2008. Thus, FY 2008 was a year of transition in regard to capacity and waiting list management for the Substance Abuse Services Division of the Alabama Department of Mental Health. During this time SASD/DMH personnel and personnel of its contract agencies who would normally manage these functions were fully consumed with training for implementation of ASAIS, with development of electronic data transfer processes between ASAIS and provider systems, and with the migration of thousands of client profiles from the old management information system to the new. Compliance with capacity management and waiting list requirements was stipulated in all contracts executed for the provision of substance abuse treatment services.

2. Activity: Training will continue to be provided for service providers regarding T.A.P. and the Block Grant requirements.

FY 2008Annual Report/Compliance:
The Treatment Access Project (T.A.P) was not utilized in FY 2008. Training was provided for each provider agency throughout FY 2008 in regard to the functionality of the new management information system, which included guidance on data reporting for fulfillment of all SAPTBG reporting requirements, including capacity management and waiting list requirements for individuals who have intravenous/injecting drug use disorders. Training was provided on-site at provider facilities and throughout the state at various venues that enabled attendance by multiple agencies. In addition, a weekly conference call was conducted with provider agencies to address technical assistance issues relative to migration to ASAIS.

3. Activity: On-site technical assistance regarding T.A.P. will be made available to all service providers.

FY 2008Annual Report/Compliance:
As reported in item #2 above.

4. Activity: Contract activity will be monitored by "desk audits". To enter any substance abuse treatment program in Alabama the 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 follows: 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 2008Annual Report/Compliance:
All contracts in FY 2008 were developed and executed as planned. Compliance with contractual requirements was monitored, primarily during the program certification on-site review process, although contract monitoring is not a prescribed part of that process. Limited data analysis was available in regard to managing compliance with capacity and waiting list requirements due to migration to a new management information system. No providers reported to SASD/DMH in FY 2008 that 90% capacity had been reached. Although stipulated in provider contracts, no formal outreach programs for intravenous/injecting drug users were conducted in FY2008.

In FY 2010, all SASD/DMH contracts executed for the provision of treatment services continue to maintain the following stipulations: (1) the State is to be notified when any program serving individuals with an intravenous/injecting drug use disorder reaches 90% capacity, (2) the State is to be notified when an individual with an intravenous/injecting drug use disorder cannot be admitted to treatment within 14-120 days, (3) programs are required to conduct outreach activities for individuals with intravenous/injecting drug use disorders, (4) utilization of the ASAIS for service reporting.

In FY 2010, the following activities have occurred in fulfillment of SAPTBG requirements for monitoring capacity relative to services for individuals with intravenous/injecting drug use disorders.

1. A monitoring toolkit was developed to include a policy on monitoring, an on-site monitoring survey, PowerPoint trainings on monitoring, a capacity management notice form, monitoring report, and templates for wait list.
2. An implementation plan and timeline was developed to phase in the new process for monitoring.
3. An electronic survey was developed to assess the actual level of provider compliance with all SASD/DMH contractual requirements.
4. A pilot version of the new on-site monitoring process was started to identify needs for fine tuning the process for full implementation in FY 2011.

The on-site pilot monitoring process, initially being conducted by SASD treatment services staff, has provided valuable information on program compliance with capacity notification. During the pilot visits it was realized that the capacity management notice form, which was originally designed to gather capacity information for providers to submit to SASD, may need revisions. Of particular concern is a means for non-residential providers to first determine capacity so that an accurate notice can be made once capacity is at 90%. Therefore, SASD is in the process of determining the corrective action necessary to remedy this issue. Efforts are also currently underway to maximize use of ASAIS' functionality to minimize the need for paper transactions in the monitoring process.

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

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 2008; Annual Report/Compliance) 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 2008 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 IVDUs in need of treatment services?

RESPONSE:
In FY 2008, the SASD established the following operational definition of an IVDU in need of treatment: “Any person meeting the diagnostic criteria of substance abuse or dependence, a six month history of injecting drugs, and injecting drug use within the thirty (30) days prior to admission.” This definition of IVDU is incorporated in all contracts executed between DMH and substance abuse treatment programs.

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 2008 and include the program’s I-SATS ID number (See 45 C.F.R. §96.126(a)).

RESPONSE:
The following language is incorporated in all contracts executed between DMH and substance abuse treatment programs: “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.” Prior to July 2008, notification depended upon self-report of each provider by way of a telephone call, fax, or mail. No programs reported reaching 90 percent capacity during FY 2008.

In July 2008, SASD’s new management information began live operations that included functionality for capacity management, independent of a direct provider report. At the same time, the SASD Treatment Services Director began a process to develop monitoring procedures that would combine the functionality of ASAIS with on-site program reviews to insure timely notifications when programs reach 90% capacity.

2. 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)).

RESPONSE:
The following language is incorporated in all contracts executed between DMH and substance abuse treatment programs:

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:
A. Fourteen (14) days after making the request for admission to such a program; or
B. 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.

In FY 2008, this contractual agreement served as the source of compliance with this performance standard. In July 2008, SASD's new management information began live operations that included functionality for management of capacity, monitoring of admission of priority populations, and waiting list management independent of a direct provider report. At the same time, the SASD Treatment Services Director began a process to develop monitoring procedures that would combine the functionality of ASAIS with on-site program reviews to insure that IVDUs are admitted to treatment within the timeframes established by 42 U.S.C. §300x-23(a)(2)(A)(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. §126(e)).

RESPONSE:
The following language is incorporated in all contracts executed between DMH and substance abuse treatment programs: "The Contractor and its Subcontractor(s) will carry out outreach activities to encourage intravenous drug users to seek treatment." In FY 2008, this contractual agreement served as the source of compliance with this performance standard. Outreach activities have been reported, anecdotally, by SASD/DMH contract providers as being unnecessary due to a steady flow of individuals seeking admission. In early FY 2008, the Director of Substance Abuse Community Programs began development of new treatment standards to govern the operations of substance abuse treatment programs in Alabama, along with development of new service codes to be utilized for service reimbursement. These processes include standards for Outreach Services, along with service reimbursement codes for the same. Full development of the standards, service codes, and a contract monitoring process also under development in FY 2008 will ensure compliance with 42 U.S.C. §300x-23(b).

Program Compliance Monitoring (formerly Attachment D)

(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 2009) 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)).

1. Notification of Reaching Capacity 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));

Strategies Utilized:
In FY 2009, the following strategies were implemented by the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) for monitoring compliance with 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)):

Exhibit SA-3 (III) (A) of each contract issued by the SASD/DMH in 2009 for the procurement of substance abuse treatment services contained the following provisions:

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.

Section V of provider contracts contains provisions for “Reporting” and specifies the following:

The contractor will submit on a timely basis to DMH the program, service, fiscal, or statistical information that is necessary or required by the applicable Division or Bureau or Bureau responsible for the management of this Agreement and/or DMH contracts or grants.

In 2009, as in previous years, the SASD/DMH relied on providers to fulfill the contract required notification and requirements. No direct provider notifications were made to SASD/DMH in 2009 relative to reaching 90% capacity.

In July 2008, the Alabama Substance Abuse Information System (ASAIS) began live operations that generated capabilities for SASD/DMH to monitor compliance with contractual reporting requirements. Among its many other functions, ASAIS was designed to capture requests for admission, actual admissions, referrals, waiting list data, and SAPTBG reporting requirements . Full utilization of ASAIS allows SASD/DMH to monitor, on a daily basis, when each program reaches 90% capacity, without reliance on self-reports from providers. Section V (3) of the DMH FY 2009 contractual agreement specified the requirement for provider

utilization of ASAIS for reporting of all service related activity. In FY 2009, the routine submission of data to SASD/DMH through ASAIS was utilized to monitor compliance with the requirement for Notification of Reaching Capacity.

Problems Identified and Corrective Actions Taken:
The SASD/DMH Director of Information Services routinely analyzes data submitted to ASAIS in regard to capacity and wait list. Data analysis in 2009 revealed that, whereas, all providers did utilize ASAIS for reporting of admission data, other functions of the system were significantly underutilized. ASAIS functionality in regard to program referrals, transfers, wait list management, and discharges was not routinely used, which adversely impacted the ability of SASD/DMH to systematically monitor when each program reached capacity.

To address the problems created by less than optimum utilization of ASAIS, as well as address the problems inherent to self-reported activities, SASD began preparations to address program monitoring of providers for compliance with Notification of Reaching Capacity in a more intentional way. In FY 2009, under the guidance of the SASD Treatment Services Director, the treatment services staff continued work that had begun in FY 2008 on development of formal policies and procedures to guide the process of monitoring compliance with Notification of Reaching Capacity, as well as, compliance with all other SAPTBG monitoring requirements. Procedures from other states were studied and development of a draft electronic survey process to support an on-site monitoring process was initiated. This work has also identified a need to address the fact that a mechanism is not in place for providers to receive payment for the provision of interim services for IVDUs, especially when interim services are provided at a facility that is primarily residential. The development of corrective measures to address this problems was, also initiated in FY 2009.

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));

Strategies Utilized:
In FY 2009, the following strategies were implemented by the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) for monitoring compliance with 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)):

Exhibit SA-3 (I) (A) of each contract issued by the SASD/DMH in 2009 for the procurement of substance abuse treatment services contained the following provisions: “The contractor and its subcontractor(s) agree to have directly or through arrangements with other public or nonprofit private entities, infection control procedures to prevent the transmission on tuberculosis. These procedures must include: a screening process for identification of high risk individuals, referral for testing if indicated by the screening process, case management as indicated, and a reporting process to appropriate state agencies as required by law.” Further, the SASD/DMH Program Certification Standard 7105 required programs to 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.

In FY 2009, the SASD monitored compliance with SAPTBG requirements through its program certification process. Program site visits occur every one to two years and assess compliance with all SASD/DMH certification standards, including those relative to infectious diseases. Site visits in 2009 indicate that treatment providers have established collaborative relationships with local Departments of Public Health (DPH) and local healthcare clinics for the provision of TB services. Typically these linkages are substantiated in a memorandum of understanding between the provider agency and the DPH and/or healthcare clinic.

Problems Identified and Corrective Action Taken:
In FY 2009, no problems relative to compliance were identified and corrective action was not required through utilization of existing strategies for monitoring compliance with the provision of tuberculosis services. Yet enhancement of the monitoring processes utilized is an SASD priority. The SASD will continue to adhere to the requirements of the SAPTBG, federal regulations, and CDC recommendations related to tuberculosis protocols. Through site certification visits and monitoring, SASD will ensure provider compliance. Trends will be identified based on aggregate data from these visits and corrective action required as necessary. Additionally this data will influence collaboration efforts and training. SASD will continue to build relationships between providers, local health departments and the DPH to ensure that substance abuse clients receive tuberculosis services. SASD will continue to sponsor and support training and technical assistance that is inclusive of TB training. Formalized standards for the provision of tuberculosis services will be implemented and revised as necessary. A mechanism for providers to utilize ASAIS to report active cases identified through collaborative relationships with DPH and healthcare clinics will be developed. The SASD Treatment Services Director will assume primary responsibility for continued implementation of all activities planned for monitoring of compliance with requirements for the provision of tuberculosis services.

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)).

Strategies Utilized:
In FY 2009, the following strategies were implemented by the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) for monitoring compliance with 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)).:

Exhibit SA-3 (I) (B) of each contract issued by the SASD/DMH in 2009 for the procurement of substance abuse treatment services contained the following provisions:

Pregnant Women and Women with Dependent Children
A. The Contractor and its Subcontractor(s), exclusive of programs operating for males only, will give

preference to pregnant women and women with dependent children in admissions to substance abuse treatment.
B. 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.

In addition, SASD/DMH's FY 2009 contract Exhibit SA-4 (B) (1) (a) indicates that pregnant women should be given first priority consideration for admission treatment programs. Monitoring of provider compliance with these contract stipulations was limited to review of program admissions criteria and protocols during scheduled certification site visits. All programs reviewed were found to be in compliance with the requirements as specified in the contracts. In addition, no referrals were made to SASD/DMH by contract providers because of insufficient capacity to provide treatment services for a pregnant woman. In 2009, three hundred ninety four (394) pregnant women were provided treatment services by SASD/DMH providers.

Problems Identified and Corrective Actions Taken:
In FY 2009, provider agencies assumed responsibility for capacity management and referrals through utilization of those functions in the Alabama Substance Abuse Information System (ASAIS). Among its many other functions, ASAIS has specific functionality to meet all SAPTBG reporting requirements and provisions to allow DMH to monitor provider compliance with capacity management requirements, without reliance on self-reports. However, each provider agency is responsible for maintaining their waiting list in ASAIS and assuring priority admission for pregnant women.

The SASD/DMH Director of Information Services routinely analyzes data submitted to ASAIS in regard to capacity management and utilization of the waiting list functions of ASAIS. Data analysis in 2009 revealed that ASAIS functionality in regard to program referrals, transfers, waiting list management, and discharges was not routinely used, which adversely impacted the ability of SASD to systematically monitor each program's compliance with the requirement to provide priority admission for pregnant women.

To address the problems created by underutilization of ASAIS functionality relative to capacity management, SASD began preparations to enhance its ability to monitor provider compliance with SAPTBG requirements for Treatment Services for Women. In FY 2009, under the guidance of the SASD Treatment Services Director, the treatment services staff began development of formal policies and procedures to guide the process of monitoring compliance with Treatment Services for Women, as well as, compliance with all other SAPTBG monitoring requirements. Procedures from other states were studied and a draft survey to support an on-site monitoring process was developed.

Goal #5: TB Services

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring: Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

In FY 2011-2013, the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) will, through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving substance abuse treatment, and monitor the process of service delivery. SASD/DMH intends to attain this goal through accomplishment of the following objectives:

Objective 1: By September 30, 2013, establish documented improvements in the delivery of tuberculosis services in SASD/DMH funded treatment programs.

Activities:

A. By December 1, 2010, the Director of Substance Abuse Community Programs will establish baseline data for all SASD/DMH funded treatment programs in regard to the provision of tuberculosis services. Baseline data will be obtained through the provision of an online survey piloted in FY 2010 that will assess compliance with DMH contract requirements for the provision of tuberculosis services.

B. The SASD/DMH will require the submission of quarterly reports of all tuberculosis services provided to clients enrolled in treatment programs and/or receiving interim services. This report will be developed, authorized, and disseminated by the Director of Treatment Services by January 1, 2011.

C. Through routine annual monitoring procedures established during FY 2010, each SASD/DMH contract treatment provider will participate in a formal review process to assess compliance with contract specified requirements for the provision of tuberculosis services.

D. In October 2011, SASD/DMH contract providers will be required to comply with new program certification regulations that will require adherence to more stringent standards in regard to infection control, including control of tuberculosis, as follows:

The entity shall develop, maintain, and document compliance with a written plan for exposure control relative to infectious diseases that shall, at a minimum, include the following requirements:

1. The plan shall be inclusive of the entity's staff, clients, and volunteers.

2. The plan shall be consistent with protocols and guidelines established for infection control in healthcare settings by the Federal Center for Disease Control, and shall at a minimum include:

Policies and procedures to mitigate the potential for transmission and spread of infectious diseases within the agency.
Risk assessment and screening of clients reporting high risk behavior and symptoms of communicable disease.
Procedures to be followed for clients known to have an infectious disease.
Provisions to offer and provide to all clients who voluntarily accept the offer for HIV/AIDS early intervention services to include, HIV pre-test and post-test counseling and case management and referral services, as needed, for medical care.
The provisions of HIV/AIDS, Hepatitis, STDs, and TB education for all program admissions.
TB testing for all program admissions whose risk assessment and screening indicates a need for such.
Annual TB testing for all employees and volunteers.
Annual employee education in regard to universal precautions and communicable diseases.
The entity shall document compliance with all laws and regulations regarding reporting of communicable diseases to the Alabama Department of Public Health.

Program monitoring of compliance with these standards will be conducted during each program's scheduled certification site visit scheduled to occur every one to two years.

E. On an annual basis, beginning October 1, 2011, using results of performance monitoring reviews, required data submission reports, and program certification findings, provider compliance improvements and deficiencies will be measured against baseline performance data by the SASD Treatment Services Director. Under the guidance of the Director of Certification and Training, technical assistance and training will be provided to assist programs in meeting compliance standards.

Objective 2: SASD/DMH will collaborate with the Alabama Department of Health (DPH) and the DMH Medical Director to insure development and implementation of efficient and effective policies and procedures for the provision of tuberculosis services in substance abuse treatment programs.

Activities:

A. By January 1, 2011, the Director of Substance Abuse Community Programs will establish a formal collaborative process with the DPH Health Officer responsible for tuberculosis services for the following purposes: (1) annual review of SASD/DMH policies, procedures, practice guidelines, and provider and client educational material regarding tuberculosis services, (2) assistance in the development of training protocols, (3) facilitation of information transfer in regard to alerts, updates, or other information from the Center for Disease Control specific to tuberculosis, and (4) facilitating service coordination between community-based treatment programs and their local departments of public health.

B. Meet with the DPH officer responsible for tuberculosis services no less than on an annual basis thru September 30, 2013 to ensure continued collaboration as described in section “A” above.

C. Meet with the DMH Medical Director no less than on a semi-annual basis to provide service updates and address internal questions, concerns, and other issues pertinent to the ongoing provision of tuberculosis services in a manner appropriate for the agency’s clientele.

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 #5)

#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.

During the 2008 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
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.

In FY2010 SASD/DMH continues to include Exhibit SA-3 as a part of its contractual agreements with providers which stipulates the following:

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.

Compliance with these contract requirements have been evidenced through site certification standard visits that occur every one to two years. An additional process has also been implemented by the SASD/DMH in 2010 to monitor compliance with SAPTBG requirements for the provision of tuberculosis services.

A newly piloted monitoring process ensures that programs are in compliance with the tuberculosis services requirements (see attachment titled: SAPTBG Monitoring Survey, p.5, Goal #5-Attachment #1).Initial visits conducted have enabled SASD staff to verify compliance with requirements for tuberculosis services. On-site visits have provided direct access to referral sources, memorandums of understandings, and memorandums of agreements. As part of the survey tool developed for program monitoring, all contracted agencies must provide the actual number of clients that they have screened, tested, referred for testing, or referred for TB specific treatments.

In FY 2010, the SASD has continued efforts to develop new program certification standards which seek to enhance the requirements for tuberculosis services (see attachment titled: SASD Proposed Standards, p.82-83; 27; 70, Goal #5-Attachment #2). Lastly, a new standardized placement assessment for providers has been developed by the SASD treatment services staff that is based on the ASAM PPC-2R. SASD/DMH

will require universal use of this assessment by all certified treatment providers that includes, within the Dimension 2 information, a TB checklist (see attachment titled: SASD Adult Integrated Placement Assessment, p.2, Goal #5-Attachment #3).

Goal #6: HIV Services

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).

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Alabama is not a HIV designated state for the 2011 SAPT BG expenditure period since the 2008 AIDS rate is 8.7 per 100,000 population. Therefore, Alabama is not required to spend any of the 2011 SAPT BG award for HIV Early Intervention Services. However, Alabama decided to use State funding to continue HIV early Intervention Services at the same level with the same providers at least for SFY 2010-2011. Continuing to utilize State funding for HIV Early Intervention services will be evaluated.

During SFY 2010-2011 Alabama will utilize the same providers, funding levels and monitoring process as described in the FY 2008 compliance and FY 2010 progress sections.

Alabama was a HIV designated State for 2008 with an AIDS rate of 11.2 per 100,000 population. The service provision and expenditure requirements of a designated State were met during the 2008 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 and Attachment #3).

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 2008 SAPT BG.

CATCHMENT AREAS RANKED
BY
AID'S RATES PER 100,000 POPULATION
2005
(applicable to the 2008 SAPT BG)

Rank	Catchment Area*	Counties	AID's Rate**
1	14	Autauga, Lowndes, Elmore, Montgomery	25.16
2	16	Washington, Mobile	17.07
3	5	Jefferson, Blount, St. Clair	16.49
4	15	Macon, Bullock, Pike	15.84
5	19	Barbour, Henry, Dale, Houston, Geneva	11.64
6	12	Tallapoosa, Chambers, Lee, Russell	9.52
7	13	Perry, Dallas, Wilcox	8.82
8	7	Calhoun, Cleburne	8.62

9 2 Limestone, Lawrence, Morgan 8.11
10 3 Madison 7.89

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

** 2005 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 2008 SAPT BG expenditure period the SASD provided HIV Early Intervention Services through contracts with the following programs.

Catchment Area	Program	2008 Expenditures
15	East Central MHC	$ 4,624
14	CAP	121,082
14	Lighthouse Counseling	89,752
5	Alcohol and Drug Treat.	373,329
5	UAB	208,120
16	Mobile MHC	205,706
3	Huntsville Madison MHC	14,053
13	Cahaba MHC	106,912
9	Cheaha MHC	64,809
	Total	$1,188,387

During the 2008 SAPT BG expenditure period the SASD monitored compliance for HIV Early Intervention Services through the billing and reporting systems (SUDS and ASAIS), 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 2008 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
Cahaba MHC	Dallas	3
Cheaha MHC	Talladega	2
CAP	Montgomery	2
East Central MHC	Pike	3
Huntsville Madison MHC	Madison	1
Lighthouse Counseling	Montgomery	3
Mobile MHC	Mobile	4

Alabama was not a HIV designated State for the 2010 SAPT BG since Alabama's 2007 AIDS rate of 8.5 per 100,000 population. However, the following HIV Early Intervention Services are reported because they were funded with 2009 SAPT BG and provided 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 and Attachment #3).

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 2010 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	2009-2010 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 SFY 2009-2010 the SASD monitored compliance for HIV Early Intervention Services through the billing and reporting system the Alabama Substance Information System (ASAIS). 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 SFY 2009-2010, the following on-site review was conducted and all non-compliant areas were corrected, therefore, certification was continued.

Program	County	Region
Alcohol and Drug Treatment	Jefferson	2

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) 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 2008 Uniform Application, Section III.4, FY 2008 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
FFY 2009 $2,147,343 x .06 $128,840 + $162,177 = $291,017
FFY 2010 $2016,201 x .06 $120,972 + $206,033 = $327,005

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.

The Alabama Public Health Department, Director of the HIV/AIDS Division, confirms that no State funds are used to support HIV Early Intervention Services through Public Health.

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
FFY 2009	0	$1,188,837.00
FFY 2010	0	$1.035,034.00*

* Estimated at time of document preparation.

Goal #7: Development of Group Homes

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.

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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.

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

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

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 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.

FY 2011 – FY 2013 (Intended Use/Plan):

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.

FY 2008 (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 2010 (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.

Goal #8: Tobacco Products

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 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)

• If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

The State's FY 2011 Annual Synar Report was submitted September 29, 2010.

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 2008 (Compliance):

Result: Accomplished.

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 2010 Block Grant Application. Accomplished.

FFY 2010 (Progress):

Result: Accomplished.

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 2011 Block Grant Application. Accomplished.

FFY 2011 (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.

Goal #9: Pregnant Women Preferences

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Pregnant women are identified at the time of screening and tagged as a priority population within the Alabama Substance Abuse Information System (ASAIS). Screenings are required to bill for an assessment and begin the treatment episode. We plan to initiate a trigger within ASAIS to notify central office staff when a pregnant woman is screened, to allow for individual tracking and that requirements for timely service are met.

Provider contracts continue to contain the following language, applying to all providers,

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.

Additionally, this language is in all provider contracts, and applies to any program receiving Special Women's funds,

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.

Contract compliance is a priority for SASD in its dealings with contract providers, and regular monitoring of all programs is essential to ensuring services are provided in accordance with the expectations of this language. Reports are generated in ASAIS that identify pregnant women and the length of time between stages of their entry into treatment and service (screening-assessment, assessment-service, length and type of treatment services).

The statewide waiting list, accessible to any ASAIS user (including all contract providers), has a clear identification for priority population and providers are instructed to treat priority populations according to the regulations and contract language identified. The waiting list system within ASAIS also allows for simple referral amongst providers, with connection to the applicable information for care coordination. This ability to see and refer clients to waiting lists at any contract provider applies across all levels of care and will include new levels of care as they are added.

Regular training is offered on the operation of the capacity management/waiting list system. In addition, all training on contract compliance includes discussion of priority populations and their proper treatment.

Alabama / SAPT FY2011 /

The Alabama Substance Abuse Information System (ASAIS) was implemented during FY2008. We were able to begin tracking pregnant women from the time of screening through the assessment and into service. Any service recipient's priority population is visible in our facility management component of ASAIS, which shows all recipients who are enrolled, as well as those who are waiting for service or have been referred for service. The implementation of ASAIS also gave all contract providers visibility to the current status of clients who are waiting for services across the state and an easy-to-use mechanism to refer clients to other providers based on the information available.

During FY2010, the SASD has continued to work to educate providers about the necessity of including priority population information in submitted screenings, as well as the need to meet contract and block grant requirements in the timeliness of serving pregnant women and other priority populations. The contract language above is included in this year's contract and the SASD has worked on and piloted a new contract monitoring process that includes substantial focus on services for pregnant women and their prioritization within the system of care.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) 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.

Provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women. 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 the 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.

In July 2008, Alabama implemented the Alabama Substance Abuse Information System (ASAIS). A key component of that system was an integrated capacity management and waiting list system. Each provider agency has "facilities" created in the system that are specific to a level of care and location. Each of these facilities has a capacity, determined in coordination with the provider. Each facility also has its own waiting list segment in the statewide system.

Policies have been implemented that spell out the necessary timelines to enable the capacity management system to function at the level of its design. These policies include entry of screenings (the means to get a client into the database) within 24 hours and entry of assessment information and referral for services within 48 hours.

ASAIS offers a means for funded providers to refer clients to many different providers who offer the indicated level of care with a single click. The records that are created in our database through this process instanteously allow the receiving provider to see the client who is in need of service and begin to work to determine their ability to serve that client. The receiving provider can then change the disposition of that record to reflect the client being added to the facility waiting list, or enroll the client for immediate service. If the client is enrolled by any of the providers who received a referral, the other records for other providers are automatically closed by the system. This allows for streamlined management of the system.

Receiving providers (as well as state level staff) have real-time visibility of the age, sex, residence county and priority population of clients who are referred or are waiting for services in

a particular facility. Referring providers can see the number of people waiting for services at every facility in the state at any time.

The SSA generates weekly reports on the priority populations who are referred or waiting for services to determine if additional intervention is needed to ensure that a client in a priority population successfully enters treatment in the timelines prescribed. We are also working toward implementing “flags” in the system that will automatically notify selected users when a member of a priority population has waited too long for service.

The SSA also has visibility to the provision of interim services. The ASAIS system is also the claims processing system for the SSA and when a client is identified, a search of activity/claims records can be performed to quickly determine if interim services are being provided, either by the provider who conducted the assessment, or by another provider in our network.

Utilization of the capacity management system is a constant struggle, as providers have had to integrate the new reporting requirements into their business processes. We have provided technical assistance to approximately half of our providers, assisting them in making the transition for their particular agency. The SSA has not mandated a particular way of meeting the requirements, but instead encouraged a variety of means to get to our goal of timely entry and management of client information.

The SSA invested hundreds of thousands of dollars in the development of the Wait List component of the ASAIS system, but have not expended any additional funds to assist with the implementation. We continue to discuss and review the possibility of incentives to providers for timely reporting of this information.

Goal #10: Process for Referring

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)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-FY 2013 (Intended Use/Plan):

In FY 2011-2013, the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) has developed a plan to greatly enhance the referral process in the State to ensure individuals get referred to the treatment modality that is most appropriate for that individual and to the closest location of available services. It is the goal of the State to build and maintain a system of care that provides a comprehensive array of quality services and supports which will be available Statewide, allowing individuals to receive care based on their needs and choices.

The SASD/DMH intends to attain goal number ten (10) through accomplishment of the following objectives and activities:

Objective 1: By September 30, 2013, there will be established documented improvements in the State for referring individuals to the most appropriate treatment modality for individuals who seek treatment services.

Activities:
A. Refresher training will be developed and implemented on ASAM PPC-2R, Standardized Screening and Assessment, Levels of Care, Provider Monitoring, and utilization of the Alabama Substance Abuse Information System (ASAIS) to support these initiatives. Provider training will be an ongoing activity in order to encompass prospective new providers and staff.

B. Training will be facilitated through participation in local, regional, and State conferences. Specifically training will be provided at the annual Alabama School of Alcohol and Other Drug Studies, the annual Alabama Community Mental Health Board Conference, annual Alabama Gulf Coast Conference, the annual Alabama Drug and Alcohol Association Conference, and the annual Alabama Methadone Treatment Association Conference, as well as The Southern Coast ATTC providing training and resources throughout the year. Technical assistance will be provided upon request, in addition to being based on identified need through program monitoring visits and program certification visits.

C. As available, technology will be utilized to enhance training/TA. More specifically, webinars, teleconferences, video streams, and storage of training to the SASD website.

Objective 2: Implementation of ASAM Patient Placement Criteria in the year 2011.

Activities:
A. All contract and certified providers will be required to utilize ASAM PPC for assessing, placement, transfer, continuing care, and referral of individuals requiring treatment services.

B. All providers will utilize the State comprehensive Placement Assessment as a mechanism to ensure individuals get referred to the appropriate level of care.

C. The comprehensive Placement Assessment will be update as needed to reflect the most essential information is being captured to ensure individuals continue to get referred to the appropriate level of care.

D. Special attention in assessments for trauma, specific to post-traumatic stress disorder for veterans and for survivors of sexual assault will be noted.

Objective 3: Program monitoring /inspections will be fully implemented in 2011 utilizing the established guidelines that were piloted during FY 2010.

Activities:
A. Each SASD/DMH certified contract treatment provider will participate in a formal review process to assess compliance with Federal SAPT Block Grant requirements and State contractual requirements.

B. Training will be provided at the Alabama School of Alcohol and Other Drug Studies in March of 2011 entitled Monitoring 101. The training material will also be made available on the SASD website.

C. For certified providers who receive Block Grant dollars a standardized checklist form will be used in the monitoring review process to denote compliance or non-compliance with Federal and State requirements. Providers receiving a non-compliance on any requirement will be required to submit a corrective plan of action.

FY 2008 (Annual Report/Compliance):

Services and activities described in the Intended Use Plan were provided. The ground work was started in the development of an assessment tool based on the ASAM PPC-2R and in the year 07 Gerald Shulman was retained as a consultant to provide direction for this project. In July of 2008 Dr. David Mee-Lee provided SASD staff and 20 identified trainers with two days of training on ASAM PPC-2R which included extensive work on the levels of care and readiness to change.

In February of 2009 Dr. Mee-Lee returned to Alabama for a two day learning session with SASD staff and in September of 2009 perspective trainers were exposed to a two day train-back with SASD staff regarding the use of ASAM and the use of the adopted comprehensive placement assessment.

FY 2010 (Progress):

Activity A: The SASD will utilize a screening, assessment and placement process that supports the adopted ASAM levels of care.

Progress:
The SASD has developed a comprehensive screening and placement assessment instrument designed to place each individual that presents for treatment in the appropriate level of care.

Activity B: The SASD will provide training regarding the screening, assessment and placement process.

Progress:
In October of 2009 the SASD conducted two days of Placement Assessment training based on ASAM criteria with the clinical directors of certified providers across the State. Between November 2009 and January 2010 regional Screening and Placement Assessment training was conducted with all direct care staff from the certified treatment providers across the State relative to implementation of ASAM levels of care.

Activity C: The SASD will modify the screening, assessment and placement process as needed to assure appropriate and timely placement of individuals.

Process:
Upon completion of the screening and placement assessment training the SASD staff reviewed provider comments and made updated changes to the placement assessment. The placement assessment will be periodically reviewed to ensure the necessary information is being collected that results in the individual being placed in the appropriate level of care.

Activity D: The SASD will monitor the effectiveness of the screening, assessment and placement process through on-site monitoring visits.

Process:
Since July of 2010, the SASD has been conducting pilot visits with providers to ensure the effectiveness and accuracy of the screening and placement assessment..

Progress:

The TAP was replaced by the updated referral criteria which is an integral component of the Alabama Substance Abuse Information System (ASAIS).

Goal #11: Continuing Education

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)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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 (certified 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.

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”, “Case Management”, “Best Practices Approaches”, and “Client Center Treatment Planning”, etc. Dates to be determined.

Activity: The Substance Abuse Services Division will partner with the Southern Coast ATTC to have the “ASAM Screening, Placement and Beyond Part 2” training professional recorded. It will be made available on the department website for provider’s continuous training needs.

Activity: The Substance Abuse Services Division will partner with the Southern Coast ATTC to aid in the development of a curriculum on Individual Treatment Planning using ASAM and Readiness to Change.

Activity: The Substance Abuse Services Division will continue to offer support and expertise in the Gulf Oil Spill crisis. The Deep Water Horizon Well oil spill has dominated state and national news since April, 2010. The coastal counties, Mobile and Baldwin, have been dealing with the effects of the oil spill since. The Department’s Director of the Office of Policy and Planning and Director of Certification and Training for the Substance Services Division has worked with the mental health centers and substance abuse providers to identify the breadth of the problem and needed interventions.

Activity: The Substance Abuse Services Division will be implementing new standards of care in the next

fiscal year. Trainings will be conducted to help providers better understand the standards.

Activity: The Substance Abuse Services Division will be continue to partner with the Director of the Nurse Delegation Program to provide continuous training regarding the MAS Nurse responsibilities and duties related to the Nurse Delegation Program.

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 (certified 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's 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.) Identifying 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 Services 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 Substance Abuse Services Division Workforce Committee has been formed with members from the certifying boards, 2 and 4 year 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 that was held in Tuscaloosa AL in March. Continuing education units were offered.

Treatment courses offered: 1.) 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. 2.) MANAGING ADDICTIONS – Participants learned how to create effective, separate and distinct, evidence-based treatment plans for separate/distinct clients and client groups. 3.) ACCIDENTAL ADDICTION: A LOOK AT PAIN PILL

ADDICTION AND SUBOXONE THERAPY – Participants developed an understanding of pain pill dependence, withdrawals, induction and dosing of Suboxone. 4.) THE ART AND SCIENCE OF INTERVENTIONS – Participants identified the three phases of the demonstrated recovery process and described the various roles of the referent, interventionist, treatment center and monitor. 5.) EVIDENCE-BASED PRACTICE: A PRIMER FOR ADDICTION TREATMENT PRACTITIONERS – This workshop provided a foundation of knowledge and skills essential for understanding and using EBPs. 6.) SMART RECOVERY "INSIDEOUT" CORRECTIONAL FACILITY TRAINING PROGRAM – Participants became familiar with aspects of the SMART Recovery 4-Point Program addressed in the InsideOut program including: a. Building motivation to abstain from addictive behavior; b. Coping with urges; c. Learning rational ways to manage one's thoughts, feelings and behaviors; and d. Balancing short-term and long-term pleasures and satisfactions in life (reduced recidivism).
7.) A COMPREHENSIVE LOOK AT METHAMPHETAMINE AND ALCOHOL ADDICTION & PREVENTION – Participants learned how easily alcohol and "Meth" can be obtained by youth in Alabama.
8.) DRUG TESTING – HOW TO TURN YOUR DRUG TESTING PROGRAM INTO A FUNDING SOURCE FOR YOUR PROGRAM –This course discussed the major goals of establishing a drug testing program; promote accurate and reliable drug testing and established a method for programs to turn their drug testing into a profit center for their organization. 9.) ETHICS FOR ADDICTION PROFESSIONALS – Participants understood the difference between ethics and personal values. They also understood the ethical relationship between supervisor and supervisee. 10.) MAPPING OUT PRIORITIES: STRESS AND TIME MANAGEMENT – Participants developed professional and personal skills to deal with multiple priorities and learned to reduce stress. 11.) WELLNESS FOR THE ADDICTION PROFESSIONAL – This course discussed the importance of maintaining balance in our professional and personal lives. 12.) CLINICAL SUPERVISION – This course introduced the prospective Clinical Supervisor to an overview of critical information needed to successfully complete and pass the IRC Clinical Supervisor Exam as well as provided a forum for discussing the business of supervision. 13.) FROM DISCOVERY TO RECOVERY: NEUROSCIENCE, SPIRITUALITY AND 12 STEP FACILITATED RECOVERY - This course gave clinicians an understanding of the neuroscience and neuropsychology of addiction and recovery. 14.) THE JUVENILE SEXUAL OFFENDER - This course provided an overview of juvenile sexual offending and an introduction to the treatment and case management of the juvenile sexual offender. 15.) AN ADVANCED PRIMER ON ADDICTION PHARMACY: WHAT BEHAVIORAL HEALTHCARE PRACTITIONERS NEED TO KNOW – Participants understood the neurobiology and pharmacology of the current psychotropic medications used in the co-occurring treatment industry. 16.) AN OVERVIEW OF THE SEXUAL OFFENDER TREATMENT FOR NON-CLINICAL AUDIENCE – This course described core elements of sex-offender specific treatment and how it differs from traditional mental health approaches; provided evidence on effectiveness of sex offender treatment and current state of treatment practices; and described what to look for in a treatment provider.
17.) PTSD: PREGNANT WOMEN WITH SUBSTANCE ABUSE/ALCOHOL ISSUES – This course provided participants with methods and materials for making learning more efficient, effective and more productive.
18). AN OVERVIEW OF THE CURRENT SUBSTANCE ABUSE STANDARDS 2008 – This two-day course was designed to provide an up-to-date overview of current Department of Mental Health/SA Division

Certification Standards. 19.) THE TROUBLED EMPLOYEE – This course focused on the many ways employees can be troubled in their own mind and spirit and/or body. They also learned how this population could affect the workplace and the co-workers in all facets of business. 20.) MOTIVATIONAL INTERVIEWING AND TREATMENT PLANNING – This workshop shifted the focus to create plans that reflect the client's autonomy in the spirit of collaboration. 21.) TRENDS AND ISSUES IN MEDICATION ASSISTED TREATMENT – This course investigated three models of intervention for persons addicted to mind/mood altering substances with special emphasis on the opiate addict. 22.) LEARNING THE 12 CORE FUNCTIONS OF COUNSELING – Students had the opportunity to observe local professionals utilize the skills discussed (attending, paraphrasing, reflection of feelings, summarizing, probing and interpreting) in a recently revised video that assisted them in their understanding of how these skills are used. 23.) THE HIJACKING OF THE ADOLESCENT BRAIN – The presentation provided taught the body of knowledge from recent research relevant to the neurobiology of ADD/ADHD, anxiety disorders, depressive disorders, substance abuse and dependence. 24.) LEARNING THE ART OF GROUP THERAPY – Participants described, selected and appropriately used strategies from accepted and culturally appropriate models for group counseling with clients with substance use disorders. 25.) JOINING FAMILIES IN RECOVERY FOR ADDICTION – This course first, described the impact of family systems and addiction, second, provided the necessary skills for family counseling interventions in addiction treatment, and finally, provided didactic exercises to practice and connected to the "language" of client family systems in addiction treatment.
26.) TREATMENT OF ADOLESCENT AND ADULT SUBSTANCE ABUSE AND THE CRIMINAL JUSTICE SYSTEM – Participants learned through lecture and role play some of the key components of the criminal justice system and the substance abuse treatment system needed to work together. 27.) UNDERSTANDING AND UTILIZING ASAM PLACEMENT CRITERIA IN THE TREATMENT SETTING – Participants were able to identify five basic levels of treatment in the ASAM PPC-2R.

Prevention courses offered: 1.) HIV/AIDS 101 FOR MENTAL HEALTH/PREVENTION/SUBSTANCE ABUSE PROFESSIONALS. – This course provided participants with a foundation of knowledge about HIV/AIDS. 2.) PREVENTION ETHICS - An ethical decision model was taught and participants were intensely involved in working through relevant case studies using the model. 3). MANAGING DISRUPTIVE AUDIENCES - These courses 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.
4.) ILLICIT DRUGS 101 – This course focused on illicit drugs and their side effects. 5.) FETAL ALCOHOL SPECTRUM DISORDERS (FASD): AN OVERVIEW AND UNDERSTANDING OF ITS IMPACT - This course was an overview of FASD, causes, and characteristics of the disorder. 6.) NICOTINE ADDICTION: THE IMPACT ON THE BRAIN – This course identified nicotine as an addictive drug and described its effect on the brain. 7.) HEPATITIS C; WHAT YOU NEED TO KNOW –This course discussed Hepatitis C, what it is and how it is treated. 8.) 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.
9.) EFFECTIVE APPROACHES TO YOUTH/GANG VIOLENCE AND DRUG DEALING - This course was

designed to help identify real gang involvement and explores strategies for organizing and developing effective approaches to the impact in the community. 10.) ENVIRONMENTAL STRATEGIES FOR YOUR COMMUNITY – This course discussed how to determine which environmental strategies are appropriate for a community. 11.) SOCIAL AND MULTICULTURAL DIVERSITY AWARENESS IN SPECIAL POPULATION OF SUBSTANCE ABUSE – This course provided a comprehensive multicultural overview on diversity issues and gender responsive strategies for addressing the social needs of special population.

Current Status: Accomplished. Total attendees: 712

The Substance Abuse Services Division (SASD) 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 provided 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 (certified 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 treatment and prevention courses at every conference.

Current Status: Accomplished. SASD's Office of Certification and Training conducted training for substance abuse program staff in various locations throughout the state. There were a total of 47 training events reaching 1859 participants though the state of Alabama. They are as follows:
1.) 4- New provider orientation – These trainings are designed to help new providers understand the state regulations that govern substance abuse service in the state.
2.) 3- SASD Site Reviewers Training – These trainings were designed to help the site reviewer stay abreast of the current issues in the Substance Abuse Services Division regarding certification issues.
3.) 5- Part 1 - Understanding the Basic Concepts of ASAM PPC-2R- These trainings were offered to assist substance abuse providers in understanding the ASAM PPC-2R concept. With the assistance of the Southern Coast ATTC, this training professionally recorded and made available on the department's website for providers to use as a continuous training aside at their facilities. As of August 2010, the department website has received 749 hits or page views for this training. This training is also available on the Alabama Alcohol and Drug Abuse Association (AADAA) website for professionals who wish to gain CEUs.
4.) 3- ASAM Screening, Assessment, Placement and Beyond Training of Trainers Train Back Sessions – This training is a continuation of training that begun in the last fiscal year. These trainings were designed to allow trainers to become more familiar with the material and allow SASD staff to provide feedback on their training skills prior to the trainers conducting the training in the field.
5.) 24- ASAM Screening, Placement and Beyond Part 2 – The SASD designed a screening and placement tool based on the ASAM criteria and Readiness to Change. SASD recruited trainers from the field and trained them on the screen and assessment tool. This training was designed to help providers understand the screening and placement tool. The foundation of this training is the Part 1 - Understanding the Basic Concepts of ASAM PPC-2R. This PowerPoint training and all related material are available on the department's website and has receive 250 hits or page views. SASD has plans to partner with the Southern Coast ATTC and professionally record this training in order for it to be available on the department's website for providers to utilized on a continuous basis.
6.) 1- Opening Doors to Sobriety, Safety and Stability – The SASD partnered with the Alabama

Coalition Against Domestic Violence to provide cross training for professionals working with domestic violence and substance abuse. This is the second of four trainings planned. In an effort to help domestic violence and substance abuse professionals become more aware of their local partners, this training is being held in 4 regions of the state.
7.) 1- Psychological Fist Aid – In an effort to provide aid to the victims of the Gulf Coast Oil Spill Crisis, SASD partnered with The Red Cross and a local mental health provider to provide training to mental health staff and local volunteers to help citizens understand ways to cope during this crisis. We anticipate more trainings during the next fiscal year.
8.) 1- 35th Annual Alabama School of Alcohol and Other Drug Studies – See below for more details regarding the courses taught at the school.
9.) 1- Mental Health Interpreter Training – SASD partnered with our Office of Deaf Services to provide training to professional interpreters who will be working in the mental health and substance abuse field.
10.) 1- Co-occurring Training – This training is designed to enhance ACT and Mental Health Specialist staff to better understand the principles of effectiveness, networking, and planning for program diversity.
11.) 1- The Substance Abuse Connect: Domestic Violence and Child Abuse and Neglect – SASD partnered with the Alabama Coalition Against Domestic Violence to present this course. This course was designed to highlight the substance abuse connect, access to services and the need for cross training professionals.
12.) 1- Using the 12 Steps in Methadone - This training discussed the structure and purpose of traditional 12 step groups. It also explored the options of Methadone Anonymous groups.
13.) 1- Moving From a Program Oriented System of Care to A Client Driven System of Care – This training discussed the importance of clinical supervision in the treatment setting and how it is the most important part of a performance improvement plan.
14.) 1- Confidentiality Training - This course discussed the importance of 42CFR Part 2 and HIPAA.

SASD also developed an on-line training course called Alabama SBIRT. This training course is on the department's website and is designed to train doctors and nurses working in maternity clinics across Alabama. As of August 2010, the department's website has received 393 hits or page views for this training.

SASD has provided on-site technical assistance to substance abuse providers. They are as follows 1.) Client centered treatment planning 2.) Certification issues 3.) Developing Policy and Procedures.

The Director of the Nurse Delegation Program provided 24 trainings through the state to substance abuse providers. These trainings were designed to help provide information regarding MAS Nurse responsibilities and duties related to the Nurse Delegation Program. It also reviewed the present requirements and provided updated information related to program revisions.

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 2011.

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 identify 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! – This 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 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 TECHNIQUES 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 - 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. 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.

Goal #12: Coordinate Services

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)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-FY 2013 (Intended Use/Plan): PREVENTION

In FY 2011-13, the Substance Abuse Services Division of the Alabama Department of Mental Health (SASD/DMH) will coordinate Prevention Services through contractual agreements with public and private non-profit agencies through a Prevention planning process. To accomplish this goal, the SASD intends to attain the following objectives:

Objective 1: By September 30, 2013, SASD continue with established Prevention Planning Guidelines that will address four (4) major areas for coordination of Prevention Services.

A. By December 1, 2010, the Director of Prevention Services will continue to use established Prevention Planning Guidelines and instructions in regard to coordinating services for all Prevention strategies. The four major areas to be addressed will be 1) Administrative, 2) Education, Alternatives, Problem Identification & Referral, 3) Community Based Process, and 4) Environmental strategies.

B. The SASD/DMH will require the submission of Prevention Plans each year during the first week of June. The Plan will be assessed each year for pertinent information that may be added for clarity and to review data sets made available via the Alabama Epidemiological Outcomes Workgroup (AEOW).

C. The Administrative requirements shall encompass the following components:

- Program Capacity-Staff credentials, training needs, technical assistance needs identified, tool/equipment needs,
- Committee composition for planning purposes
- Program planning
- Children's Policy Council Collaboration
- Department of Education collaboration and identification of funding streams that may be leveraged
- Drug Free Communities partnerships that may be expanded
- Program Evaluation criteria
- Program Monitoring, Program Improvement & Outcome assessment

D. SASD will require service descriptions for CSAP six strategies as they relate to risk factors, data sources and the identified vulnerable population to be served. Service coordination of services must involve community stakeholders such as schools, juvenile courts, youth centers, faith based entities and other community related service organizations.

E. SASD will continue to contract with qualified substance abuse prevention agencies for the provision of prevention services with individuals of all ages.

F. During FY 2011-2013, the SASD Prevention Services Director will work in conjunction with the DMH Contracts office to ensure that all contracts issued by DMH for the provision of prevention services, at a minimum, the following stipulations:

1. The Contractor and its Subcontractor (s) shall agree to provide prevention services that gather, review and utilize data sources provided by the Alabama Epidemiological Outcomes Workgroup (AEOW).
2. The Contractor and its Subcontractor(s) shall agree that funding from DMH will utilize all of the tenets of the Strategic Prevention Framework (SPF).
3. Sufficient time and consideration will be applied to programmatic decisions to determine the most vulnerable populations to be served.
4. State coalitions and service organizations that work with specialized populations shall have access to data provided by DMH.

G. During FY 2011-2013, the SASD Prevention Services staff will continue the participation in the State Prevention Advisory Board (SPAB) to facilitate on-going exchange, guidance and support in the implementation of the Strategic Prevention Framework (SPF) in Alabama.

1. Membership consists of a diverse group of individuals that represent government, private sector, business, faith based community, military, health and education and alcohol and drug agencies.
2. Meetings convene on a quarterly basis in different locations in the state
3. The membership produces a quarterly newsletter to communicate state and national Prevention news.
4. The AEOW chairperson presents on-going data updates to the SPAB.
5. The SPAB will continually receive training on the SPF process to utilize the tenets-Assessment, Capacity, Planning, Implementation, Evaluation and to have the core elements of Sustainability and Cultural Competence to be relevant

H. During FY 2011-2013, the SASD Prevention Services staff will continue collaboration with the Alcohol Beverage Control Board (ABC) to participate in the Access to Youth Tobacco Task Force meetings that are held quarterly.

1. Membership consists of Department of Health epidemiologist, NPN-AL, ABC enforcement agents, Alabama legislators, Alabama Oil & Petroleum representatives, Grocery Store Association and Public Safety.
2. The routine meetings discuss sale rates for alcohol and tobacco and review the number of inspections that take place in all sixty-seven counties across Alabama.
3. The Legislative review/discuss pending and/or new legislation introduced in House Bill/Senate Bills through the Alabama legislation.
4. SASD has assigned membership to the Task Force and will continue to participate and collaborate for

the sharing of information.

I. During FY 2011-2013, the SASD Prevention Services Director will continue to participate in the Coalition for a Tobacco Free Alabama that was formed in 1986 under the leadership of former State Health Officer, Dr. Ira Myers. The organization has evolved into a partnership of businesses, organizations and individuals, whose goal is to achieve a tobacco free society in Alabama.

1. The coalition's mission is to eliminate unwanted exposure, sickness and death and to reduce the economic burden caused by tobacco use in Alabama.
2. The NPN-AI collaborates with this group to reduce tobacco use by increasing tobacco control efforts; to utilize tobacco prevention efforts to increase school-based interventions in combination with Environmental strategies and the use of policy change to create support; and protect non-smokers from second hand smoke.
3. It is the goal of Prevention services to continue to coordinate and collaborate with state partners to monitor establishments that sell tobacco products and control the Youth contact with tobacco products that are controlled through retail sales, permit regulations, law enforcement and education.

J. During FY 2011-2013, the SASD Prevention Services staff will continue the work of the Alabama Epidemiological Outcomes Workgroup to support data-driven research and review surveillance information.

1. The AEOW produced a charter that describes its principles, functions and organization. The charter states the goal and purposes of the AEOW, and includes a work plan that identifies the issues related to substance abuse prevention services in Alabama.
2. The AEOW will continue to submit the National Outcomes Measures (NOMS) at the State and Community level, where available and utilize pre-populated data provided by SAMHSA where necessary.
3. The AEOW will continue to work with prior deliverables such as the Community Epidemiological Profile and the State Epidemiological Profile. Both summarize and characterize the nature, magnitude and distribution of substance use and related consequences in the State and Communities.
4. The Epidemiological Profiles will continue to enable the SASD to have a concise, clear picture of the burden of substance abuse in Alabama and its Communities using tables, graphs, and narrative content to communicate this information to state and local stakeholders.
5. SASD will facilitate internal and external training and Technical assistance to staff, AEOW members, state partners and community stakeholders. This process will be on-going to accommodate the needs of service providers, staff and state partners.
6. The SASD Epidemiologist will continue in-service training and technical assistance with Prevention staff on an on-going basis to articulate the direction of research and programmatic needs for Prevention services.

K. During FY 2011-2013, the SASD Prevention Services staff will continue to collaborate with contract entities to ensure that the assistance and support is communicated for community stakeholders to participate in Town Hall Meetings (THM) on diverse topics such as Underage Drinking, Methamphetamines,

Prescription Drug Use, and other related topics that pertain to the overall wellness of communities in Alabama.

FY 2011-2013 (Intended Use/Plan): TREATMENT

In FY 2011-2013, The Substance Abuse Services Division of the Alabama Department Mental Health (SASD/DMH) will coordinate Prevention and Treatment services through contractual agreements with public and private non-profit agencies and through a planning process involving all stake holders. The State continues to support the development and implementation of a coordinated SA prevention and treatment system.

Objective 1: Continue to collaborate with State, Federal, and local government to better address the prevention and treatment needs of individuals and the needs of their families.

Activities

A. The SASD/DMH participates in a wide range of external and internal workgroups to facilitate the coordination of prevention and treatment services. These include, but not limited to, State agency workgroups with the Department of Public Health, Department of Youth Services, Department of Education, Department of Corrections, Administrative Office of Courts, State Medicaid, Pardons and Parole Board, Alabama Beverage Control Board, Veterans Administration, Division of Mental Illness, Division of Intellectual Disabilities, as well as treatment and prevention community providers and advocates.

B. Educate and train local community leaders in the State related to ongoing substance abuse prevention and treatment issues.

C. Provide technical assistance to communities in the State who express an interest to collaborate and partner with other stake holders to strengthen and expand prevention and treatment services.

Objective 2: Partner with other State agencies to coordinate the development and implementation of initiatives to expand access to treatment services.

Activities:

A. SASD will focus on extending treatment services to the Drug Courts established within the 41 court circuits in Alabama. SASD currently contracts with 15 circuits to provide SA treatment and there is 300, 000.00 dollars available for perspective new treatment providers.

B. Continue to partner with State Medicaid to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for OBGYN physicians to use in evaluating their pregnant patients for possible substance use issues. In order for the physician to bill Medicaid for SBIRT he/she must have completed a 3 module test and received a passing score.

C. Continue to work with community providers to identify and deliver evidence base /best practice models in the treatment of specialized populations (Pregnant Women/Women with Dependent Children, Co-occurring, adolescents, etc.).

FY 2008 (Annual Report/Compliance): PREVENTION

The Substance Abuse Services Division, Prevention Services has thirty-two (32) contractual agreements to provide Prevention Services to community providers in the state of Alabama. Fourteen (14) non-profit agencies and eighteen (18) community mental health centers collaborate and plan with community stakeholders that include education, juvenile justice, faith-based entities, higher education, children services, public safety, law enforcement and others to promote substance abuse prevention efforts. Alabama's prevention efforts are in four metropolitan cities that include Montgomery, Mobile, Birmingham and Huntsville and sixty-three (63) remaining rural areas of the state that encompass large land mass areas. These areas have diverse populations and experience various barriers to services and program implementation. Statewide efforts to plan prevention services have synthesized through changes to the overall system under the System Improvement Initiative. Prevention services can not be based on community "relationships", but on a compilation of information and trend data to support multiple sources such as Department of Education data, PRIDE Survey(s), juvenile justice, public safety, law enforcement, public housing, health/medical surveillance information and other data sources. This paradigm shift has experienced some challenges around capacity, workforce development, technical assistance and training. Contractual positions (Prevention Consultants) have been designed in the state to provide on-going assistance via technical assistance and training directly from Prevention Services. Prevention Consultants have provided in excess of 1,000 hours of direct technical assistance and training to new and seasoned personnel in the Prevention field. Several new opportunities have been developed to create training and technical assistance opportunities through national and state exposure. Historically, the Alabama School for Addictions studies has offered limited topics for Prevention staff. Therefore, prevention resource development topics have been expanded as a result of needs depicted in Prevention Plans and data needs. The State Prevention Advisory Board (SPAB) was created under the auspices of the Alabama Commission for the Prevention and Treatment of Substance Abuse. The Commission was created to accomplish thee following;

1. Support the efforts of the Alabama Department of Mental Health to fulfill its statutory mandate to supervise, coordinate, and establish standards for all operations and activities of the State of Alabama related to alcoholism and drug addiction;
2. Recommend initiatives to minimize the impact of substance abuse and addictions in Alabama;
3. Identify areas of interrelationship and opportunities for collaboration between substance abuse prevention, treatment, education, health and enforcement programs and resources, and;
4. Develop formal policies and procedures for coordination and efficient utilization of programs and resources.

The following agencies are represented on the State Prevention Advisory Board:

Department of Education

Drug Demand Reduction Administration-Military

Alabama Department of Economic & Community Affairs
Private Business (Big Lots Inc.)
Jackson State University
Alabama A&M University-Dean of Social Work
Veterans Assistance-U.S. Army
Advocate/Consumer
Alabama Coalition Against Domestic Violence
Alabama State University-Commuter Program Director
Juvenile Court Judge-Elmore County
310 Board Representatives (Mental Health Centers)
Central Alabama Opportunity Industrialization Center
Alabama Campaign to Prevent Teen Pregnancy
Mobile County Sheriff's Office-Public Affairs
Title I Director-Montgomery County Public Schools
One Base Center for Youth (Homeless Center)
Children's Trust Fund of Alabama
Partnership for a Drug Free Community-Huntsville
Public Safety
Alabama Association of Child Care Agencies

The SASD, Prevention Services utilizes 100% evidenced based curricula for education strategies and information dissemination through the Regional Information Clearinghouses. Fifty per cent of community planning is targeted toward population based level change through Environmental change that will address policy, practice and normative changes in the designated environment. Coordinated prevention efforts to mobilize community partners to accomplish stated goals and objectives will enhance program outcomes and fidelity.

FY 2008 (Annual Report/Compliance): TREATMENT

The SASD engaged in various efforts to continue to work in partnerships with other agencies to develop, coordinate, and implement initiatives directed at the expansion of access to treatment and other services for persons with substance use issues. These efforts included:

- The development of a rate- setting survey and a committee formed to address the requirements to expand access to substance abuse services by requiring uniformed rates, income eligibility, sliding fee scales, and expanded coverage of health insurance as a result of parity passing.

- Continued primary role of Single State Authority with regulatory responsibilities and assertive advocacy for uninsured and under-insured persons on interagency and intra-agency task forces and work groups. (i.e., Endangered Children's Workgroup, West Alabama AIDS Coalition, MH Specialist/ ACT Team Statewide

Workgroup, SAMHSA Returning Service Members, Veterans and Families, Juvenile Justice and Mental Health Taskforce, Supportive Employment Workgroup, etc)

• In addition, the SASD continued participation with the Department of Mental Health's SMART Operational Planning Initiative through the Governor's Executive Planning Office process in which eleven priorities were developed for clients, family members, and other community stakeholders to rank, revise, review and address or to develop other planning priorities. The priorities were:

o Create additional residential services for adult substance abuse services.
o Expand the availability of co-occurring services for individuals diagnosed with substance abuse and mental illness.
o Improve access to appropriate affordable, accessible supported housing options for adults.
o Increase communication, education, and advocacy regarding substance abuse service needs,
o Improve the availability of services to drug courts.
o Measure the ten National Outcomes Measures for substance abuse.
o Expand the number of detoxification programs.
o Create additional IOP services for adult substance abuse services.
o Identify ways to reduce the length of time individuals wait for substance abuse treatment services.
o Provide prevention, treatment, and recovery supports for adults in all 67 counties.
o Identify transportation resources for individuals receiving substance abuse treatment services.

• Partnered with providers to assess their capability and where necessary, their need to expand and develop additional adult, adolescent, medication-assisted and co-occurring disorders treatment services.

Goal #13: Assessment of Need

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The SASD will continue to utilize the previously identified data sources to document the need for both prevention and treatment services in Alabama. However, procedural changes will be made to enhance the needs assessment process. The analysis of treatment need will be integrated into the role of the Alabama Epidemiological Outcomes Workgroup (AEOW). The SASD will also pursue the completion of a formalized comprehensive prevention and treatment needs assessment study.

Prevention

The AEOW will continue to operate according to the charter (Goal #13-Attachment # 1). At a minimum the following data sources will be used to estimate prevention needs in Alabama.

- Alabama Pride Survey
- Alabama Department of Education Reports
- Juvenile Arrest Reports
- Alabama Alcoholic Beverage Control Board Reports
- Alabama Criminal Justice Information Center (Arrest Data)
- National Survey on Drug Use and Health
- Alabama Department of Public Health
- Local Planning Process – Identified Needs

At a minimum the following data sources will be used to estimate treatment needs in Alabama.

- National Survey on Drug Use and Health
- Alabama Criminal Justice Information Center (Arrest Data)
- Alabama Department of Public Health
- Waiting List Data
- Resource Shortages
- Local Planning Process – Identified Needs

The analysis will be published in the Alabama Epidemiological Outcomes Workgroup Annual Report. The results will be used in the planning process to assist in resource allocation, selection and application of evidence-based practices and the evaluation of effectiveness.

This goal was met during the 2008 SAPT BG expenditure period.

Prevention:

The Alabama Epidemiological Outcomes Workgroup (AEOW) continued to pursue their mission 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. The objectives, activities, membership, officers, committees and other pertinent descriptive information are included in the Alabama Epidemiological Outcomes Workgroup Charter, Goal#13-Attachment #1.

The 2008 AEOW Report – Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama, is included as Goal#13-Attachment #2.

Prevention Planning Overview

The prevention planning system in Alabama is based on 22 catchment areas as described in Planning-Attachment #1. Each catchment area has its own local board (referred to as 310 boards) that is responsible for planning mental health, intellectual disabilities, 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 AEOW annual report including data from the Alabama Pride Survey, Alabama Department of Education Reports (Adequate Yearly Progress, Free/Reduced Lunch, School Incident Reports, In School Suspension Reports, Truancy Reports), Juvenile Court Arrest Reports, Alabama Alcoholic Beverage Control Board Compliance Rates, Alcohol Density Reports (Licensees, Violations), Adult Arrest Reports, and the National Survey on Drug Use and Health (NSDUH) are disseminated to the local 310 boards for use in the development of their local prevention plans.

Each 310 Board is required to develop an annual local prevention plan based on identified need including priority populations. Submission of the annual plan is required prior to the beginning of each State fiscal year.

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 NSDUH; arrest data; health data; waiting list data; the identified resource shortages; and the local needs assessment process.

Original Needs Assessment Study

In 1999 Alabama completed a formal needs assessment study which indicated that approximately 273,000 Alabama 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 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 (NSDUH) annual report is used as a source to indicate trends, prevalence and unmet treatment needs. According to the 2007 report, 7.36% of Alabama's population suffered with dependence or abuse of alcohol or any other drug in the past year. The 2007 report also indicated that 5.68% of Alabama's population needed treatment for alcohol use but did not get it and 2.40% of Alabama's population needed treatment for other drug use but did not get it.

Regions	Dependence on or Abuse of Illicit Drug Or Alcohol in Past Year
Region 1	7.09%
Region 2	7.82%
Region 3	7.28%
Region 4	7.09%
State Total	7.36%

Regions	Needing But Not Receiving Treatment for Illicit Drug Or Alcohol Use in Past The Past Year

Region 1	7.81%
Region 2	8.47%
Region 3	8.19%
Region 4	7.75%
State Total	8.08%

Arrest Data

The Alabama Criminal Justice Information Center (ACJIC) reported that 32,790 Alabamians were arrested on DUI and Other Drug Related charges during 2007.

Regions	DUI	Other Drugs	Total
Region 1	4,653	5,424	10,077
Region 2	3,785	6,011	9,796
Region 3	2,056	2,408	4,464
Region 4	3,366	5,087	8,453
State Total	13,860	18,930	32,790

Health Data

The Alabama Public Health Department reported new cases in the following health areas which are identified as substance use disorder prevalence indices. The data were reported as cases per 100,000 population per region.

Regions	Hep.B	AIDS	TB
Region 1	2.81	3.90	4.76
Region 2	2.95	8.44	3.95
Region 3	3.75	11.84	2.66
Region 4	1.66	11.78	3.21
State Total	2.77	8.54	3.78

Waiting List Data

Alabama specific waiting list data indicate that approximately 600 Alabamians were determined to need residential treatment and were on waiting lists each day. Further analysis indicates that only one-half of those on waiting lists were admitted the same year they went on the lists.

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 did not offer adult outpatient treatment services. Forty-seven counties did not offer adolescent outpatient services. Forty-four counties did not offer prevention services.

Local Needs Assessment

During SFY 2007-2008 the DMH expanded local needs assessment efforts. These efforts are described in Planning-Attachment #3. 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 following Goals were developed during SFY 2008-2009.

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 abuse.

The identified needs were 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.

Prevention:

The Alabama Epidemiological Outcomes Workgroup (AEOW) continues to pursue their mission 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. The objectives, activities, membership, officers, committees and other pertinent descriptive information are included in the Alabama Epidemiological Outcomes Workgroup Charter, Goal #13-Attachment #1 .

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Prevention Planning Overview

The prevention planning system in Alabama is based on 22 catchment areas as described in Planning-Attachment #1. Each catchment area has its own local board (referred to as 310 boards) that is responsible for planning mental health, intellectual disabilities, 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 AEOW annual report including data from the Alabama Pride Survey, Alabama Department of Education Reports (Adequate Yearly Progress, Free/Reduced Lunch, School Incident Reports, In School Suspension Reports, Truancy Reports), Juvenile Court Arrest Reports, Alabama Alcoholic Beverage Control Board Compliance Rates, Alcohol Density Reports (Licensees, Violations), Adult Arrest Reports, and the National Survey on Drug Use and Health (NSDUH) are disseminated to the local 310 boards for use in the development of their local prevention plans.

Each 310 Board is required to develop an annual local prevention plan based on identified need including priority populations. Submission of the annual plan is required prior to the beginning of each State fiscal year.

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 NSDUH; arrest data; health data; waiting list data; the identified resource shortages; and the local needs assessment process.

Original Needs Assessment Study

In 1999 Alabama completed a formal needs assessment study which indicated that approximately 273,000

Alabama 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 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 (NSDUH) annual report is used as a source to indicate trends, prevalence and unmet treatment needs. The NSDUH annual report historically provides prevalence and unmet treatment needs data applicable for the four planning regions in Alabama. For planning purposes data applicable to the twenty-four mental health catchment areas would be much more useful. During SFY 2009 – 2010 the SASD requested the SAMHSA Office of Applied Studies (OAS) for assistance in carrying the NSDUH findings to the catchment area level. OAS met the request by combining NSDUH surveys for the years of 2002 through 2008 (refer to Goal #13-Attachment #4). According to the 2002-2008 report, 7.00% of Alabama's population suffered with dependence or abuse of alcohol or any other drug in the past year. The 2002-2008 report also indicated that 5.40% of Alabama's population needed treatment for alcohol use but did not get it and 2.30% of Alabama's population needed treatment for other drug use but did not get it.

The ranking below indicates the summation of all of the NSHUH data categories from the 2002-2008 surveys.

Regions	Ranking
Region 3	1
Region 2	2
Region 4	3
Region 1	4

Arrest Data

The Alabama Criminal Justice Information Center (ACJIC) reported that 32,387 Alabamians were arrested on DUI and Other Drug Related charges during 2009.

Other

Regions	DUI	Drugs	Total
Region 1	5,223	4,578	9,801
Region 2	3,899	6,558	10,457
Region 3	2,259	1,998	4,257
Region 4	3,850	4,022	7,872
State Total	15,231	17,156	32,387

Health Data

The Alabama Public Health Department reported new cases in the following health areas which are identified as substance use disorder prevalence indices. The data were reported as cases per 100,000 population per region.

Regions	Hep.B	AIDS	TB
Region 1	2.22	2.60	4.13
Region 2	2.50	2.63	4.08
Region 3	1.56	6.02	2.17
Region 4	.86	4.78	3.25
State Total	1.89	3.72	3.57

Waiting List Data

The Alabama Substance Abuse Information System (ASAIS) provides for real time waiting list management. On average 800 to 900 Alabamians are waiting daily for substance abuse treatment services through the publicly funded system. Further analysis indicates that approximately one-half of those on the waiting list are admitted for treatment the same year they go on the list.

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 counties do not offer adult outpatient treatment services. Forty-two counties do not offer adolescent outpatient services. Thirty-six counties do not offer prevention services. Goals have been established and included in the State budget development process that would provide basic substance abuse prevention and treatment services for all the sixty-seven counties by 2015.

The DMH local needs assessment process was continued. The process is 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 2011 SAPT BG application (Planning-Attachment #3) 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 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

September 2010

- State funding for substance abuse prevention and treatment services in Alabama is inadequate:

- 320,000 Alabamians are estimated to need but do not get substance abuse treatment.
- Approximately 17,000 Alabamians are admitted for treatment in the public system per year.
- Approximately 800 Alabamians are on waiting lists for residential substance abuse treatment.2
- Adult treatment services are available in 47 of 67 counties. 2
- Adolescent treatment services are available in 25 of 67 counties.2
- Prevention services are available in 31 of 67 counties. 2

- State agencies spend considerable portions of their budgets on citizens suffering from substance abuse or addiction:

- Adult Corrections 77% or $ 245 million
- Juvenile Justice 65% or 55 million
- Judiciary 78% or 135 million
- Education (Elementary/Secondary) 10% or 303 million

- Health 26% or 300 million
- Child Welfare 69% or 82 million
- Regulation/Compliance 100% or 215 million
- Public Safety 31% or 11 million

Total $ 1.3 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.5
- Families receiving addiction treatment spent $363 less a month on regular medical care than untreated families.6
- Children whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care.7
- When mental health and drug and alcohol disorders are treated collaboratively patients have better outcomes.8
- Fetal Alcohol Syndrome affects an estimated 40,000 infants per year nationally and is totally preventable.9

- 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. Substance Abuse and Mental Health Services Administration (SAMHSA), 2006-2007 National Surveys of Drug Use and Health.
2. Department of Mental Health and Mental Retardation, Substance Abuse Services Division – Alabama Substance Abuse Information System (ASAIS).
3. National Center on Addiction and Substance Abuse at Columbia University. (2005). Shoveling up: The impact of substance abuse on state budgets. Page #88. New York, NY, http://www.casacolumbia.org.
4. 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.
5. 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.
6. 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.
7. Child Welfare League of America. (2001). Advocacy Fact Sheet. Retrieved May 8, 2006, from http://www.cwla.org/advocacy/aodfactsheet.htm.
8. 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.
9. 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.

Goal #14: Hypodermic Needle Program

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)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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.

The goal was met during the SAPT BG 2008 expenditure period.

The following statement was included in Exhibit SA-3 of each contract issued by the SASD during the SAPT BG 2008 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-fedral 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 2008 expenditure period no audit reports indicated that the requirement related to hypodermic needles or syringes had been violated.

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.

Goal #15: Independent Peer Review

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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 and reports will be complied to develop a summary report used to generate training needs.

MODALITIES PARTICIPATING IN THE 07-08 IPR

Huntsville/Madison Mental Health Center - Adult Intensive Outpatient
Reviewer: Kathy Goodwin

Aletheia House - Male Residential Rehabilitation
Reviewer: Hank Wade

Southeast Intervention Group Inc. - Adult Male Residential Rehab
Reviewer: Phillip Drane

Tri County Methadone Program – Opiate Replacement Therapy
Reviewer: Becky Clayton

New Pathways - Adult Intensive Outpatient Drug Court
Reviewer: Travis Abshre

UAB Adult Special Women's Intensive Outpatient
Reviewer: Luciana Coleman

UAB Adolescent Intensive Outpatient
Reviewer: Luciana Coleman

2007-2008 FINDINGS

The following table outlines the percentage for each section reviewed.

SECTION	EXCELLENT	GOOD	FAIR	POOR
1	90%	10%		
2	40%	40%	20%	
3	40%	60%		
4	40%	60%		
5	10%	60%	30%	
6	60%	40%		
7	90%	10%		

SECTION 1 Determine if the admission/intake process respects the dignity of the clients.

Of the programs reviewed 90 % scored excellent, 10% scored good indicating staff presented themselves to the clients in a manner that respected the dignity of the clients.

Comments

* 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:
* Client areas were hospitable with easy access to vending machine, rest rooms.
* Clients placed on the waiting list are mailed an information package that answers general questions about the program. Wait time less than 2weeks on average
- * Counselors coming to waiting area to greet the client and escort them to their office.

* Adolescents were asked about what interest they had or what they liked to do for fun and were incorporated into their treatment plans.
*A * Staff interviews described a well organized, responsive screening and assessment process which is carried out in a manner that respects patient privacy and attempts to engage patients early in the admission process.
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.

IRP reports indicated 40% scored excellent, 40 % scored good, and 20 % scored fair. Through interviews with clinicians, intake staff, and an examination of the client records, assessment process identified the need for care and the appropriate level of care in most cases. Therapist appeared to be passionate about wanting clients to feel they are in control of their treatment.

Comments

* Both the assessment and physical forms ensure that DSM -IV criteria are established prior to admission. The assessment and intake documentation facilitate identification and prioritization of

patient needs.

SECTION 3 Determine if the treatment plan provides a flexible guide for helping clients get better.

Of the programs reviewed 40% scored excellent and 60% scored good. It was determined the treatment plans provided measurable goals helping the client see the progress they were making. In all of the seven programs reviewed the treatment plans addressed the problems noted in the assessment.

Comments

* IPR reports continue to indicate treatment planning seems to be a problem area for all programs reviewed. Reviewer's notes indicated treatment goals appeared to be standardized. However, staff appears to be trying to individualize how clients respond to each goal.

* Issues identified in the assessment were present on the treatment plan in a majority of charts reviewed. Treatment barriers were addressed and client readiness to change was also addressed.

SECTION 4 Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs in a timely manner.

In the programs reviewed, IPR reports indicated that 40 % scored excellent and 60% scored good. The 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.

Comments

* Program staff considers treatment engagement issues and address treatment barriers by meeting clients where they are in their readiness to change.

SECTION 5 Determine if the discharge plan supports the client's recovery.

Of the reports received, 10% scored excellent, 60 % scored good, and 30% scored fair. Discharge plans support the client's recovery, were consistent with the documented history and indicated clients participated in the development of the plans. They also addressed the continuing care needs.

Comments

* One reviewer recommended to a program to give a written recovery plan to each client to complete prior to discharge to use as a guide after treatment including support phone numbers and contacts.

* In most cases discharge planning reflected the patient participation and aftercare needs were evident except in cases of unanticipated patient departure.

SECTION 6 Determine the program's policies, procedures and practices regarding treatment outcome.

Of the report received 60% scored excellent and 40% scored fair. The most common outcome instruments used by programs continue to be client satisfaction and follow-up surveys. The follow-up survey consist of the client's status in 5 domains; alcohol and drug use, family/living conditions, education/employment/income, crime/criminal justice, and mental/ physical health. Surveys are mailed out to clients 6-12 months after discharge. Once the follow-up form is returned, outcome data is collected, reviewed and examined for trends which might serve to improve the provision of services

Comments

* Programs seem excited about the new information system presented by the SASD which will provide on demand outcome measures for all contracted program

SECTION 7 Determine client satisfaction with the program.

The IPR reports indicated 90 % of programs reviewed score excellent and 10% scored good.

Comments

* 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.

* Reports indicated clients felt the programs serve their needs. Clients also indicated they are aware of the process 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. They are also informed of their right to file a grievance through advocates meetings.

SECTION 8 Administrative Reviews

The administrative review selection offered useful suggestions from reviewers to help manage an agency. They are as follows.

1. Communication and assistance from administration to programs was present. Data flow to billing was complete even though the state has new information and billing system.
2. Opiate Replacement Programs are demonstrating evidence based practices by offering Buprenorphine as an option and referrals to private doctor for Suboxone.
3. Support special needs groups as women/mother groups.
4. Extended case management services.
5. Most programs were using evidenced based program material for Intensive Outpatient Programs.

SECTION 9 Reviewer's Summary of Peer Review Process

All programs reviewed were well organized and are at different levels of efficiency. Programs reviewed ranged from one year to more than twenty-five years in operation. Innovative approaches noted are listed below.

1. The Aletheia House program modality in itself is innovative using case management in a residential setting in conjunction with an IOP
2. Creative thinking and strategic use of every inch of space in a crowded situation helps the flow and general operation of Tri-County Treatment Center. Well qualified staff Mastered degree was a plus. Management of this facility is to be commended in their effort to relocate and find

adequate space to serve the demand of clients currently in this clinic while maintaining control during high traffic time at current location.

3. UAB offered case management services from the beginning of treatment all the way through out the system of care.

4. Paperless, computerized records are continuing to be utilized by more programs.

SCETION 10 - Providers Assessment of the Independent Peer Review Process

Below are comments received for the programs who participated in the peer review process in FY 2007-2008.

1. What part(s) of the Peer Review Process did you find most helpful/useful?

The reviewer's experience and knowledge was very helpful

2. What parts(s) of the Peer Review did you find least helpful/useful?

I fell like the process s well planned and well executed

3. What additional areas would you include as a part of the review?

I cannot think of any additional areas to include in this process

4. What changes to the review would you recommend?

Actually all of it was helpful

TRAINING NEEDS FOR 2007-2008.

The IPR indicated the following training is needed:

1. Treatment plan.
2. Clinical documentation
3. Discharge plan.

The following trainings were presented to providers.

1. Clinical Supervision - This training focused on understanding the function and purpose of clinical supervision.

2. Motivational Interviewing and Treatment Planning - This training focused on using the spirit of motivational interviewing to create more personal individualized treatment plans.

3. 12 Core Functions of Counseling - This training was developed and presented to improve

counseling skills, increase understanding of how communication skills play in counseling and to allow therapist to gain insight into the role of the counselor in the treatment process

MODALITIES PARTICIPATING IN THE 09-2010 IPR

Birmingham Fellowship House - Residential Rehabilitation
Reviewer: Hank Wade

Aletheia House - Adult Special Women's Intensive Outpatient Program
Reviewer: Linda Peoples

Hope House - Adolescent Intensive Outpatient Program
Reviewer: Mark Spurlock

The Shoulder - Adult Intensive Outpatient Program
Reviewer: Barbara Zander

Chemical Addictions Program - Adult Intensive Outpatient Program
Reviewer: Fran Shadix

Family Life Center Centre - Adult Intensive Outpatient Program
Reviewer: Fran Shadix

Alta Point Mental Health - Methadone Treatment
Reviewer: Becky Clayton

2009-2010 FINDINGS

The following table outlines the percentage for each section reviewed.

SECTION	EXCELLENT	GOOD	FAIR	POOR
1	80%	20%		
2	80%	20%		
3	80%	10%	10%	
4	20%	70%	10%	
5	20%	70%	10%	
6	80%	10%	10%	
7	80%	20%		

SECTION 1 Determine if the admission/intake process respects the dignity of the clients.

Of the programs reviewed 80% scored excellent and 20% scored good indicating the staff presented themselves to the clients in warm, informative, and non-threatening manner. Comments made by reviewers in this section are:

Comments

* Reviewer was not able to observe an actual intake; however she did interview the employee from admissions. After the interview and upon reviewing all related forms. Process seemed comprehensive and client centered.
* Time between assessment and intake average 1-2 days. Group begins the day of intake somewhat long wait for assessment.

* The Pretreatment Program is a high quality case management and educational process that Birmingham Fellowship House does (without added funding) to prepare clients for treatment. It is a great approach made possible because of their focus on and move toward a Recovery Oriented System of Care.

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

IPR reports indicated 80% scored excellent 20% scored good 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 and forms the basis for a treatment plan.

Comments

* As levels of care and a Recovery Oriented System of care are implemented the need for a standardized assessment tool is evident.

*Client records indicate an appropriate Bio-Psycho-social being used by Qualified Staff

Assessment by both a Licensed Nurse Practitioner and a MD.

SECTION 3 Determine if the treatment plan provides a flexible guide for helping clients get better.

It was determined that 80% scored excellent, 10% scored good, and 10% scored fair 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.

Comments

* There may be more participation of the client in the treatment planning process, than what I viewed in the charts. The program needs to increase documented participation; counselors need to write more detailed notes.

* Counselors need to be sure to address ongoing issues and follow through on objectives. In one chart reviewed; there was an ongoing client issue which had good objectives in the treatment plan, but they were not followed through.

* Follow through with issues identified later in treatment needs to be improved. Many issues identified in group or individual notes were never added to the treatment plan.

* The treatment plan appears to be a collaborative effort between the client and clinician and reviews are completed within the guidelines of the state standards. The goals are based on the program guidelines and would be more beneficial if the treatment goals addressed just the client's needs.

SECTION 4 Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs in a timely manner

In the programs reviewed, IPR reports indicated that 20% scored excellent, 70% scored good, and 10% scored fair demonstrating that documentation demonstrated appropriate delivery of treatment services. Documentation of progress in notes indicated they are a reflection of the treatment plan. Documentation indicated treatment was provided on a timely basis and also reflected the client's functioning. Documentation was related to the treatment plans.

Comments

* The program needed help completing the therapeutic process with regard to daily documentation for example when a 'Feelings Check' was used. The program needed to correlate the feelings check to an issue in a group or an issue on the treatment plan. We also discussed the value of using client quotes (some of which was documented in the charting).

* Some release forms were incomplete and/or incorrectly filled out. Reviewer discussed with the clinical team 'the 9 elements of a release', etc. I also suggested they use the state approved release forms located on the DMH website.

* Based on chart reviews, the process notes reflected treatment goals and justified the client's admission into the Intensive Outpatient Program as an adjunct to residential treatment. Documentation complies with state standards and program policy and procedure.

SECTION 5 Determine if the discharge plan supports the client's recovery

Of the reports received, 20% scored excellent, 70% scored good, and 10% scored fair all indicated improvement in discharge planning.: They did support the client's recovery; They were consistent with the documented history; clients did participate in the development of the plans; They did address the continuing care needs, and plan did meet the client's needs.

Comments

* Aletheia House has a Discharge Plan which the client fills out, then is reviewed by the clinical team. Modifications are made and discussed with the client. Good tool - well used.
Their clinical Discharge Summary, however, lacks depth and thoroughness. I have shared a sample Discharge Summary that lends itself to be more comprehensive and thorough.

* Each discharge plan reflected the client's level of functioning and the documented history, as identified in the assessment and progress notes, and was factored into the most appropriate plan at discharge. Clients appeared to have input into the development of their personal plan at discharge to insure a successful outcome upon discharge.

SECTION 6 Determine the program's policies, procedures and practices regarding treatment

outcome

Of the reports received, 80% scored excellent, 10% scored good, and 10% scored fair.
The most common outcome instruments used by programs were client satisfaction and follow-up surveys. The follow up survey consist of the client's status in 5 domains; alcohol and drug use, family/living conditions, education/employment/income, crime/criminal justice, and mental/ physical health. Surveys are mailed out to clients 6-12 months after discharge. Once the follow-up form is returned, outcome data is collected, reviewed and examined for trends which might serve to improve the provision of services. One program reviewed showed no evidence that the information collected is used to improve the program and services.

Comments

* Client Satisfaction Surveys are one method utilized to evaluate treatment quality. These surveys have 25 items to answer with a mark, ranging from excellent to poor. In addition there is a section for free form written expression of likes, dislikes, suggestions, and comments.
The Clinical Director also is quite knowledgeable and oversees all clinical actions, making corrections ongoing an ongoing basis.

* Reviewed documents on follow-up surveys and satisfaction surveys. Talked to administrator on how information was utilized for improvements.

SECTION 7 Determine client satisfaction with the program.

Of the reports received, 80% scored excellent and 20%scored good. All programs use a client satisfaction survey. In addition to a client satisfaction survey, one program has a staff satisfaction survey.

Reports indicated they are aware of the process 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. They are also informed of their right to file a grievance through advocates meetings.
Advocate numbers are posted.

Comments

* Through interviews with client it was apparent they knew the procedure to voice complaints and express their request. All clients that I spoke seemed quite confident about using this process if necessary. Aletheia House also uses a Client Satisfaction Survey, as previously noted and discussed.

* In addition to client satisfaction surveys Birmingham Fellowship House also uses staff satisfaction Surveys to determine changes that may need to be made for staff retention and improved job performance.

SECTION 8 Administrative Review

The administrative review selection supported the system improvements directly attributed to the implementation of ASAIS and a Recovery Oriented System of Care.

Comments

* Along with the ASAIS system, Birmingham Fellowship House is using an electronic medical record system. With “claim Trak” records will be more accessible to each staff member at their desktop and billing will be more accurate and compatible with ASAIS.

* Through interviews with administrator and clinicians, I saw records on computer and was given copies of recent surveys.

SECTION 9 Reviewer’s Summary of Peer Review Process

The section on innovative approaches by far was the most informative:

Comments

* Clients seem to have some autonomy in the program and allowed choices which will encourage rehabilitation. Some of their programs/classes celebrate achievements the clients make, other classes such as Arts and Crafts; have had surprisingly positive and therapeutic value for many of the clients also. Having the clients present and defend their discharge plan to Clinical Staff could have strong beneficial aspects for the transitioning client. The Clinical Director seems very knowledgeable and aware of her program and staff; thus she can catch mistakes early and redirect her staff. She also seems to be solution centered, staying within guidelines, but also

allowing creativity, which fosters growth and ingenuity of the staff.

* Movement toward a Recovery Oriented System of Care across the Board.

* Implementation of a Standardized assessment tool.

* Integration of levels of care standards has begun.

SCETION 10 - Providers Assessment of the Independent Peer Review Process

Below are comments received for the programs who participated in the peer review process in FY 2009-2010.

1. What part(s) of the Peer Review Process did you find most helpful/useful?
Reviewing files and getting suggestions from reviewers on ways to improve.
The one on one interaction with an experienced knowledgeable professional
in our field.
2. What parts(s) of the Peer Review did you find least helpful/useful?
The complete process was seen by all peer reviewers and review sites as very helpful.
3. What additional areas would you include as a part of the review?
All felt the process was comprehensive and complete.
4. What changes to the review would you recommend?
No suggestions to change peer review process.

TRAINING NEEDS FOR 2009-2010

The 2009-2010 IPR indicated the following training is needed:

1. Treatment planning documentation
2. Discharge/Recovery planning

The following training was provided to providers:

1. Practical Tools for Recovery Management – This workshop discussed the helpful step to building a strength discharge/recovery plan that ensures long term recovery.
2. Individualize Treatment Planning Using ASAM PPC and Stages of Change – This workshop

focused on an innovative, practical approach that enlists the client's participation in the treatment planning process from beginning to end. Participants learned to conceptualize treatment planning using the Stages of Change and ASAM PPC. They also learned the difference between clinical goals and the goals of the client.

Independent Peer Review (formerly Attachment H)

(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 2009 (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.

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.

Appendix B
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:

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:

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:

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:

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

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
d. Reviewer's documentation:

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:

SECTION 9. REVIEWER'S SUMMARY OF THE PEER REVIEW PROCES INNOVATIVE APPROACHES:

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
c. What additional areas would you include as a part of the review?
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

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.

Goal #16: Disclosure of Patient Records

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).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

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 Oct 2007-Septemeber 2008.

Program County Region
Alabama Abuse Counseling Walker, Jefferson,
Tuscaloosa 2
Alabama Recovery Madison 1
Alta-point Health Services Mobile 4
Angels Outreach Montgomery 3
Anniston Fellowship House Calhoun, Cleburne 2
Baldwin County Mental Health Baldwin 4
Bibbs, Pickens, Tuscaloosa Mental Health Center Tuscaloosa 2
Birmingham DUI School Jefferson 2
Birmingham Fellowship House Jefferson 2
Birmingham Metro Treatment Center Jefferson, 1
Bradford Health Services Jefferson, Lawrence, Morgan Shelby, Cleburne Etowah, Marshall, Lauderdale 1,2,3,4
Cahaba Mental Health Center Dallas 3
Calhoun County Treatment Center Calhoun 2
CED Fellowship House Etowah 1

Cheaha Mental Health Center Talladega Clay, Randolph 2
Chemical Addictions Program Montgomery 3
Cherokee County Prevention Cherokee 1
Cullman Area Mental Health Center Cullman 1
Cullman County Treatment Center Cullman 1
Dauphin Way Lodge Mobile 4
Dothan Houston Treatment Center Houston 4
East Central Mental Health Center Pike 3
EDC Mobile 4
Emma's Harvest Home Mobile 4
Franklin Primary Healthcare Mobile 4
Freedom Rains Jefferson 2
Gadsden Treatment Center Etowah 1
Gulf Coast Counseling Baldwin 4
Gulf Coast Treatment Center Mobile 4
Health Services Inc Etowah 1
Hope House Blount 1
Houston County Treatment Center Houston 4
Human Resource Development Institute Elmore 3,4
Huntsville Metro Treatment Center Madison 1
Huntsville Recovery Treatment Center Madison 1
Insight Mobile ,Baldwin 4
Lighthouse Counseling Center Montgomery 3
Marion County Treatment Center Marion 1
Marwin Counseling Winston, Marion 2,3
Mobile Mental Health Center Mobile 4
Mobile Metro Treatment Center Mobile 4
Montgomery Metro Treatment Center Montgomery 3
Mountain Lakes Mental Health Center Marshall 1
Mt View Hospital Intensive Outpatient Program Etowah 1
New Choices Randolph 2
New Choices Tallapoosa 3
New Life Counseling Autauga 3
New Pathways St Clair
North Central Alabama MHC Morgan 1
Northwest Mental Health Center Walker, Winston Fayette, Lamar 1,2

Northwest Treatment Center Jefferson 2
Outpatient Recovery Group Etowah 1
Pathfinder Madison 1
Pathfinders Madison 1
Phoenix City Court Referral Wings Lee 3
Rapha Christian Home Etowah 1
Recovery Services Of DeKalb County DeKalb 1
Riverbend Mental Health Center Lauderdale 1
Sandy's Place Etowah 1
SAYNO Montgomery 3
Second Choice Mobile 4
Shelby County Treatment Shelby 2
Shoals Treatment Center Colbert 1
South Central Mental Health Center Covington 4
South Eastern Intervention Group Houston 4
South West Mental Health Center Monroe 4
Spectra Care Houston Geneva Henry 4
St Clair County Day Treatment St Clair 2
Starting Over Autauga 3
Substance Abuse Council Of North Alabama Lauderdale, Colbert 1
Sumter County Treatment Center Sumter 3
TEARS Inc Russell 2
The Family Center Cleburne 2
The Shoulder Baldwin 4
Townsend Recovery Baldwin 4
Tri County Treatment Jefferson 2
Tri County Treatment Center Jefferson 2
Tuscaloosa Treatment Center Tuscaloosa 2
Tuscaloosa Treatment Center Tuscaloosa 2
Walker County Recovery Program Walker 1
West Alabama Mental Health Sumter 3

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.

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.

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.

During the 2007 SAPT BG 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 Trainings related to certification issues are listed below. A full description of all the trainings conducted in FY 2007-2008 are listed in Goal 11.

1.) 3- HIPPA with an AOD Twist trainings offered in different regions in the state to help providers better understand 42CFR part 2 and HIPAA.
2.) 2 - Documentation Trainings that outlined the importance of keeping accurate records.
3.) 4- New provider orientation – These trainings are designed to help new providers understand the state regulations that govern substance abuse service in the state

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 2009-2010.

PROGRAM COUNTY REGION
Alabama Abuse Counseling Jefferson, Fayette, Shelby, Walker 2
Alabama Aids Jefferson 2
Alabama Recovery Services Madison 1
Aletheia House Jefferson, Walker 2
Baldwin County Mental Health Baldwin 4
Birmingham Health Care for the Homeless Jefferson 2
Birmingham Metro Jefferson 2
Bibbs, Pickens, Tuscaloosa Mental Health Center Tuscaloosa, Bibb, Pickens 2
Bradford Health Services Jefferson, Calhoun, Lauderdale, Lee, Madison, Marshall, Mobile, Montgomery, Morgan, Shelby, Tuscaloosa 1, 2, 3, 4
Calhoun Treatment Center Calhoun 2
CED Fellowship Houses Etowah 2
Cherokee County Substance Abuse Council
Cherokee
2
Lighthouse of Cullman Cullman 2
Cullman Mental Health Center Cullman 2
Cullman County Treatment Center Cullman 2
Dauphin Way Lodge Mobile 4
Dothan Houston Treatment Center Houston 4
EDC Treatment Center Mobile 4
Franklin Primary Health Care Mobile 4
Substance Abuse Council of Northwest Alabama Lauderdale, Franklin 1
Freedom Rains Ministries TLC Jefferson 2
Gadsden Treatment Center Etowah 3
Gateway Jefferson 2
Gulf Coast Treatment Center Mobile 4
Hamilton Economic Development Jefferson 2
Southeastern Intervention Group Houston 4

Hope House Blount 3
Huntsville Metro Treatment Center Madison 1
Huntsville Recovery Madison 1
Infinity Counseling Services Baldwin 4
Insight Treatment Program Clarke, Coffee, Dale, Geneva 4
JCCEO Jefferson 2
Lighthouse Counseling Center Montgomery 3
Marion County Treatment Center Marion 1
Marwin Counseling Services Marion, Winston, 2
Mental Health Center of Madison County Madison 1
Mobile Metro Treatment Center Mobile 4
MOM's Inc Lauderdale 1
MOM Treatment Program Lauderdale 1
Montgomery Metro Treatment Center Montgomery 3
Southeastern Psychiatric Management Inc Etowah 2
New Centurions Inc Etowah 2
New Pathways St.Clair 2
Phoenix City Court Referral Program Russell, Tallapoosa, Macon, Lee 3
Rapha Christian Ministries Etowah 2
Sandy's Place Inc Etowah 2
Second Choice Mobile 4
Shelby County Treatment Center Shelby 2
Shoals Treatment Center Colbert 1
South Central Mental Health Center Covington, Conecuh, Coffee 4
SpectraCare Houston, Geneva, Houston 4
Tears Inc Russell 3
The Bridge Etowah, Cullman, DeKalb, Mobile, St Clair, Tuscaloosa 1,2,4
The Shoulder Baldwin 4
Therapeutic Resources Inc Houston 4
Tri County Treatment Center Jefferson 2
Tuscaloosa Treatment Center Tuscaloosa 2
West Alabama Mental Health Center Marengo, Clarke 4

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.

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.

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.

There were a total of 47 training events reaching 1859 participants though the state of Alabama. Trainings related to certification issues are listed below. A full description of all the trainings conducted in FY 2009-2010 are listed in Goal 11.

1.) 4- New provider orientation – These trainings are designed to help new providers understand the state regulations that govern substance abuse service in the state.
1.) 3- SASD Site Reviewers Training – These trainings were designed to help the site reviewers to stay abreast of the current issues in the Substance Abuse Services Division regarding certification issues.
3.) 2- Confidentiality Training - This course discussed the importance of 42CFR Part 2 and HIPAA.

SASD has also provided on-site technical assistance to substance abuse providers. They are as follows 1.) Client centered treatment planning 2.) Certification issues 3.) Developing Policy and Procedures.

Goal #17: Charitable Choice

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).

Note: In addressing this narrative *please specify if this provision was not applicable because State did not fund religious providers. If* the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: *Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Although the SASD utilizes State funds to contract with faith-based providers, we 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.

During SFY 2008 – 2009 the SASD contracted with three faith-based programs – Rapha Ministries, Inc., Etowah County (Region 1); New Centurions, Etowah County (Region 1); and The Shoulder, Baldwin County (Region 4). Although these contracts were supported 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 requirement and delineate reporting requirements for referrals.

During SFY 2009 -2010 the SASD contracted 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.

Each of the contracted faith-based programs continues to follow their internal procedure, which is in compliance with Charitable Choice requirements, by informing each client of the faith-based nature of the program. Reports from the programs indicate that during SFY 2009-2010, no clients requested transfers based on opposition to the faith-based nature of the programs.

Charitable Choice (formerly Attachment I)

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 Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2010) 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.

Waivers (formerly 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.

Waivers

Waivers

If the State proposes to request a waiver at this time for one or more of the 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 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 10/1/2008 To: 9/30/2009

	Source of Funds					
Activity	**A. SAPT Block Grant FY 2008 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	$ 16,637,413	$ 2,611,732	$ 101,686	$ 11,372,223	$	$
Primary Prevention	$ 4,753,547		$ 2,207,294	$	$	$
Tuberculosis Services	$	$	$	$	$	$
HIV Early Intervention Services	$ 1,188,387	$	$	$	$	$
Administration: Excluding Program/Provider	$ 1,188,386		$	$ 737,132	$	$
Column Total	**$23,767,733**	**$2,611,732**	**$2,308,980**	**$12,109,355**	**$0**	**$0**

***Prevention other than Primary Prevention**

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 270,979	$	$	$	$
Education	$ 1,247,623	$	$	$	$
Alternatives	$ 921,201	$	$	$	$
Problem Identification & Referral	$	$	$	$	$
Community Based Process	$	$	$	$	$
Environmental	$ 2,313,744	$	$	$	$
Other	$	$	$	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$4,753,547**	**$0**	**$0**	**$0**	**$0**

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 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 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
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)	$845,936	$1,939,591	$763,931	$159,248	$373,328
0002	AL300037	Statewide (optional)	$510,723	$1,562,330	$393,970	$242,248	
0004	AL750041	Statewide (optional)	$11,945	$178,289	$0	$0	$0
0005	AL900547	Region 2	$83,203	$0	$0	$252,270	$0
0006	AL750561	Region 4	$86,531	$217,624	$0	$122,661	$0
0007	AL900091	Region 2	$103,171	$536,240	$121,184	$219,195	$0
0008	AL302108	Region 3	$60,068	$357,543	$151,027	$59,585	$106,912
0009	AL900109	Region 2	$17,272	$231,332	$0	$0	$0
0010	AL900604	Region 3	$1,041,769	$874,262	$0	$0	$121,082
0011	AL750157	Statewide (optional)	$12,814	$239,863	$0	$0	$0
0012	AL900570	Region 1	$17,272	$95,806	$0	$177,435	$0
0013	AL750272	Statewide (optional)	$14,104	$0	$0	$246,854	$0
0014	AL900620	Region 2	$132,688	$553,547	$0	$72,829	$64,808
0015	AL900554	Statewide (optional)	$29,712	$68,309	$0	$0	$0
0016	AL750090	Region 2	$84,883	$118,869	$0	$201,057	$0
0017	AL901362	Region 4	$60,407	$793,984	$0	$0	$0
0018	AL100551	Region 1	$93,213	$0	$0	$494,940	$0
0019	AL900612	Region 3	$32,234	$400,610	$137,116	$231,576	$0
0020	AL302371	Region 3	$8,312	$77,187	$0	$29,202	$4,624
0021	AL100106	Region 2	$6,143	$0	$0	$188,473	$0
0022	AL750058	Region 2	$296,402	$1,007,502	$0	$0	$0
0023	AL100502	Region 4	$2,461	$0	$0	$62,090	$0
0024	AL750074	Region 2	$64,217	$162,137	$0	$103,548	$0
0025	AL900737	Region 1	$277,564	$198,844	$0	$336,095	$14,053
0026	AL301407	Region 3	$79,405	$453,520	$134,948	$55,402	$89,752
0027	AL900588	Region 3	$18,726	$185,197	$0	$0	$0
0028	AL900786	Region 1	$107,104	$610,485	$0	$128,514	$0

0029	AL901206	Region 4	$226,529	$455,975	$131,077	$0	$205,706
0030	AL100429	Region 2	$76,617	$143,467	$0	$163,578	$0
0031	AL750512	Region 1	$0	$0	$0	$0	$0
0032	AL900117	Region 1	$75,122	$441,257	$215,409	$222,614	$0
0033	AL750199	Region 2	$495,002	$235,742	$0	$148,199	$0
0034	AL900653	Region 1	$114,234	$71,835	$0	$0	$0
0035	AL750371	Region 2	$154,118	$316,731	$0	$0	$0
0036	AL900778	Region 1	$54,226	$641,533	$180,765	$181,258	$0
0037	AL750140	Region 4	$56,289	$450,624	$0	$0	$0
0038	AL900513	Region 4	$37,103	$281,312	$95,332	$57,917	$0
0039	AL750082	Region 2	$26,730	$192,067	$0	$0	$0
0040	AL302330	Region 1	$2,001,779	$625,746	$0	$0	$0
0041	AL100049	Region 2	$345,142	$656,311	$131,890	$220,833	$208,120
0042	AL900687	Region 3	$21,351	$55,245	$0	$50,634	$0
0043	AL750124	Region 4	$326,592	$828,950	$0	$208,920	$0
0044	AL100668	Region 1	$150,224	$242,084	$99,756	$0	$0
0051	X	Statewide (optional)	$30,057	$0	$0	$0	$0
0053	X	Statewide (optional)	$737,132	$0	$0	$0	$0
0056	X	Statewide (optional)	$49,075	$0	$0	$0	$0
0057	X	Region 3	$1,748,923	$0	$0	$0	$0
0058	X	Region 2	$84,458	$0	$0	$0	$0
0059	X	Region 2	$3,287	$30,000	$0	$0	$0
0064	X	Region 3	$50,000	$0	$0	$0	$0
0065	X	Region 3	$0	$0	$0	$0	$0
0066	X	Region 4	$86,741	$2,281	$0	$0	$0
0067	X	Region 3	$1,265	$0	$0	$31,635	$0
0068	X	Region 1	$239,440	$0	$0	$0	$0
0069	X	Region 3	$0	$0	$0	$0	$0
0070	X	Region 1	$0	$0	$0	$0	$0
0071	X	Region 1	$0	$0	$0	$0	$0
0072	X	Statewide (optional)	$0	$0	$0	$0	$0
0073	X	Statewide (optional)	$256,795				
0074	X	Region 2	$16,632				
0075	X	Region 2	$37,136				
0076	X	Region 2	$2,159				
0077	X	Region 1	$41,347				
0078	X	Region 4	$2,333				
0079	X	Region 2	$20,549				
0080	X	Region 2	$35,978				
0081	X	Region 4	$43,150				
0101	X	Region 1	$1,000	$9,893	$0	$0	$0
00SC	X	Region 4	$328,900	$0	$0	$0	$0
0ABC	X	Statewide (optional)	$0	$0	$0	$0	$0

cmha	X	Region 1	$33,662	$93,289	$0	$84,736	$0
Totals:			**$12,109,356**	**$16,637,413**	**$2,556,405**	**$4,753,546**	**$1,188,385**

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
		Colonial Management Group

0073	Colonial Management Group	14050 Town Loop Blvd. Suite 204 Orlando, FL 32827
0074	Northwest Alabama Treatment Center	Northwest Alabama Treatment Center Bessemer, AL 35021
0075	Shelby County Treatment Center	750 Highway 31 South Alabaster, AL 35007
0076	Walker Recovery Center	2195 North Airport Road Jasper, AL 35501
0077	Family Life Center	2070 County Road 280 Fort Payne, AL 35967
0078	Insight Treatment Program	1111 East I-65 Service Rd South Suite A-7 Mobile, AL 36606
0079	Marwin Counseling Services	PO Box 1576 1065 US Highway 43 Winfield, AL 35594
0080	New Pathways, LLC	1508 Bunt Drive Pell City , AL 35125
0081	The Shoulder	7400 Roper Lane Daphne, AL 36526
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 9a (formerly 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, meetings, seminars [7]	6
	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

	]	15
	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
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 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 10/1/2008 To: 9/30/2009

	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	1011	834	$ 638.96	$ 508	$ 250.51
Rehabilitation / Residential					
Hospital Inpatient			$	$	$
Short-term (up to 30 days)	3435	3169	$ 1334.51	$ 1110	$ 650.87
Long-term (over 30 days)	1602	1490	$ 2969.44	$ 2150	$ 3212.98
Ambulatory (Outpatient)					
Outpatient			$	$	$
Intensive Outpatient	16554	16554	$ 757.22	$ 253.50	$ 1061.40
Detoxification			$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	250	250	$ 735	$ 545	$ 451.44

Form 10b (formerly 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	2,256	891	395	791	136	1	0	0	3	5	3	10	9	10	2	1,683	537	25	11
2. 18-24	4,190	1,685	980	1,171	295	1	2	4	2	7	8	13	5	15	2	2,858	1,285	38	9
3. 25-44	11,242	4,015	2,675	3,351	1,069	1	0	17	7	24	12	21	6	35	9	7,375	3,749	89	29
4. 45-64	6,903	1,269	504	1,412	3,675	0	1	5	2	12	6	3	0	10	4	2,694	4,189	17	3
5. 65 and over	327	52	6	35	4	3	3	23	11	46	6	47	20	54	17	260	67	0	0
6. Total	24,918	7,912	4,560	6,760	5,179	6	6	49	25	94	35	94	40	124	34	14,870	9,827	169	52
7. Pregnant Women	240		159		71		0		0		4		6		0		235		5

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. 3,546

Numbers of Persons Served outside of the levels of care described in Form 10a. 0

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)).

Alabama
Description of Calculations

If revisions or changes are necessary to prior year's 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 for 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 at $92,200 in 1992. Aletheia House, Inc., NFR ID # 300037, expended $92,200 for services to pregnant women or women with dependent children during 1992. As per Section 1922 of the Block Grant, five percent of the FFY 1993 Block Grant was identified for services to pregnant women and women with dependent children. The FFY 1993 Block 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 Block Grant amount was $13,083,374 X .05 = $654,168.70. Adding $712,121.90 from FFY 1993 and $654,168.70 from FFY 1994 established a MOE base of $1,366,290.60 for FFY 1994 and subsequent fiscal years.

The following expenditures have been reported for treatment services provided to pregnant women and women with dependent children.

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

SFY 2009	2,556,405.00
SFY 2010	2,960,087.00*

* Estimated expenditures

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 MOE base for tuberculosis services provided to substance abuse clients, the SASD coordinated with the Alabama Department of Public Health. 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 MOE base was established by multiplying the Department of Public Health's budget (100% State funding) by the estimated 6% for SFY 1992, yielding a MOE base of $148,200.

The following expenditures have been reported for TB services related to the SAPT BG MOE.

Public Health

FFY	TB Expenditures	X .06	SA Exp. +	Adol. Assess.	Total
1991	2,470,000	148,200	0	148,200	
1992	2,470,000	148,200	0	148,200	
1993	2,880,000	172,800	0	172,800	
1994	2,600,000	156,000	0	156,000	
1995	2,600,000	156,000	0	156,000	
1996	2,675,905	160,554	0	160,554	
1997	2,739,148	164,348	0	164,348	
1998	2,740,997	164,459	0	164,459	
1999	1,400,665	84,039	130,537	214,576	
2000	1,552,233	93,134	140,560	233,694	
2001	1,827,974	109,678	147,760	257,438	
2002	2,012,030	120,721	147,640	268,361	
2003	1,767,116	106,026	132,905	238,931	
2004	2,609,454	156,567	128,987	284,987	
2005	2,450,783	147,046	144,815	291,861	
2006	2,873.796	172,427	118,795	246,440	
2007	2,159,415	129,564	88,219	217,784	
2008	2,119,052	127,143	246,734	373,877	
2009	2,147,343	128,840	162,177	291,017	
2010	2,016,201	120,972	206,334	327,006*	

* Estimated expenditures

The MOE for Special Women and TB was researched and verified through a Center for Substance Abuse Treatment (CSAT) sponsored technical assistance, “Validating compliance with SAPT Block Grant Maintenance of Effort Requirements” conducted by Mr. Jeffery A Hunter. Mr. Hunter’s findings were reported in February 2006 (Contract No. 270-99-7070) (Description of Calculations-Attachment #1). In accordance with Mr. Hunter’s recommendation #1, on page #5 of his report, the SASD is requesting CSAT to accept the calculation and reported expenditures.

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 2008 (1)	**$11,190,776**	**$13,547,285**
SFY 2009 (2)	**$15,903,793**	
SFY 2010 (3)	$ 14,757,045	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2008 (•) Yes ( ) No
FY 2009 (•) Yes ( ) No
FY 2010 ( ) Yes (•) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy): 1/31/2011

The MOE for State fiscal year(SFY) 2010 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 2010 (3)	$ 2,016,201	16.218910 %	$ 327,006

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 2010 (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**	
2008		**$2,252,822**
2009		**$2,556,405**
2010		$ 2,556,405

Enter the amount the State plans to expend in FY 2011 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

Form T1

Most recent year for which data are available	From: 10/1/2009 To: 9/30/2010

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]	2320	2573
Total number of clients with non-missing values on employment\student status [denominator]	6797	6797
Percent of clients employed (full-time and part-time)	34.13%	37.85%

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: 10/1/2009 To: 9/30/2010

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]	5350	5642
Total number of clients with non-missing values on living arrangements [denominator]	6756	6756
Percent of clients in stable living situation	79.19%	83.51%

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
    - [ ] 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)

	☑ 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: 10/1/2009 To: 9/30/2010

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]	4103	4969
Total number of clients with non-missing values on arrests [denominator]	5130	5130
Percent of clients without arrests	79.98%	96.86%

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
  - [ ] 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)

	☑ 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: 10/1/2009 To: 9/30/2010

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]	1316	2028
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	3584	3584
Percent of clients abstinent from alcohol	36.72%	56.58%

(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)** ☑ Client Self Report Client self-report confirmed by another source: ☐ urinalysis,blood test or other biological assay ☐ Collateral source ☐ 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 ☑ 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)** ☑ 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: 10/1/2009 To: 9/30/2010

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]	1617	2564
Total number of clients with non-missing values on "used any drug" variable [denominator]	4656	4656
Percent of clients abstinent from drugs	34.73%	55.07%
(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)** ☑ Client Self Report Client self-report confirmed by another source: ☐ urinalysis,blood test or other biological assay ☐ Collateral source ☐ 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 ☑ 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)** ☑ 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: 10/1/2009 To: 9/30/2010

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]	437	2262
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	3309	3309
Percent of clients participating in social support activities	13.21%	68.36%

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
    - [ ] 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)

	☑ 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 self-help participation status 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: 10/1/2009 To: 9/30/2010

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	6	5	3-7
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	67	28	21-29
5. Long-term (over 30 days)	75	66	30-93
Ambulatory (Outpatient)			
6. Outpatient	152	119	55.75-216.25
7. Intensive Outpatient	174	114	54-207
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	1299	1299	942.75-1654.25

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?

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.

The Alabama Substance Abuse Information System (ASAIS) has increased the capacity of the Alabama Department of Mental Health/Substance Abuse Services Division's capacity to make data driven decisions. Since its implementation on June 1, 2008, we have been able to construct a complete picture of the population served by our contractors and what services are delivered. The system has also provided the necessary support and data collection to be able to implement the ASAM levels of care. We have the ability to provide feedback to providers of the outcome data they are reporting to the state. We also have the ability to report to staff on the recipients of services through the division. Barriers related to taking action based on the data provided include historical funding mechanisms based on population, not performance and a focus on availability of services as opposed to quality of services. We continue to work to overcome these barriers through education about the difference quality services can make in the lives of Alabama citizens, utilizing the data from ASAIS and other sources.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

A weekly waiting list report is distributed to key staff in the Alabama SASD, as part of our process to ensure that priority populations are being treated as priority by our programs and that we don't allow clients to fall through the cracks. We also generate semi-monthly payments and service reports for each provider to allow for constant monitoring.

There are a variety of ad hoc reports available to be generated by provider-level or SSA level users regarding the demographics of people served, the types of services received and services provided by level of care. These reports can also be utilized to clean data that may be incorrectly entered into the system. This cleaning is conducted by provider-level and SSA-level users.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

We currently do not set benchmarks, performance targets or quantified objectives for treatment services, but have the infrastructure in place to set values when it is deemed appropriate.

What actions does the State take as a result of analyzing performance management data?

The SASD makes decisions about training and technical assistance needs based, in part, on the service provision that is evident from our reporting system. The SASD also makes decisions about allocation of

funds based on past expenditures, as well as ongoing monitoring of contract expenditures throughout the year.

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.

We are currently developing a comprehensive training program that will include hands-on and online training opportunities for new staff and refresher courses for current users. In the past, we have offered annual training for all users of the system.

Do workforce development plans address NOMs implementation and performance-based management practices?

Workforce development plans do not currently address NOMS implementation, but performance-based management practices are a part of workforce development efforts and we continually seek out resources that will assist staff and providers in implementing performance-based practices in the substance abuse delivery system.

Does the State require providers to supply information about the intensity or number of services received?

We do collect information about the number of units of each service and enrollment and discharge dates that allow us to determine intensity by client and by level of care.

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 18+ - CY 2008	41.60	
		Ages 12–17 - CY 2008	12.90	
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 - CY 2008	12.30	
		Ages 18+ - CY 2008	29	
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 18+ - CY 2008	10	
		Ages 12–17 - CY 2008	7.40	
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 - CY 2008	4.30	
		Ages 18+ - CY 2008	4.30	
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 - CY 2008	4.80	
		Ages 18+ - CY 2008	3.50	

((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 18+ - CY 2008	80.70	
		Ages 12–17 - CY 2008	77.80	
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 - CY 2008	87.70	
		Ages 18+ - CY 2008	92.50	
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 18+ - CY 2008	79.70	
		Ages 12–17 - CY 2008	83.80	

((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 - CY 2008	12.80	
		Ages 18+ - CY 2008	18.20	
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 18+ - CY 2008	15.60	
		Ages 12–17 - CY 2008	12	
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 18+ - CY 2008	17.70	
		Ages 12–17 - CY 2008	12.50	
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 - CY 2008	13.50	
		Ages 18+ - CY 2008	18.80	
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 18+ - CY 2008	21.50	
		Ages 12–17 - CY 2008	12.90	

((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 - CY 2008	87.80	
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 - CY 2008	82.20	
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 - CY 2008	85.70	
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 - CY 2008	85.30	
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 - CY 2008	85.10	

((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 18+ - CY 2008	50.90	
		Ages 15–17 - CY 2008	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((s))	

((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.	CY 2008	96.10	

((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.	CY 2008	38	

((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.	CY 2008	116.40	

((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 - CY 2008	54.80	
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+ - CY 2008	93.70	

((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 - CY 2008	87.20	

((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.

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2009	9/30/2010
Form P12b Population-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2009	9/30/2010
Form P13 (Optional) Number of Persons Served by Type of Intervention	10/1/2009	9/30/2010
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	10/1/2009	9/30/2010
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	10/1/2009	9/30/2010

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.

Category	Description	Total Served
A. Age	1. 0-4	774
	2. 5-11	16219
	3. 12-14	9317
	4. 15-17	1658
	5. 18-20	291
	6. 21-24	30
	7.25-44	359
	8. 45-64	171
	9. 65 And Over	20
	10. Age Not Known	46
B. Gender	Male	15136
	Female	14031
C. Race	White	14871
	Black or African American	12847
	Native Hawaiian/Other Pacific Islander	40
	Asian	88
	American indian/Alaska Native	37
	More Than One Race (not OMB required)	728
	Race Not Known or Other (not OMB required)	343
D. Ethnicity	Hispanic or Latino	1004
	Not Hispanic or Latino	27950

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	27247
	2. 5-11	63448
	3. 12-14	72043
	4. 15-17	63640
	5. 18-20	21005
	6. 21-24	28006
	7.25-44	176082
	8. 45-64	164339
	9. 65 And Over	245969
	10. Age Not Known	484680
B. Gender	Male	417917
	Female	396923
	Gender Unknown	413182
C. Race	White	663939
	Black or African American	254160
	Native Hawaiian/Other Pacific Islander	282
	Asian	102851
	American indian/Alaska Native	5960
	More Than One Race (not OMB required)	7571
	Race Not Known or Other (not OMB required)	357206
D. Ethnicity	Hispanic or Latino	17736
	Not Hispanic or Latino	1374233
	Ethnicity Unknown	

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	29888	N/A
2. Universal Indirect	N/A	1357784
3. Selective	894	N/A
4. Indicated	330	N/A
5. Total	31112	1357784

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 theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders 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	69	45		7	5	
2. Total number of Programs and Strategies Funded	72	50		7	5	
3. Percent of Evidence-Based Programs and Strategies	95.83%	90.00%	NaN	100.00%	100.00%	NaN

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	43	$ 2028165.06
2. Universal Indirect	51	$ 169911533.50
3. Selective	7	$ 226084.25
4. Indicated	4	$ 34088
5. Totals	105	$172,199,870.81

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 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 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 2008 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 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2008 Program/Strategy Name Universal Direct	**FFY 2008 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2008 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2008 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 2008 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.

Attachment A, Goal 2: 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)

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

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?
Motor vehicle drivers under age 21?

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

Communities:

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

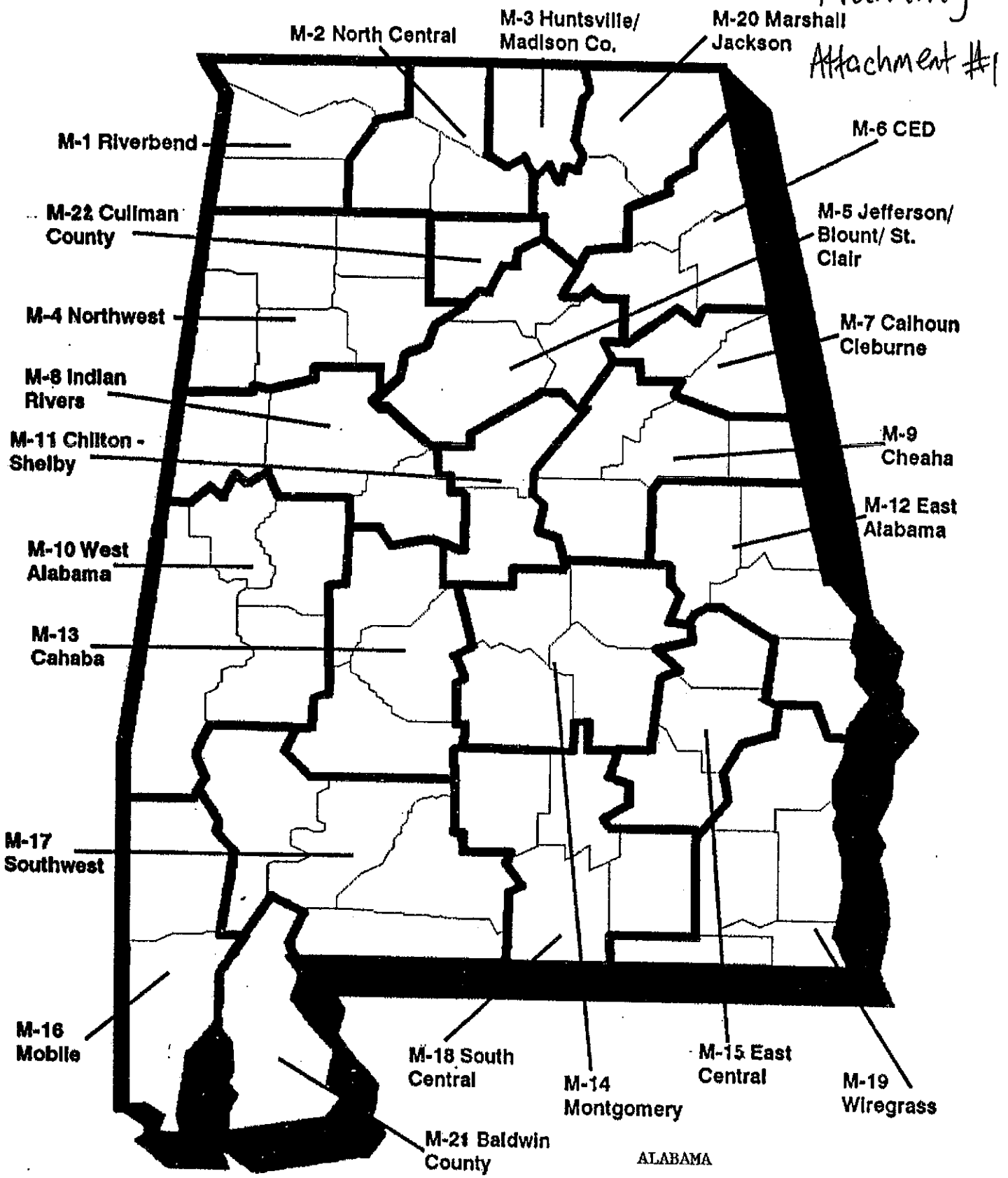
Appendix A - Additional Supporting Documents (Optional)

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.

Planning

Attachment #1



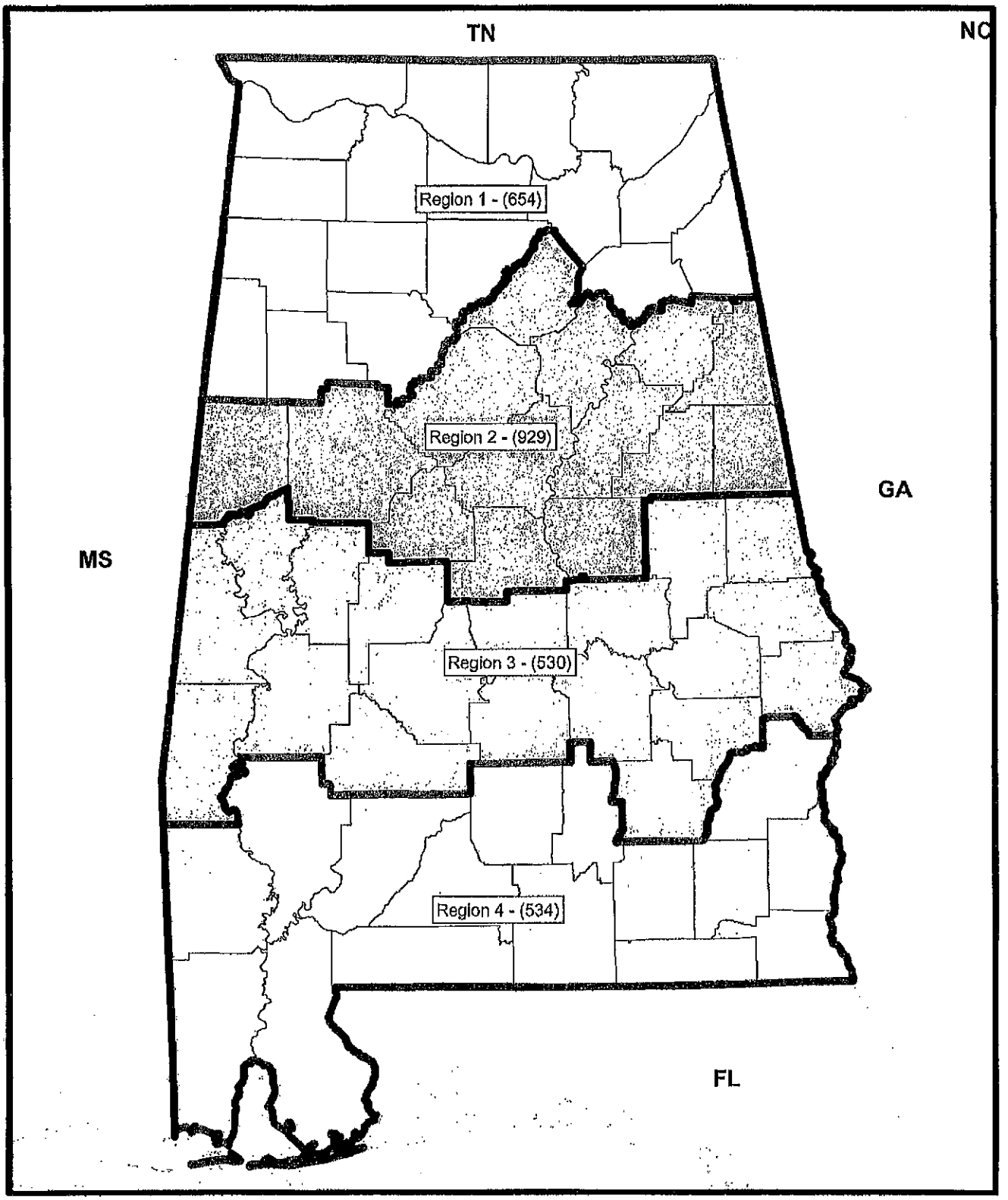
ALABAMA

310 BOARD CATCHMENT AREAS

Planning 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	

Planning
Attachment #3

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.

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.

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.

Summary of Responses
Questionnaire Regarding SA Division – Adult Service Priorities

The DMH Office of Policy and Planning helps divisions and stakeholders identify priorities to submit to the Governor's Executive Planning Office via the SMART Operational Plan. Assistance is provided by facilitating meetings, encouraging family and individual participation in a planning process, gathering data relevant to planning, and distributing measures for identified priority areas. In the fall of 2009, local meetings were facilitated to gather community input on division priorities, discuss the significance of forecasted budgets, and identify needs and concerns. Local meeting summaries were distributed, accompanied by a questionnaire for those who indicated further interest in the planning process.

Below is a summary of the information collected through the questionnaire. It can be used along with quarterly reports and division planning activities to identify improvements to the FY 2011 Operational Plan. Any updates to the FY Operational Plan will be submitted in September 2010. Thank you for your investment in prioritizing Department of Mental Health services.

Number of surveys distributed – 130
Number of surveys completed – 18

Current Priorities – FY 2010 Operational Plan

Current Goals	Response Options	# of Total Responses (including family/consumers)	% of Total Responses (including family/consumers)	# of family/consumers Responses by themselves	% of family/consumers Responses by themselves
Provide prevention, treatment, and recovery supports for adults in all 67 counties.	"should remain a priority" or "should remain a top 3 priority"	10	59%	2	100%
	"there may be bigger priorities" or "no longer a priority"	7	41%	0	N/A
Measure/report national outcome measures for substance abuse	"should remain a priority" or "should remain a top 3 priority"	10	59%	2	100%
	"there may be bigger priorities" or "no longer a priority"	7	41%	0	N/A

First Choice for Future Priorities – FY 2011

Recommended 1st Priority for future plans	Total # choosing as #1 priority (including families/consumers)	Total # choosing as a #1 priority (including families/consumers)	Total # of Families/Consumers choosing as #1 priority	Total % of Families/Consumers choosing as #1 priority
Provide prevention, treatment, and recovery supports for adults in all 67 counties. (current goal)	4	25%	0	N/A
Expand the availability of co-occurring services for individuals with substance abuse and mental illness.	3	19%		
Create additional residential services for adult substance abuse services.	3	19%	0	N/A
Expand the number of detox programs available	2	12.5%	0	N/A
Identify ways to reduce the length of time individuals wait for substance abuse services.	2	12.5%	0	N/A
Improve access to appropriate affordable, accessible supported housing options for adults.	1	6%	0	N/A
Identify transportation resources for individuals receiving substance abuse services.	1	6%	0	N/A
Measure ten national outcome measures for substance abuse. (current goal)	0	N/A	0	N/A
Increase communication, education, and advocacy regarding substance abuse service needs.	0	N/A	0	N/A
Improve the availability of services to drug courts. They need appropriate programs to send referrals.	0	N/A	0	N/A
Create additional IOP services for adult substance abuse services.	0	N/A	0	N/A

Based on the results of this sampling, the group at large (and families and consumers when responses are separated,) suggested that expanding co-occurring services to provide for needs of individuals with substance abuse and mental illness is a common first priority. However, the group at large identified providing prevention, treatment, and recovery supports for adults in all 67 counties as their highest ranked first priority. This is consistent with support indicated by these groups for the current goal (see previous page.) The highlighted areas show the highest ranked items for first priority in each grouping.

Second Choice for Future Priorities – FY 2011

Recommended 1st Priority for future plans	Total # choosing as #1 priority (including families/consumers)	Total # choosing as a #1 priority (including families/consumers)	Total # of Families/Consumers choosing as #1 priority	Total % of Families/Consumers choosing as #1 priority
Create additional residential services for adult substance abuse services.	3	19%		
Expand the availability of co-occurring services for individuals with substance abuse and mental illness.	3	19%	0	N/A
Improve access to appropriate affordable, accessible supported housing options for adults.	2	12.5%	0	N/A
Increase communication, education, and advocacy regarding substance abuse service needs.	2	12.5%	0	N/A
Improve the availability of services to drug courts. They need appropriate programs to send referrals.	2	12.5%	0	N/A
Measure ten national outcome measures for substance abuse. (current goal)	1	6%	0	N/A
Expand the number of detox programs available	1	6%	0	N/A
Create additional IOP services for adult substance abuse services.	1	6%	0	N/A
Identify ways to reduce the length of time individuals wait for substance abuse services.	1	6%	0	N/A
Provide prevention, treatment, and recovery supports for adults in all 67 counties. (current goal)	0	N/A	0	N/A
Identify transportation resources for individuals receiving substance abuse services.	0	N/A	0	N/A

Based on the results of this sampling, the group at large (and families and consumers when separated,) suggested that creating additional residential services for adult substance abuse services was their highest second priority. The group at large identified expanding co-occurring services to provide for needs of individuals with substance abuse and mental illness as an equally ranked second priority, which was also their second highest ranked first priority. This was also families and consumers highest ranked first priority. Family and consumers highest ranked second priority, expanding the availability of co-occurring services for individuals with substance abuse and mental illness matches the group at large as the highest ranked first priority.

It appears through the small sampling of questionnaire responses given, that two common elements between all responders and the family or consumer who responded are:

- Availability of co-occurring services
- Increased adult residential services

The summary of the questionnaire is a tool to use as the division's stakeholders make recommendations for revision to the Department of Mental Health FY 2011 Operational Plan. These items may support current goals, may be strategies to address current goals, or may be new goals to consider.

Planning Attachment #4

FY 11 SMART Operations Plan
Agency Level Summary

Program / Activity Level

Agency:	**061 - Mental Health, Department of**	**Program:**	**425 - SUBSTANCE ABUSE PROGRAM**
Organization:	-	**Activity:**	-
Mission:	To provide substance abuse services for the people of Alabama		
Statutory Cite:	1975 Alabama Code 22-50-1 to 22-50-91.		

Workload Measures and Quarterly Projections

	First Quarter		Second Quarter		Third Quarter		Fourth Quarter		Annual	
Workload Measure	**Projected**	**Actual ***	**Projected**	**Actual ***	**Projected**	**Actual ***	**Projected**	**Actual ***	**Projected**	**Actual ***
W1: Number of unduplicated people receiving substance abuse treatment services	8700		5100		5100		5100		24000	
W2: Number of participants receiving substance abuse prevention services	25000		25000		25000		25000		100000	
W3: Number of adolescents at residential treatment facilities who go to school on-site	135		105		105		105		450	
W4: The number of SA residential female bed days paid through state funds.	16400		16400		16400		16400		65600	

* Actual workload data is not currently available for this quarter.

Resource History	FY 11 Requested	FY 11 Budgeted
TOTAL APPROPRIATION	$63,416,766.00	$43,934,660.00
TOTAL FTE	2.00	2.00

FY 11 SMART Operations Plan
Agency Level Summary

Agency: 061 - Mental Health, Department of	Program: 425 - SUBSTANCE ABUSE PROGRAM
Organization: -	Activity: -

Key Goal:			
Goal 1	**By 2015, a continuum of outcome supported prevention, treatment, and recovery ~~substance abuse~~ support services for adults will be available in all 67 counties.**	**Governor's Priority:**	5

Strategies:	
Strategy 1:	Develop and implement rate models for substance abuse services delivery that reflect sufficient support for services based on a validated rate study.
Strategy 2:	Implement standards that will establish supported levels of care throughout the State of Alabama.
Strategy 3:	Expand service offerings through contracts with local providers to support implementation of levels of care.

Objectives and Quarterly Targets:

Performance Measures		First Quarter		Second Quarter		Third Quarter		Fourth Quarter		Annual	
Objectives	**Unit of Measure**	**Target**	**Actual ***	**Target**	**Actual ***	**Target**	**Actual ***	**Target**	**Actual ***	**Target**	**Actual ***
(O1-Efficiency) The number of counties offering Intensive Outpatient Treatment will increase by 5 counties each year over FY 2010 baseline of 47.	# of counties with adult IOP services	47		47		50		52		52	
(O2-Quality) At least 50% of all ASAM levels of care service codes for adults will be utilized for contract billed services during FY 2011.	percent of all standard codes that are billed for in the state	.20		.30		.40		.50		.50	
(O3-Efficiency) The number of substance abuse service delivery regions that have an available residential detoxification and outpatient detoxification program will increase by 1 region from the FY 2010 baseline of 1 region. (4 regions expected by 2015)	Number of regions with detox program	--		--		--		--		2	
(O4-Efficiency) The number of certified residential treatment beds for females with substance related disorders (through publicly funded providers) will be increased by 25% above the FY 2010 level of 284.	number of certified women's beds.	284		305		330		355		355	

* Actual performance data is not currently available for this quarter.

Critical Issues (Optional)		Category	Critical Issues Strategies
External CI1	The demand for substance abuse services continues to outweigh the availability of services.	Other	See strategies above.

FY 11 SMART Operations Plan
Agency Level Summary

Agency: 061 - Mental Health, Department of	Program: 425 - SUBSTANCE ABUSE PROGRAM
Organization: -	Activity: -

Key Goal:			
Goal 2	By ~~2012~~ 2015, a continuum of outcome supported prevention, treatment, and recovery ~~substance abuse~~ support services for children and adolescents will be available in all 67 counties.	Governor's Priority:	5

Strategies:	
Strategy 1:	Develop and implement rate models for substance abuse services delivery that reflect sufficient support for services based on a validated rate study.
Strategy 2:	Implement standards that will establish supported levels of care throughout the State of Alabama.
Strategy 3:	Expand service offerings through contracts with local providers to support implementation of levels of care.

Objectives and Quarterly Targets:

Performance Measures		First Quarter		Second Quarter		Third Quarter		Fourth Quarter		Annual	
Objectives	Unit of Measure	Target	Actual *	Target	Actual *	Target	Actual *	Target	Actual *	Target	Actual *
(O1-Efficiency) The number of counties with community based prevention programs will increase by 9 each year from FY 2010 baseline of 31 counties.	# of counties with publicly funded prevention prog	31		33		37		40		40	
(O2-Efficiency) At least 50% of all ASAM levels of care service codes for children and adolescents will be utilized for contract billed services during FY 2011.	percent of adolescent billing codes used	.20		.30		.40		.50		.5	
(O3-Efficiency) The number of counties offering publicly funded adolescent outpatient services will increase by 9 each year over the FY 2010 baseline of 25.	number of c&a outpatient counties	25		27		31		34		34	
(O4-Efficiency) One child and adolescent non-detention residential program with continuing care services will be added to the FY 2010 baseline of 2 child and adolescent non-detention residential programs. (total of 4 by the end of 2015)	Number of C&A residential group homes	--		--		--		--		3	

* Actual performance data is not currently available for this quarter.

FY 11 SMART Operations Plan
Agency Level Summary

Critical Issues (Optional)		Category	Critical Issues Strategies
External CI1	The demand for substance abuse services continues to outweigh the availability of services.	Other	See strategies above.

FY 11 SMART Operations Plan
Agency Level Summary

Agency: 061 - Mental Health, Department of	Program: 425 - SUBSTANCE ABUSE PROGRAM
Organization: -	Activity: -

Key Goal:			
Goal 3	By ~~2012~~ 2015, prevention and treatment outcomes will be measured using the ten national outcome measures for substance abuse.	Governor's Priority:	2

Strategies:	
Strategy 1:	The National Outcome Measures will be included in the Alabama Substance Abuse Information system (ASAIS). Provider participation in ASAIS will be contractually required.

Objectives and Quarterly Targets:

Performance Measures		First Quarter		Second Quarter		Third Quarter		Fourth Quarter		Annual	
Objectives	Unit of Measure	Target	Actual *	Target	Actual *	Target	Actual *	Target	Actual *	Target	Actual *
(O1-Efficiency) The percentage of clients reporting employment from admission to discharge will increase by 6% from FY 07 baseline of 12.66%.	% of clients employed from admission to discharge	--		--		--		--		18.66%	
(O2-Efficiency) The percentage of clients arrested from admission to discharge will decrease by 18% from FY 07 baseline of (-.41%).	% clients arrested from admission to discharge	--		--		--		--		-18.41%	
(O3-Efficiency) The percentage of clients reporting abstinence from alcohol from admission to discharge will increase by 16% from the FY 07 baseline of 30%.	% client report alcohol abstinence; admit-dischrg	--		--		--		--		46%	
(O4-Efficiency) The percentage of clients reporting abstinence from illegal drugs from admission to discharge will increase by 9% from FY 07 baseline of 62%.	% client report illeg. drug abstain; admit-dischrg	--		--		--		--		71%	

* Actual performance data is not currently available for this quarter.

FY 11 SMART Operations Plan
Agency Level Summary

	Critical Issues (Optional)	Category	Critical Issues Strategies
External CI1	Recovery from substance abuse addictions can be influenced by factors beyond treatment outcomes.	Other	Continue collecting National Outcome Measures to explore the connection between treatment options and outcomes.

Planning
Attachment #5

Alabama

Planning – Attachment #3: Data Sources

1. Unduplicated numbers of Alabama citizens receiving prevention or treatment services supported by the Alabama Department of Mental Health are reported through the Alabama Substance Abuse Information System (ASAIS).

2. DUI and Other Drug Arrests are reported through the Alabama Criminal Justice Information Center.

3. Hepatitis B cases are reported through the Alabama Public Health Department, Division of Epidemiology.

4. AIDS cases are reported through the Alabama Public Health Department, HIV/AIDS Division.

5. TB cases are reported through the Alabama Public Health Department, TB Control Division.

6. Pride Survey data reflects the responses from a statewide survey of school children conducted during SFY 2009-2010.

7. Waiting list data is collected through the Alabama Department of Mental Health's ASAIS system.

8. NSDUH data was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies (OAS), National Survey on Drug Use and Health, 2002-2008. At Alabama's request, OAS compiled surveys conducted from 2002 through 2008 so that the combined responses would allow for analysis at the Mental Health Catchment Area level.

9. County profile data was provided through the Alabama Substance Abuse Data Book 2003: State and County Profiles of Substance Abuse Indicators.

Goal #1
Attachment #1

DEPARTMENT
OF
MENTAL HEALTH/MENTAL RETARDATION

SUBSTANCE ABUSE SERVICES DIVISION

CONTRACT BILLING MANUAL

EFFECTIVE
OCTOBER 1, 2002

TABLE OF CONTENT

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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.**

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. **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

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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

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.

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.

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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

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.

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.

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).

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.

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.

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.

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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.

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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.

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.

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.

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.

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.

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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.

(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

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.

SERVICE RATES
FY 08 -09 (INCLUDES 2.8% INCREASE)

Goal #1

Attachment #3

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 # 13
Attachment # 1

ALABAMA EPIDEMIOLOGICAL OUTCOMES WORKGROUP

CHARTER

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 (DMH) 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'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 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. Provide ongoing surveillance, assessment, and analysis of the consumption and consequences of ATOD use throughout the State of Alabama.

2. 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.

3. Monitor state and community ATOD data needs and assist in the development of strategies to address those needs.

4. 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.

5. Facilitate the utilization of ATOD consumption and consequence data by community organizations throughout the state for prevention planning efforts.

E. ACTIVITIES

The AEOW will implement the following activities to accomplish its stated objectives:

1. Maintain an adequate membership base to support its mission.

2. Develop and maintain operational and reporting procedures for continued assessment, surveillance, analysis, and reporting of ATOD use/abuse and related problems throughout Alabama.

3. Identify ATOD consumption and consequence variables and the quality and validity of the data sources.

4. Collect and analyze qualitative and quantitative ATOD data.

5. Update the annual State Epidemiological Profile that provides a description of the burden of substance abuse in the State of Alabama, including patterns of ATOD use, emerging trends, sub-group differences, and social and health consequences.

6. Develop and disseminate periodic reports on emerging ATOD use patterns and consequences.

7. Establish priorities and parameters for ATOD needs assessments. Assist in conducting statewide and community needs assessments.

8. Collaborate with community organizations and provide technical assistance and support for local ATOD prevention planning efforts.

9. Serve as a resource for each ACPTSA member agency to encourage and support the use of ATOD epidemiological data in the development and implementation of related public policy and funding strategies.

10. Submit timely reports of work, findings, and progress to DMH, SAMHSA, ACPTSA, and the Governor's Office.

11. Establish collaborative partnerships with state and local universities and colleges to encourage the study, collection, and use of ATOD epidemiological information.

12. Comply with all state and federal reporting requirements.

F. COMPOSITION AND TERMS OF MEMBERSHIP

The AEOW shall be composed of a maximum of 35 organizational and individual members as follows:

1. Each ACPTSA member agency will have the opportunity to appoint an organizational representative to the AEOW, who shall be selected on the basis of recognized data competence and interest in ATOD epidemiology. Appointing state and community organizations include:

    - Administrative Office of Courts;
    - Alabama Alcohol and Drug Association;
    - Alabama Association of Addiction Counselors;
    - Alabama Council of Community Mental Health Boards;
    - Alabama Faces and Voices of Recovery;
    - Alcoholic Beverage Control Board;
    - Board of Pardons and Paroles;
    - Department of Children's Affairs;
    - Department of Corrections;
    - Department of Economic and Community Affairs;
    - Department of Education;
    - Department of Human Resources;
    - DMH Division of Mental Illness;
    - DMH Division of Mental Retardation;
    - Department of Public Health;
    - Department of Public Safety;
    - Department of Rehabilitation;
    - Department of Senior Services;
    - Department of Youth Services;
    - Governor's Office of Faith-Based and Community Initiatives;
    - Medicaid Agency;
    - Office of the Attorney General;
    - Office of the Governor;
    - State House of Representatives; and the
    - State Senate.

2. DMH's Substance Abuse Services Division will appoint the following employees as members of the AEOW:

    - Director of Prevention Services/NPN;
    - Director of Treatment Services/NTN;
    - Director of Information Services;
    - Epidemiologist;
    - Executive Assistant to the Associate Commissioner; and
    - Mental Health Specialist, Prevention Services Assistant.

3. The AEOW may invite up to five individuals to serve as members of the workgroup who have distinguished themselves in the field of ATOD or related health services research, statistics, data collection, data analysis, epidemiology, and/or the delivery of health services.

4. Duration of terms of appointment to the AEOW shall be continuous, with the following exceptions:

- A member of the AEOW submits a letter of resignation;
- An appointing agency terminates an appointment; or
- The AEOW terminates a member's appointment due to lack of attendance, cooperative efforts, completion of assigned tasks, or any other behavior which conflicts with the workgroup's mission and responsibilities.

G. OFFICERS

1. Officers of the AEOW shall consist of a Chairperson and a Co-Chairperson. The AEOW Chairperson, as designated by ACPTSA, shall be the Director of Prevention Services/NPN from the Substance Abuse Services Division. During a calendar year that ends in an even number, the Epidemiologist from the Substance Abuse Services Division shall serve as Co-Chairperson. During a calendar year that ends in an odd number, the Co-Chairperson shall be elected during the last quarter of the preceding calendar year by AEOW members. A quorum is required for election of officers.

2. A quorum for the AEOW shall consist of one-half of the active membership, with active being defined as attending at least one formal AEOW meeting during the preceding year.

3. Chairpersons of permanent subcommittees shall be elected by the specific subcommittee's membership for a period not to exceed one year.

4. Chairpersons of any ad-hoc subcommittees shall be appointed by the AEOW Chairperson or Co-Chairperson for a period not to exceed one year.

H. COMMITTEES

1. Permanent subcommittees shall be established by majority vote of the AEOW membership at any regular meeting when a quorum is met.

2. Ad-hoc subcommittees shall be established by the AEOW Chairperson or Co-Chairperson, as needed, to assist the AEOW in the performance of its duties and/or to carry out specific tasks.

3. Subcommittee members shall be members of the AEOW whose major interests and expertise fall within the role and scope of the designated committee.

4. Nominations may be made by the AEOW membership for non-AEOW members to serve on a particular committee. Invitations for participation of non-AEOW members shall be rendered by the AEOW Chairperson or Co-Chairperson.

I. RELATIONSHIP TO THE STATE PREVENTION SERVICES SYSTEM

1. The Single State Agency (SSA) is the Substance Abuse Services Division of DMH and has statutory authority to manage and monitor Alabama's public system of prevention services and is working collaboratively with the ACPTSA to establish a unified prevention services system based upon the Strategic Prevention Framework.

2. The SSA will assume primary responsibility for the continued operation of the AEOW and shall provide administrative support consisting of fiscal management, personnel support, space, supplies, equipment, and training.

3. The designated Chairperson of the AEOW shall be the Director of Prevention Services/NPN. The Chairperson shall preside at all AEOW meetings and shall serve as the workgroup's liaison to ACPTSA's Prevention Planning Committee.

4. The Epidemiologist from the Substance Abuse Services Division will have primary responsibility for the management of the AEOW. Working in collaboration with AEOW members, the Epidemiologist will develop data collection processes and obtain data for use by the AEOW from multiple archival, administrative, and survey databases kept by various governmental and other agencies.

5. The Executive Assistant to the Associate Commissioner of the SSA will evaluate the AEOW with regard to attainment of its stated goals and objectives and will submit evaluations to the AEOW Chairperson and the SSA Director.

6. The SSA's Associate Commissioner, in his role as Chairperson of the ACPTSA, will utilize reports on the activities and findings of the AEOW, along with recommendations, to support prevention service planning in the State of Alabama and to inform the Governor's Office as part of the ACPTSA's reporting requirements.

J. TIMELINE

Designation of AEOW as a standing committee of the Alabama Commission	April 2006
Recruit AEOW members	Ongoing
Provide progress reports to SEOW Administrator	Ongoing
Include links to AEOW reports and documents on DMH website	Not approved yet
Submit quarterly reports of AEOW activities	Ongoing
Meet regularly and communicate (e.g. email, newsletter) between Meetings	Ongoing
Monitor and evaluate AEOW progress toward attainment of goals	Ongoing
Submit Dissemination Plan	October 2009
Submit Sustainability Plan	January 2010
Submit Substance Abuse Monitoring System	March 2010
Submit Charter Work Plan & Goals	March 2010
Submit NOMs Community Data and Performance Management	March 2010
Submit Update of State/Jurisdiction Epidemiological Profile	March 2010
Submit Update of Community Epidemiological Profile	March 2010

K. EVALUATION METHODOLOGY

An annual evaluation report shall be completed in September to determine:

1. The extent to which activities of the AEOW are performed and objectives are attained.

2. The use of AEOW documents and available data to inform state and community ATOD policies.

3. The use of AEOW documents and available data to update the state's prevention services system.

4. Strengths and weaknesses in the AEOW's organizational structure and procedures.

5. Opportunities for enhancement of the role and function of the AEOW.

L. WORKGROUP SCHEDULE

1. The AEOW shall meet as frequently as necessary to accomplish it mission, with the provision that a minimum of one formal meeting be held quarterly.

2. Subcommittees of the AEOW shall meet as needed to accomplish their stated purpose.

M. TERMINATION DATE

The AEOW shall be a continuous workgroup, subject to dissolution only with rescinding of Executive Order Number 23.

N. PRIMARY CONTACT

The primary points of contact for the AEOW shall be the Director of Prevention Services/NPN or the Epidemiologist for the Substance Abuse Services Division.

Member Affiliation	Member Name(s)
1. Administrative Office of Courts	**Vacant**
2. Alabama Council of Community Mental Health Boards	**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	**Mr. Brandon Folks** **Ms. Sarah Harkless** **Ms. Stephanie McCladdie** **Dr. Ting Withers** **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**

Goal # 13
Attachment # 2

Alcohol, Tobacco, and Other Drugs: Consumption and Consequences in Alabama

Department of Mental Health and Mental Retardation
Substance Abuse Services Division
Office of Prevention

2008 Report

Contact information:

Alabama Department of Mental Health and Mental Retardation
Substance Abuse Services Division, Office of Prevention
RSA Union Building
100 North Union Street, Suite 430
Montgomery, Alabama 36104

Phone: (334) 242-3961
Fax: (334) 242-0759

Toll-free advocacy line: (800) 367-0955

http://www.mh.alabama.gov/

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List of Abbreviations

AEDS	Alcohol Epidemiologic Data System
ARDI	Alcohol-Related Disease Impact
ATOD	Alcohol, Tobacco, and Other Drugs
AYTS	Alabama Youth Tobacco Survey
BAC	Blood Alcohol Concentration
BRFSS	Behavioral Risk Factor Surveillance System
CDC WONDER	Centers for Disease Control and Prevention Wide-ranging OnLine Data for Epidemiologic Research
CLRD	Chronic Lower Respiratory Diseases
DEA	Drug Enforcement Administration
DHR	Department of Human Resources
DOC	Department of Corrections
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th edition
DYS	Department of Youth Services
FARS	Fatality Analysis Reporting System
ICD-10	International Classification of Diseases, 10th Revision
MVA	Motor Vehicle Accident
NSDUH	National Survey on Drug Use and Health
PRAMS	Pregnancy Risk Assessment Monitoring System
SAMMEC	Smoking-Attributable Mortality, Morbidity, and Economic Costs
SAPT	Substance Abuse Prevention and Treatment
SEER	Surveillance, Epidemiology, and End Results
TEDS	Treatment Episode Data Set
UCR	Uniform Crime Reports
YPLL	Years of Potential Life Lost
YRBS	Youth Risk Behavior Surveillance System

Executive Summary

This state epidemiological profile of substance use evaluates the consumption and consequences of alcohol, tobacco, and other drugs (ATOD) in Alabama among adults and youth.

Alcohol

- The per capita consumption of alcohol in Alabama is among the lowest in the country, ranking in the 9th decile.
- In 2006, 37% of Alabama adults reported consuming an alcoholic beverage within the past 30 days.
    - More adults reported binge drinking (10.4%), defined as consuming 5 or more drinks on one occasion, than heavy drinking (3.8%), defined as more than 2 drinks per day for men or more than 1 drink per day for women.
    - Binge drinking and heavy drinking were more common among men than women.
- In 2004-2005, 225,000 adults in Alabama were estimated to be alcohol dependent or abuse alcohol and 209,000 were estimated to have needed but did not receive treatment for alcohol use.
- In 2005, 39.4% of Alabama youth in 9th-12th grades reported consuming an alcohol beverage within the past 30 days.
    - Alabama youth reported alcohol use before age 13 (30.9%) and binge drinking (23.8%).
- In 2004-2005, 21,000 Alabama youth ages 12-17 were estimated to be alcohol dependent or abuse alcohol and 20,000 were estimated to have needed but did not receive treatment for alcohol use.

Tobacco

- Alabama ranks 40th out of all states and the District of Columbia for its tax rate on cigarettes.
- The rate of current smoking in Alabama ranks above the national median.
- In 2006, 23.2% of Alabama adults were current smokers.
- In 2005, 24.4% of youth in 9th-12th grades smoked on one or more days in the past 30 days.
- The use of chewing tobacco, snuff, or dip was higher in Alabama compared to national estimates.
    - In 2005, 14.1% of 9th-12th graders in Alabama reported current use of chewing tobacco, snuff, or dip compared to 8.0% nationwide.

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- The use of chewing tobacco, snuff, or dip was nearly 2-fold greater for Alabama boys (25.9%) than boys nationwide (13.6%).
- Also, more Alabama youth (21.2%) reported smoking their first whole cigarette before age 13 than youth nationwide (16%).

Other Drugs

- The use of other illicit drugs in Alabama is comparable to national averages.
- The leading other drugs used (lifetime, past year, and past month) in Alabama were marijuana and non-medical use of prescription pain relievers.
- In 2004-2005, 13.9% of Alabama adults ages 18-25 years and 3.1% ages 26 years and older reported using marijuana in the past month. Similarly, 14.0% of adults ages 18-25 years and 3.0% of adults ages 26 years and older reported non-medical use of prescription pain relievers in the past month.
- In 2004-2005, 94,000 Alabama adults were estimated to abuse or be dependent on illicit drugs and 75,000 were estimated to have needed but did not receive treatment for illicit drug use.
- Overall, current marijuana use declined among youth in 9^{th}-12^{th} grades in Alabama between 1999 and 2005.
    - More boys (14.0%) reported trying marijuana before age 13 than girls (4.5%).
- In 2004-2005, 8.7% of youth ages 12-17 years reported non-medical use of prescription pain relievers.
- In 2004-2005, 19,000 Alabama youth ages 12-17 were estimated to abuse or be dependent on illicit drugs and 17,000 were estimated to have needed but did not receive treatment for illicit drug use.

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Alabama

Alabama is located in the southeastern United States, bordered by the states of Florida, Georgia, Mississippi, and Tennessee. The capital city of Alabama is Montgomery (located in Montgomery County) and the most populous city is Birmingham (located in Jefferson County). Alabama is the 30th largest state based on total land area and 23rd most populous with an estimated population of 4,599,030 in 2006.[1] It consists of 67 counties, of which 51 have greater than 50% of their population residing in rural areas.[2] Approximately 29% of Alabama residents live in rural areas.

The overall socio-demographic characteristics for Alabama are presented in Table 1. The median age is 37.4 years. The majority of Alabama residents are white (71.4%) and African-Americans represent the largest minority group in the state (26.4%). Urban and rural areas of Alabama have different socio-demographic profiles, with rural areas being less advantaged than urban areas. In 2004, the state's overall poverty level was 16.1% with rural areas having a higher poverty level (17.4%) than urban areas (15.5%). Similarly, rural areas had fewer residents with a college degree (12.8%) and a higher unemployment rate (4.1%) compared to urban Alabama at 21.7% and 3.4% respectively.[3]

Table 1—Socio-demographic characteristics of Alabama

Characteristic	Alabama
Population, 2006 estimate	4,599,030
Median age, years	37.4
% Female, 2005	51.5
% White, 2005	71.4
% Hispanic or Latino, 2005	2.3
% Bachelor's degree or higher, 2000	19.0
% below poverty level, 2004	16.1
Median household income, 2004	$37,062
% Homeownership, 2000	72.5
Median value of owner-occupied housing units, 2000	$85,100

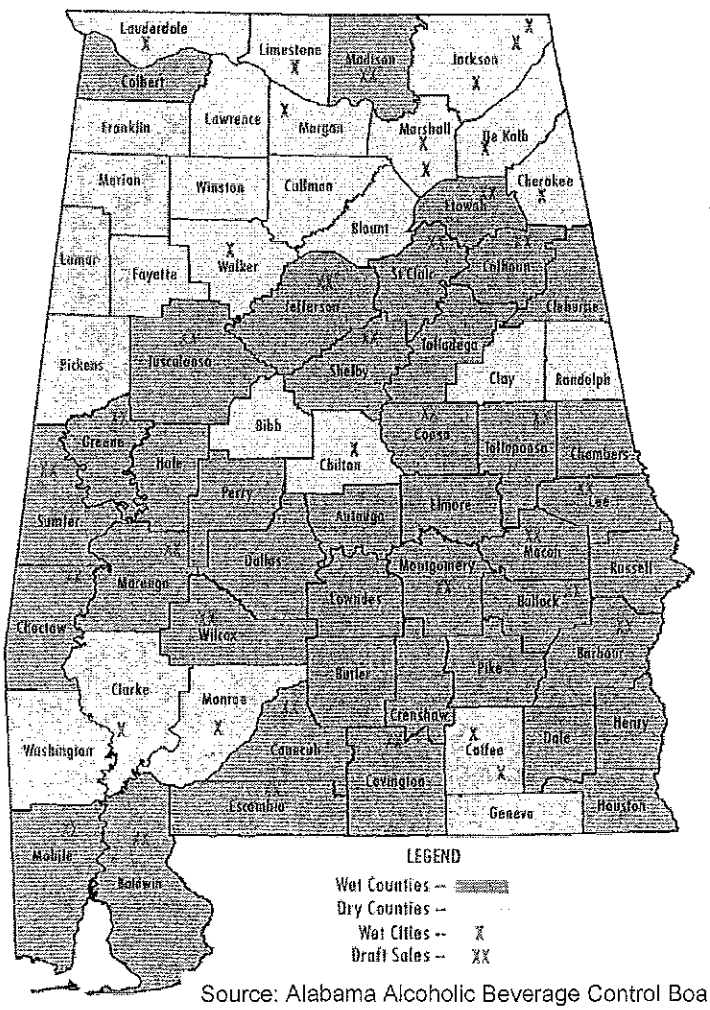
Source: US Census Bureau Alabama Quick Facts

Alcohol

Alcohol

- The minimum legal age to purchase, use, possess, or transport alcoholic beverages in Alabama is 21 years.
- Alcohol sales are regulated by the Alabama Alcoholic Beverage Control Board, which is responsible for the distribution of alcohol, licensing of retail outlets, and enforcement of policies.
- Alabama has 26 dry counties that do not permit the sale of any alcoholic beverages, except in designated wet cities (Figure 1).

Figure 1—Wet and dry counties and cities in Alabama



Source: Alabama Alcoholic Beverage Control Board

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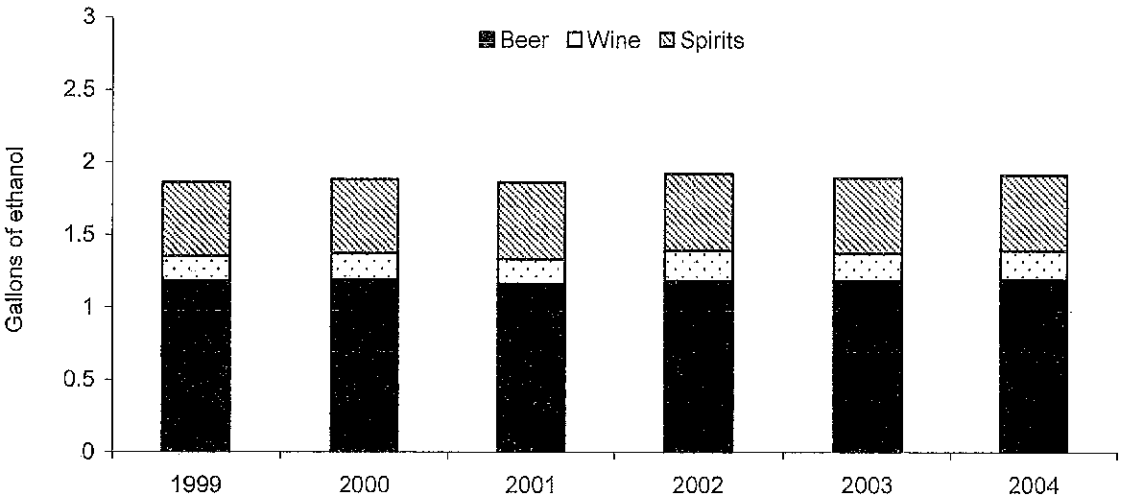
Alcohol Consumption

Per Capita Consumption

- Alabama has one of the lowest levels of per capita consumption of alcohol in the United States, ranking in the 9th decile of per capita consumption for beer, wine, and spirits.[4]
- The per capita consumption of alcohol in the state was stable between 1999-2004, with beer having the greatest per capita consumption followed by spirits and wine (Figure 2).

Figure 2—Per capita ethanol consumption in Alabama by type and year, 1999-2004

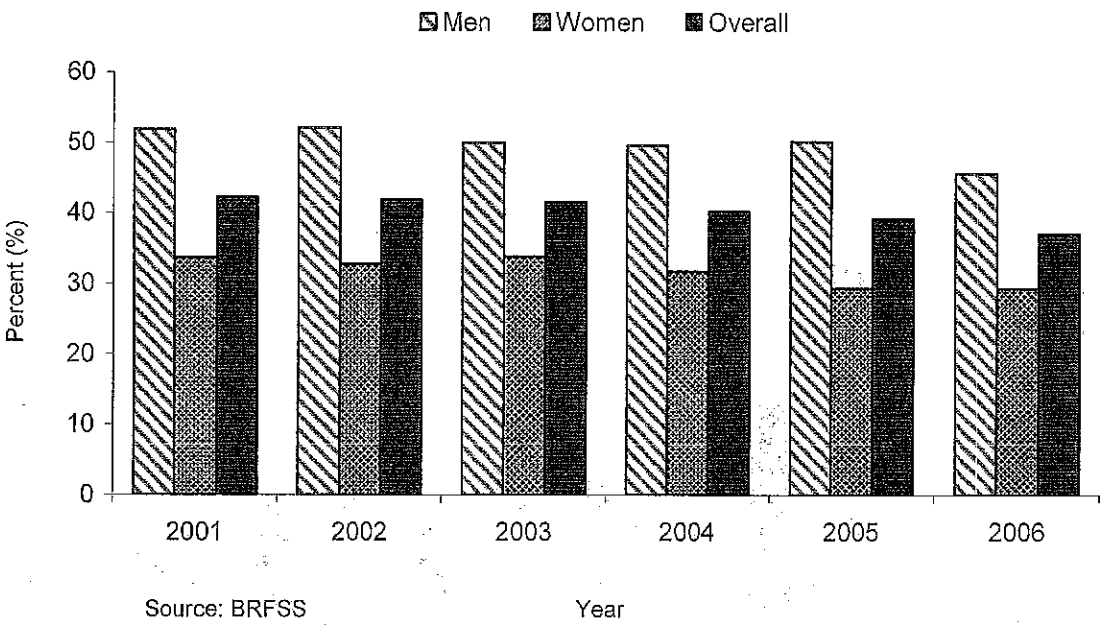


Source: AEDS

Adults—Current Use

- In 2006, 37% of Alabama residents ages 18 years and older reported having at least one alcoholic drink in the past 30 days, with significantly more men (45.6%) reporting current use of alcohol than women (29.3%).
- On average, approximately 40% of Alabama adults reported having at least one alcoholic drink in the past 30 days during 2001-2006, with more men than women reporting consuming at least one alcoholic drink in the past 30 days for each study year (Figure 3).

Figure 3—Percent of adults who had at least one alcoholic drink in past 30 days, 2001-2006

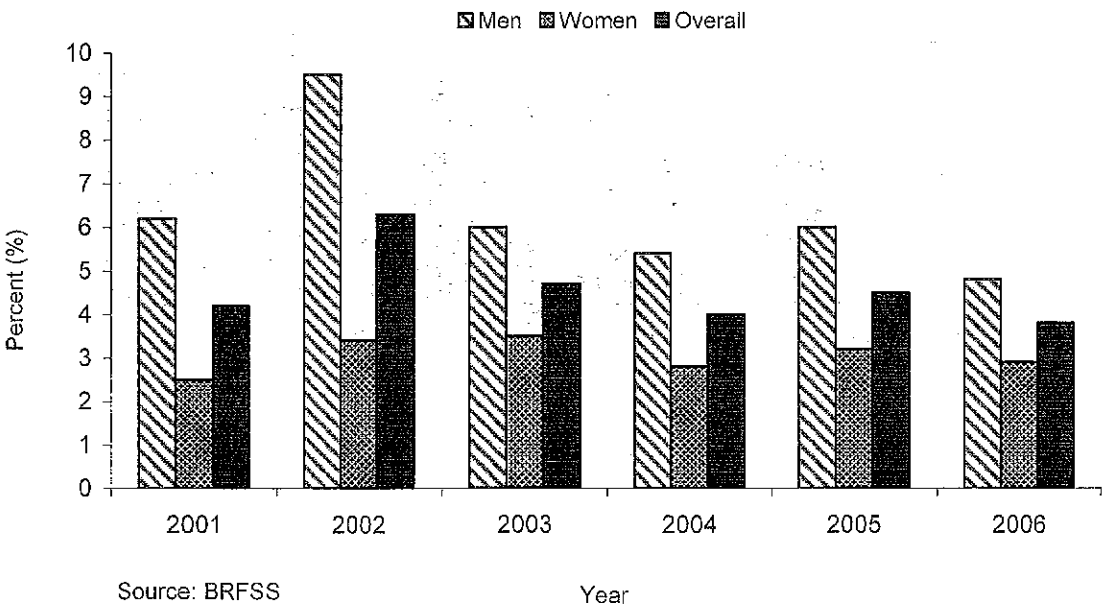


Source: BRFSS

Adults—Excessive Use

- While moderate consumption of alcohol has been associated with positive health outcomes, excessive alcohol intake can have adverse health effects.[5]
- Alabama ranks below the national median for measures of excessive alcohol intake, specifically heavy drinking defined as an average daily consumption of >2 drinks for men or >1 drink for women, and binge drinking defined as 5 or more drinks on at least one occasion in the past 30 days.
- In 2006, 3.8% of Alabama adults reported heavy drinking (Figure 4). During 2001-2006, more men reported heavy drinking than women although these differences were only statistically significant for 2001, 2002, and 2004 ($p<0.05$).

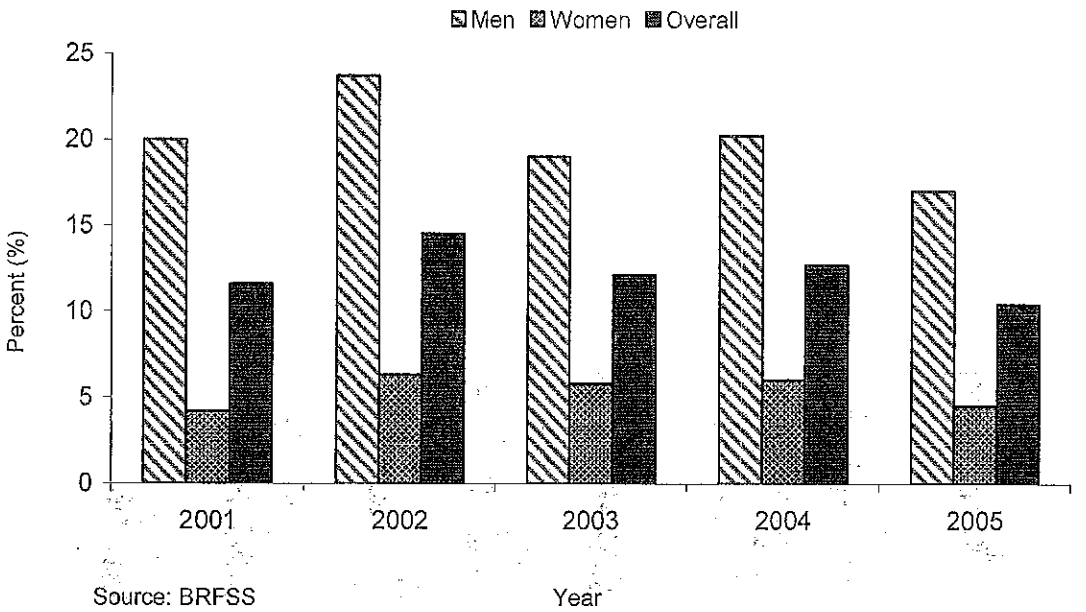
Figure 4—Percent of adults reporting heavy drinking, 2001-2006



Source: BRFSS

- In 2005, 10.4% of Alabama adults reported binge drinking (Figure 5). The gender difference was much more pronounced for binge drinking with 3-5 times more men than women reporting binge drinking during 2001-2005.

Figure 5—Percent of adults reporting binge drinking in past 30 days, 2001-2005*

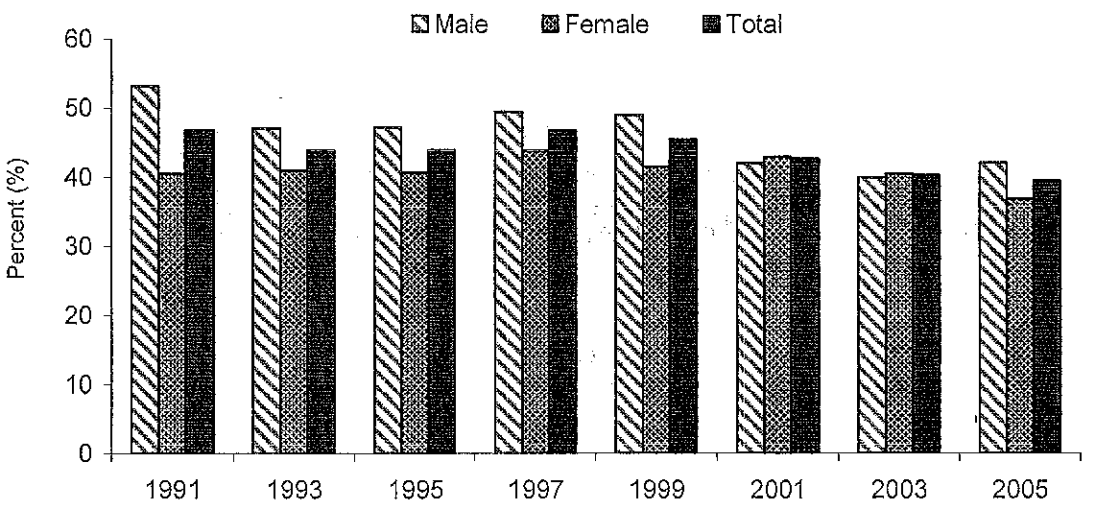


* 2006 data not included because binge drinking definition changed to 5 or more drinks for men and 4 or more drinks for women.

Youth—Current Use

- In 2005, 39.4% of youth in 9th-12th grades in Alabama reported having at least one alcoholic drink in the past 30 days (Figure 6).
- Current alcohol use by youth in Alabama was stable between 1991-2005, with more males than females reporting alcohol use in the past 30 days, although these differences were only statistically significant in 1991, 1995, and 1999 ($p<0.05$) and weakened during the later years.

Figure 6—Percent of youth who had at least one alcoholic drink in past 30 days, 1991-2005

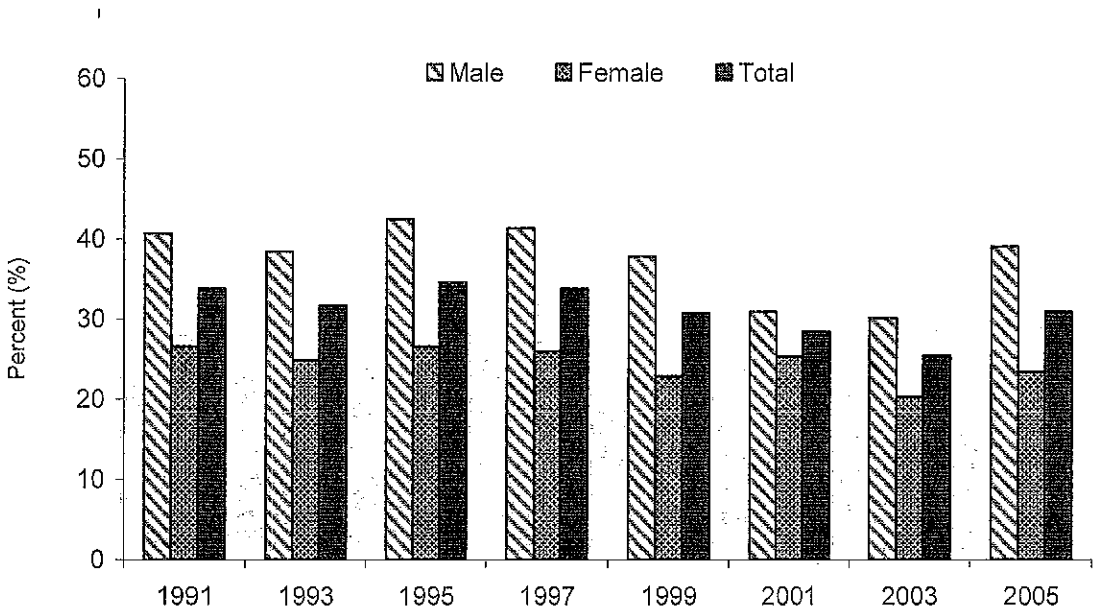


Source: YRBS

Youth—Age at First Use

- A factor that may be related to current alcohol use by youth and alcohol abuse in young adulthood is the age at first use of alcohol.[6]
- In 2005, 30.9% of youth in Alabama reported alcohol use prior to age 13, with more males (39%) reporting early alcohol use than females (23.4%) (Figure 7).
- A significant gender difference for alcohol use prior to age 13 was apparent for each study year except 2001, with more males than females reporting early use.

Figure 7—Percent of youth who reported first use of alcohol before age 13, 1991-2005

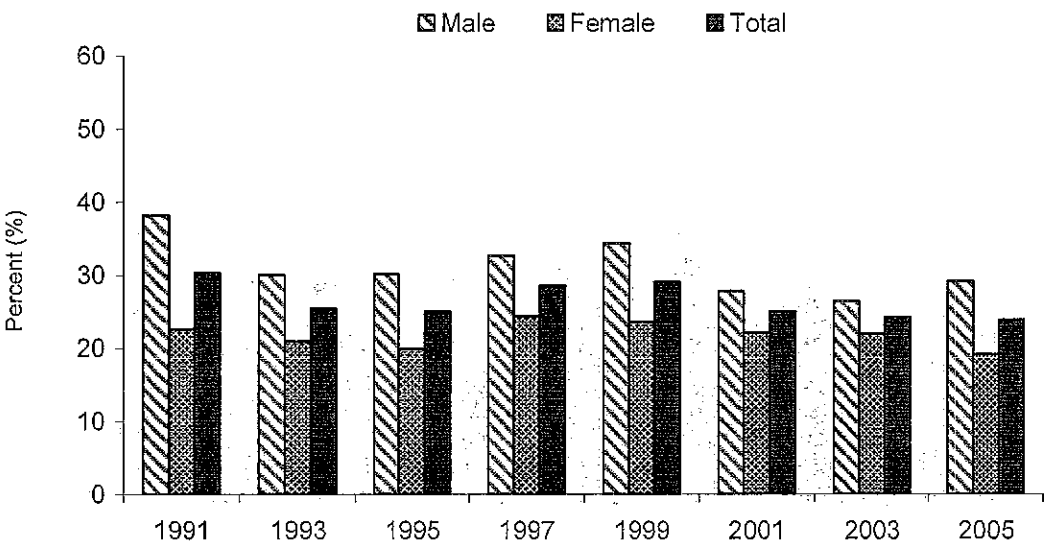


Source: YRBS

Youth—Excessive Use

- Excessive alcohol intake among youth also increases with grade in school.[7]
- The percent of youth in 9th-12th grades in Alabama who reported binge drinking, defined as 5 or more drinks in a row within a couple of hours, in the past 30 days was 23.8% in 2005, which is comparable to estimates from previous years (Figure 8).
- More males (29.1%) reported binge drinking than females (19.1%) in 2005 and this gender difference in the prevalence of binge drinking among youth was statistically significant ($p<0.05$) throughout most of the study years, except for 2001 and 2003.

Figure 8—Percent of youth who reported binge drinking in past 30 days, 1991-2005

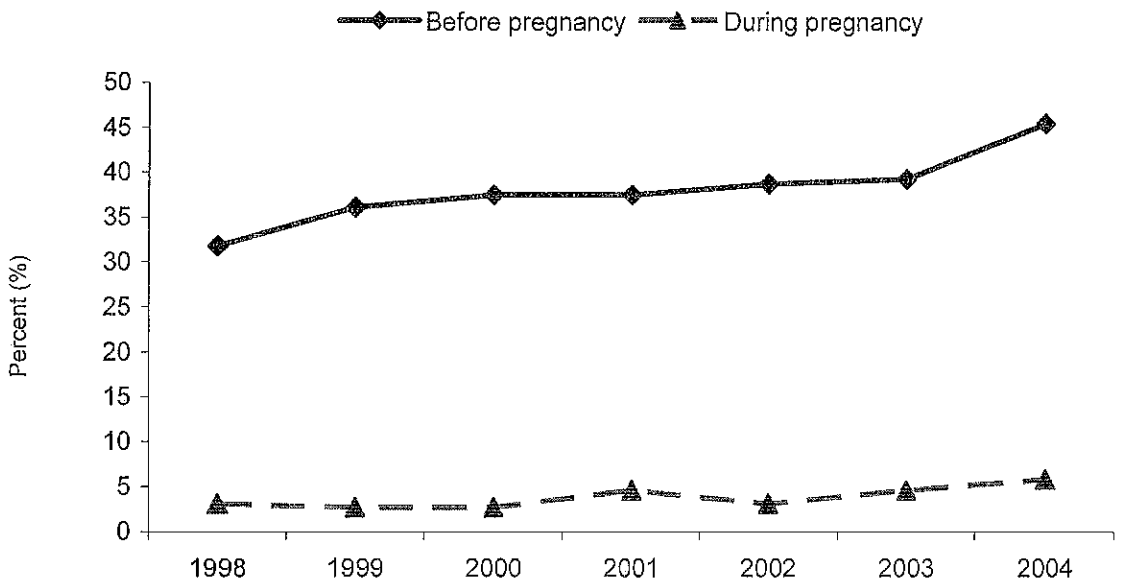


Source: YRBS

Pregnant Women

- Prenatal alcohol consumption can lead to fetal alcohol spectrum disorders (FASD), a group of adverse health conditions that are characterized by birth defects, developmental disabilities, and behavioral issues in babies exposed to alcohol *in utero*.[8,9]
- To prevent FASD, the U.S. Surgeon General updated a 1981 advisory that had recommended women limit their alcohol intake during pregnancy with a 2005 advisory that recommended total abstinence from alcohol consumption for women who are pregnant or may become pregnant.[10]
- In 2004, 45.4% of Alabama mothers who had recently given birth reported drinking alcoholic beverages during the 3 months preceding their pregnancy and 5.8% reported drinking alcoholic beverages during the last 3 months of their pregnancy (Figure 9).

Figure 9—Percent of mothers who had recently given birth who reported drinking alcohol during the 3 months prior to their pregnancy or during the last 3 months of their pregnancy, 1998-2004



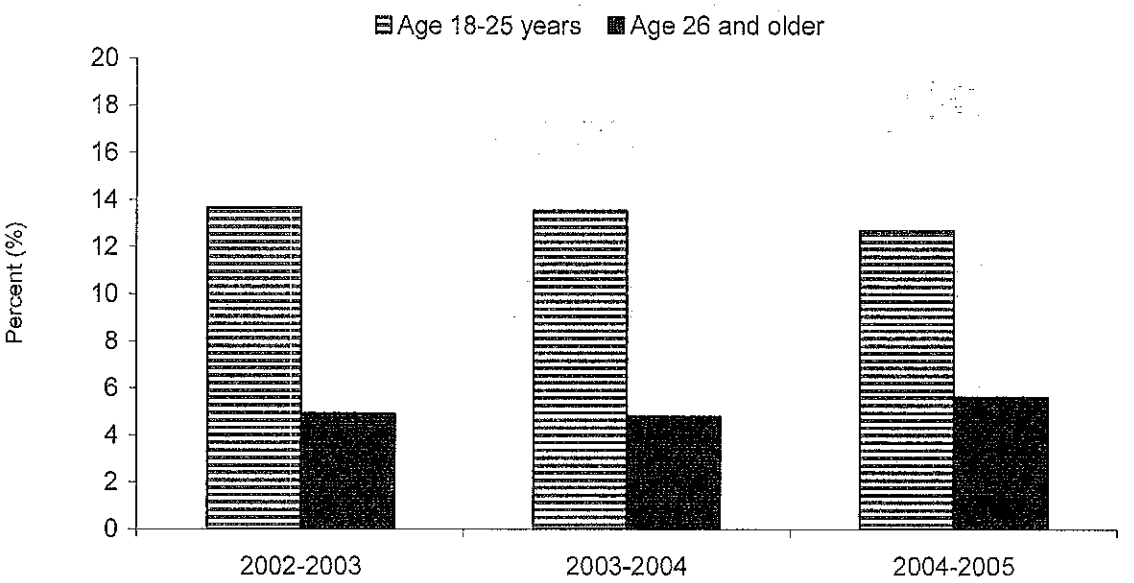
Source: PRAMS

Alcohol Consequences

Adults—Abuse or Dependence

- The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) defines alcohol abuse or dependence as maladaptive patterns of alcohol use leading to clinically significant impairment or distress, and identifies specific criteria for the clinical diagnosis of these conditions based on occurrences within a 12-month period.[11]
- In 2004-2005, 12.7% of adults ages 18-25 years and 5.6% of adults 26 years and older in Alabama met DSM-IV criteria for alcohol abuse or dependence (Figure 10), which was comparable to previous years.
- The prevalence of alcohol abuse or dependence among Alabama adults was lower than national estimates although compared to adults 26 years and older age group, the 18-25 year age group had a higher prevalence of alcohol abuse or dependence at both national and state levels.

Figure 10—Percent of adults meeting DSM-IV criteria for alcohol abuse or dependence in past year, 2002-2005

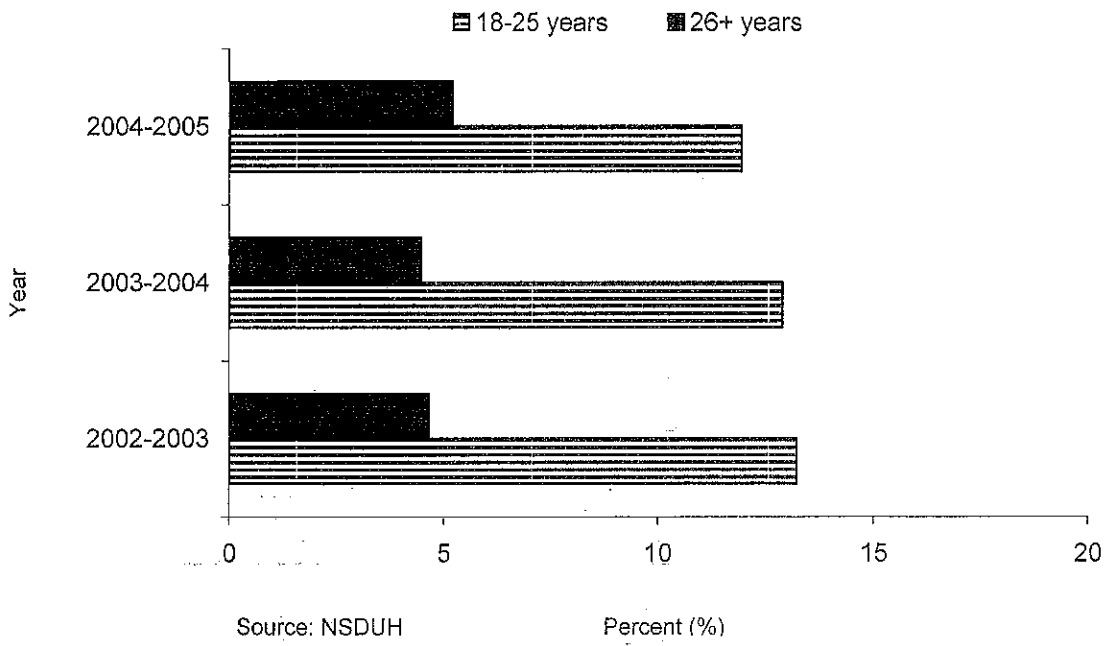


Source: NSDUH

Adults—Needing Treatment

- Alcohol abuse or dependence can adversely impact normal daily activities, such as job performance and family responsibilities, in addition to causing deleterious health effects if left untreated.[12]
- In 2004-2005, 11.9% of Alabama adults ages 18-25 years and 5.2% of Alabama adults ages 26 years and older were identified as needing treatment for an alcohol problem but not receiving treatment at a drug and alcohol rehabilitation center, mental health center, or hospital (Figure 11).

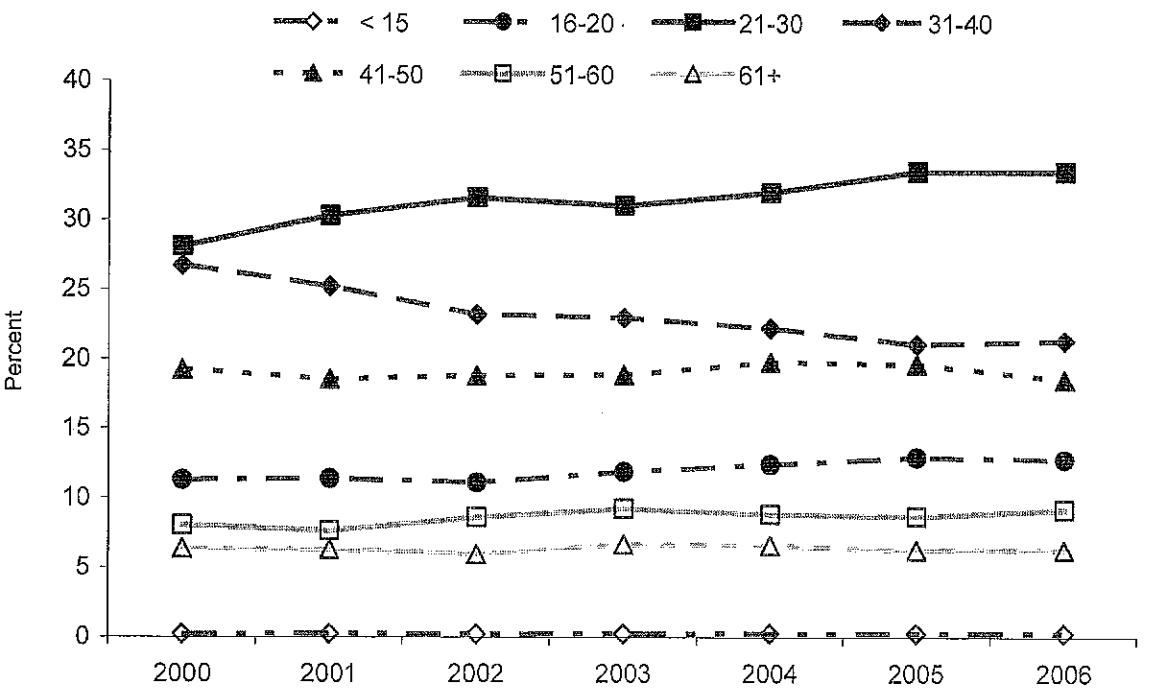
Figure 11—Percent of adults who needed treatment for an alcohol problem but did not receive treatment, 2002-2005



Alcohol-Related Motor Vehicle Accidents

- In Alabama, the total number of alcohol-involved motor vehicle accidents (MVAs) declined during 2000-2006.
- In 2006, the 21-30 year age group accounted for 33.5% of alcohol-involved MVAs in Alabama followed by the 31-40 year age group (21.3%), the 41-50 year age group (18.5%), and the 16-20 year age group (12.8%).
- The proportion of alcohol-involved MVAs by those in the 21-30 year age group increased from 28.1% in 2000 to 33.5% in 2006 while there was a decrease from 26.7% in 2000 to 21.3% in 2006 by those in the 31-40 year age group (Figure 12).

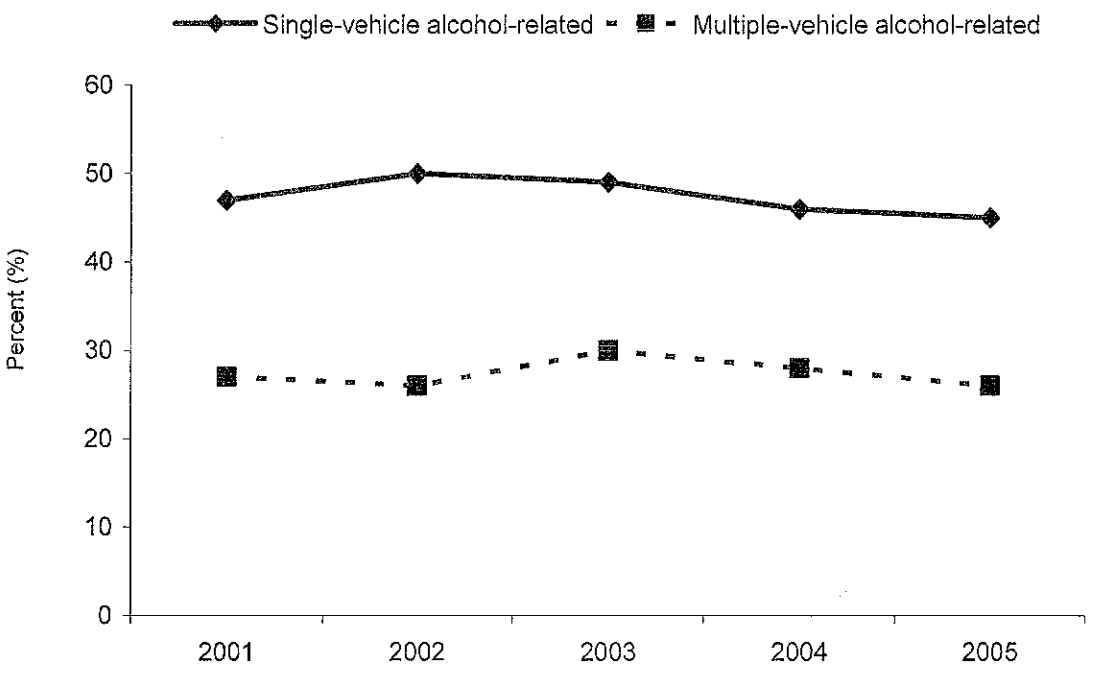
Figure 12—Percent of alcohol-involved accidents that occurred in Alabama by age group of driver, 2000-2006



Source: Alabama Department of Public Safety

- During 2001-2005, 38.8% of fatal motor vehicle accidents in Alabama were alcohol-related, defined as at least one driver, pedestrian, or cyclist who had been drinking and was involved in the accident.
- In 2005, more fatal single-vehicle accidents were alcohol-related (45%) than fatal multiple-vehicle accidents (26%), which was consistent with previous years (Figure 13).

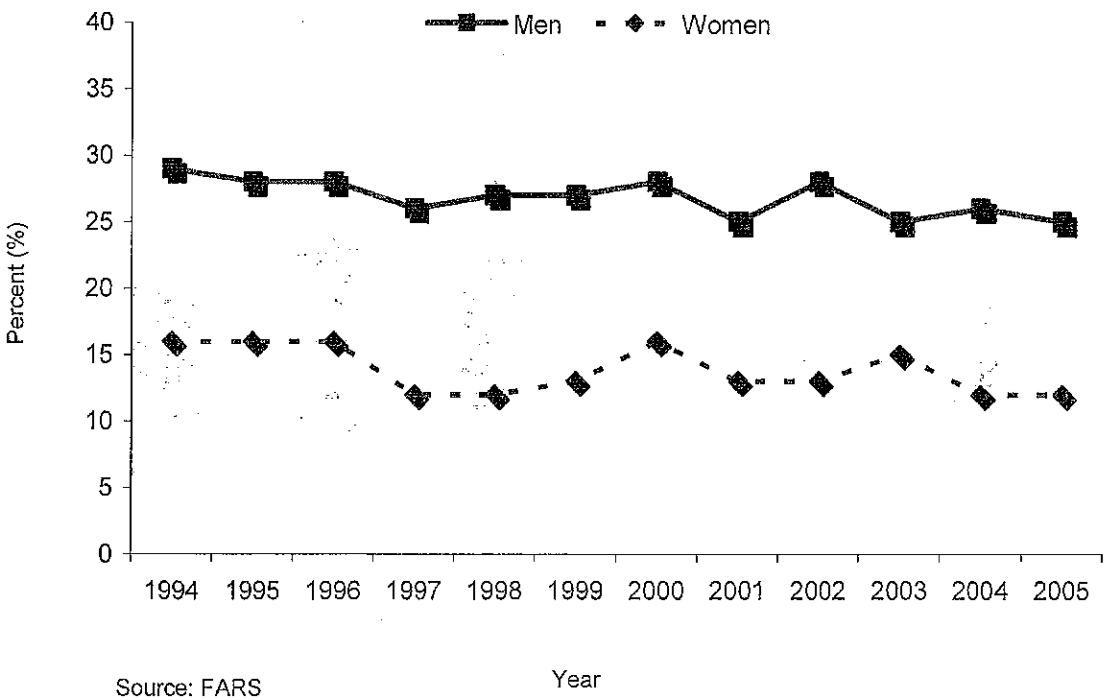
Figure 13—Percent of fatal crashes in Alabama that were alcohol-related by single- or multiple-vehicle involvement, 2001-2005



Source: FARS

- While alcohol-related fatal motor vehicle accidents include those accidents with any alcohol involvement, the legal limit for operating a motor vehicle in Alabama is a 0.08 blood alcohol concentration (BAC) for adults 21 years and older and a 0.02 BAC for minors (Code of Alabama 1975, §32-5A-191).
- In 2005, 25% of male drivers involved in fatal crashes had a BAC ≥ 0.08 compared to 12% of female drivers and this difference was evident from 1994 to 2005 (Figure 14).

Figure 14—Percent of drivers involved in fatal crashes in Alabama who had a blood alcohol concentration of ≥0.8 by gender, 1994-2005

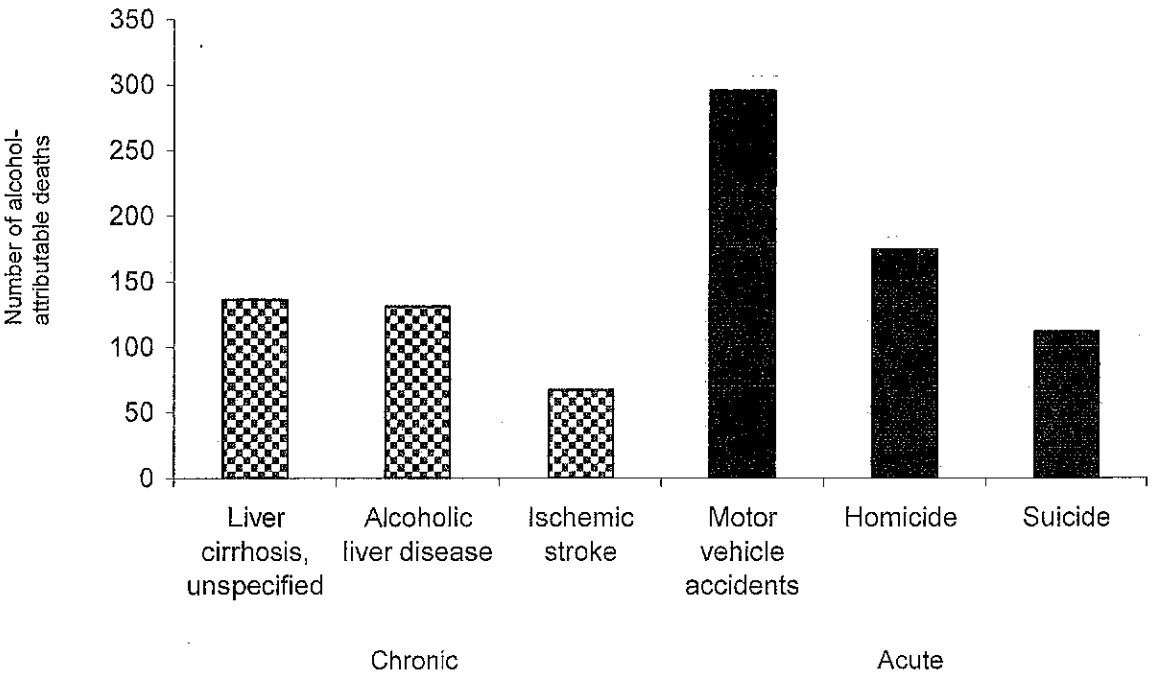


Source: FARS

Alcohol-Related Mortality

- Excessive alcohol intake is also associated with mortality from other chronic and acute causes.
- In 2001, the leading chronic causes of alcohol-attributable deaths in Alabama were liver cirrhosis, alcoholic liver disease, and ischemic stroke and the leading acute causes were motor vehicle accidents, homicide, and suicide (Figure 15).

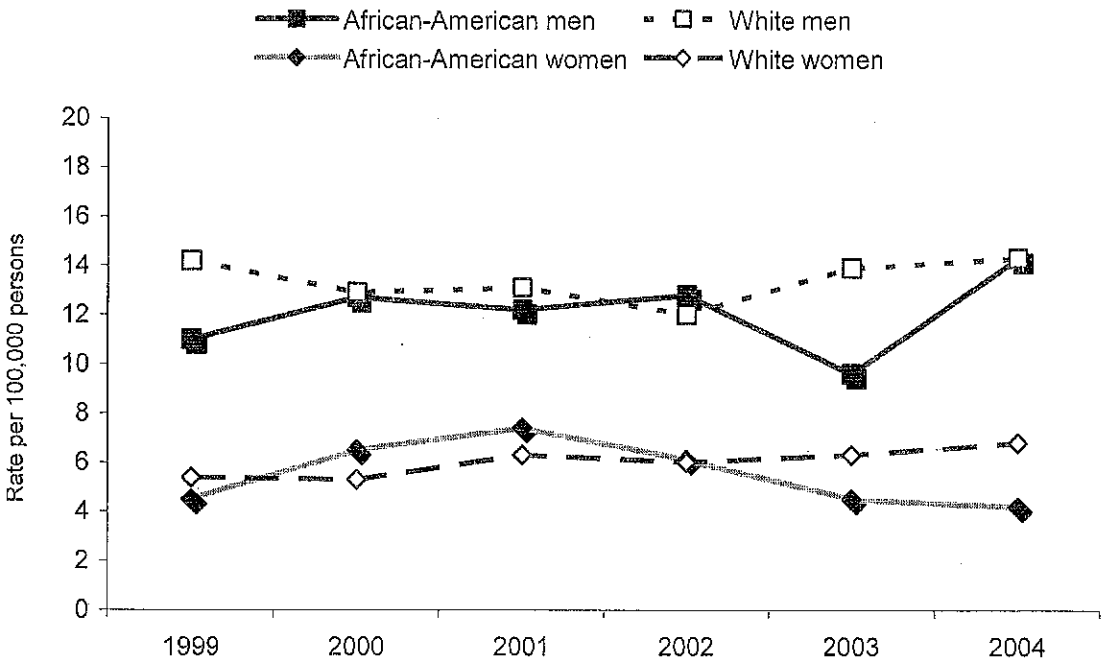
Figure 15—Chronic and acute causes of alcohol-attributable deaths in Alabama, 2001



Source: ARDI

- The leading chronic and acute conditions for alcohol-attributable deaths are all in the top fifteen leading causes of death for Alabama overall.
- The mortality rate for chronic liver disease and cirrhosis in Alabama has been relatively stable since 1999, with higher rates for men than women (Figure 16).

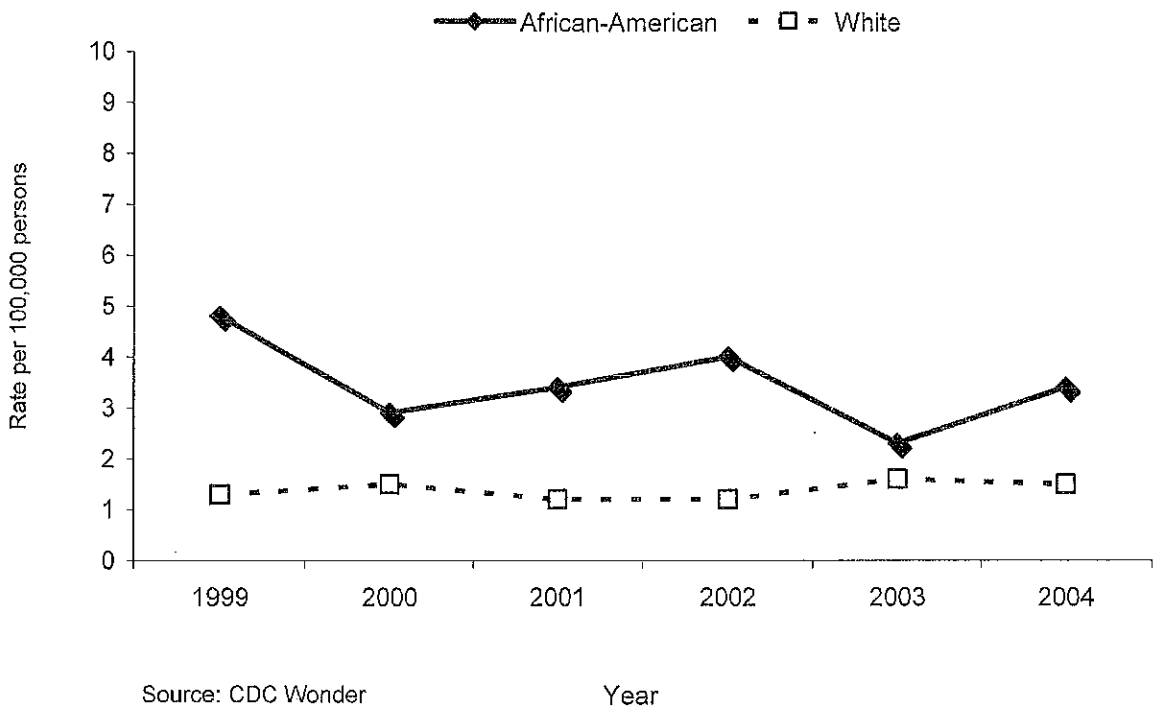
Figure 16—Age-adjusted mortality rate for chronic liver disease or cirrhosis by race and gender in Alabama, 1999-2004



Source: CDC Wonder

- The mortality rate for alcohol-induced mental disorders and alcohol dependence syndrome has also been stable in Alabama since 1999, with higher rates for African-Americans than whites (Figure 17). Note: Gender-specific data unavailable due to small numbers.

Figure 17—Age-adjusted mortality rate for alcohol induced mental disorders or alcohol dependence syndrome by race in Alabama, 1999-2004

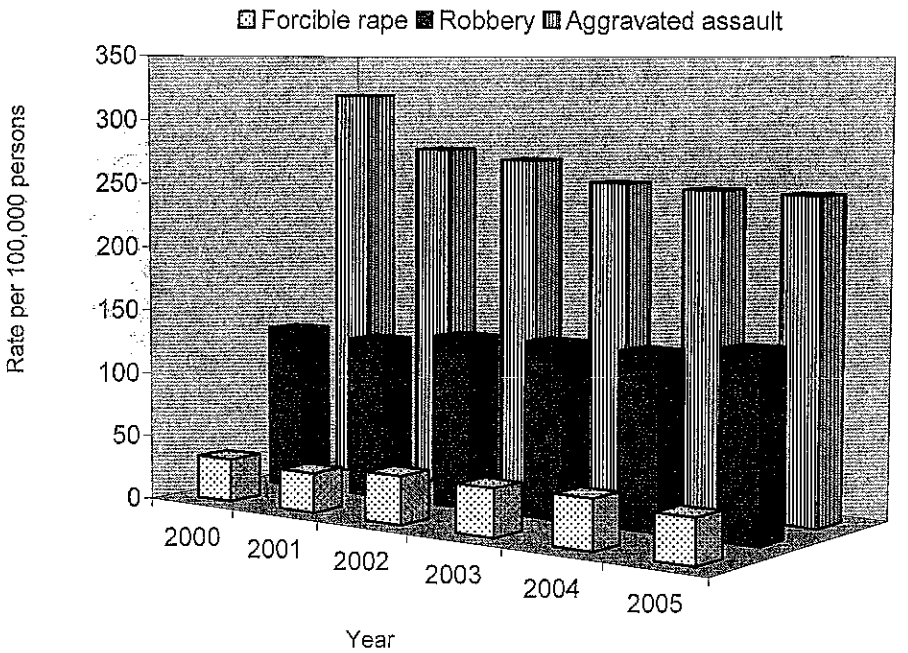


Source: CDC Wonder

Alcohol-Related Crime

- Another possible consequence of excessive alcohol consumption is violent crime, such as forcible rape, robbery, and aggravated assault, although the proportion due to alcohol abuse or dependence is unknown.
- In 2005, the rate per 100,000 Alabama residents was 247.8 for aggravated assault, 141.4 for robbery, and 34.3 for forcible rape (Figure 18).

Figure 18—Rate per 100,000 persons for forcible rape, robbery, and aggravated assault in Alabama, 2000-2005

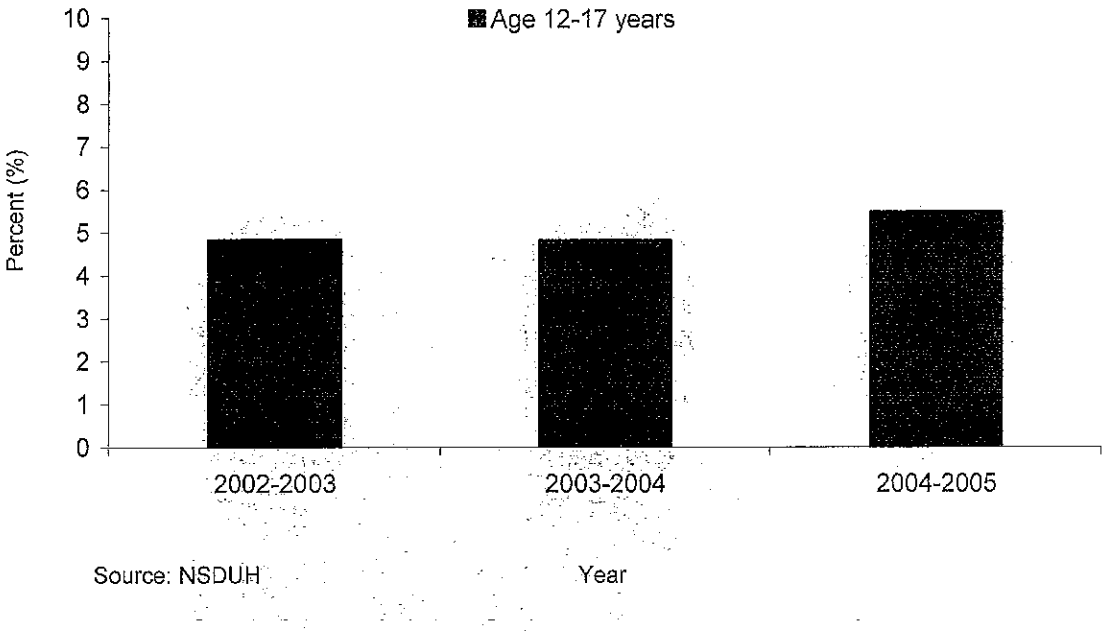


Source: UCR

Youth—Abuse or Dependence

- Alcohol abuse or dependence during youth can lead to continued abuse or dependence in young adulthood if left untreated.
- In 2004-2005, 5.5% of children in Alabama ages 12-17 years met the DSM-IV criteria for alcohol abuse or dependence (Figure 19).

Figure 19—Percent of youth, ages 12-17 years, who met DSM-IV criteria for alcohol abuse or dependence, 2002-2005

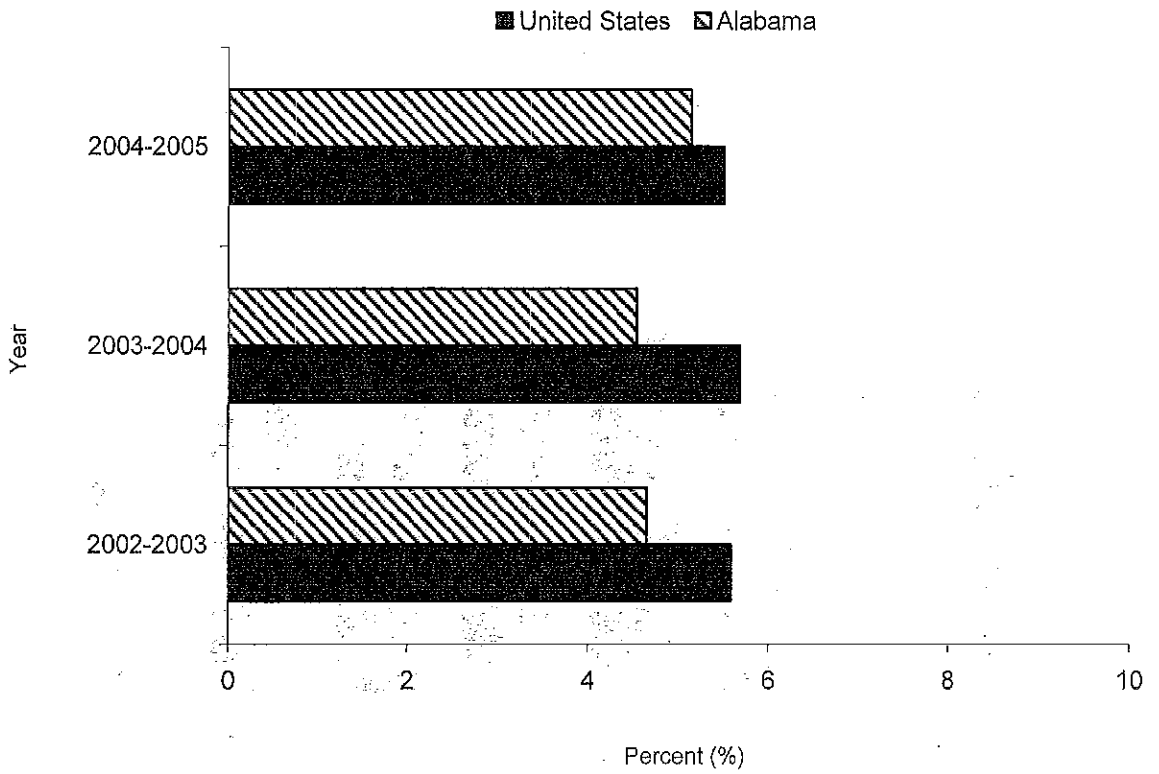


Source: NSDUH

Youth—Needing Treatment

- Alcohol abuse or dependence can adversely affect school performance and family relationships and have long-term health implications for youth.
- In 2004-2005, 5.1% of Alabama youth, ages 12-17 years, were identified as needing treatment for an alcohol problem but not receiving treatment at a specialty trained facility, i.e. drug or alcohol rehabilitation center, mental health center, or hospital (Figure 20).

Figure 20—Percent of youth identified as needing treatment for an alcohol problem but not receiving treatment for Alabama and United States, 2002-2005



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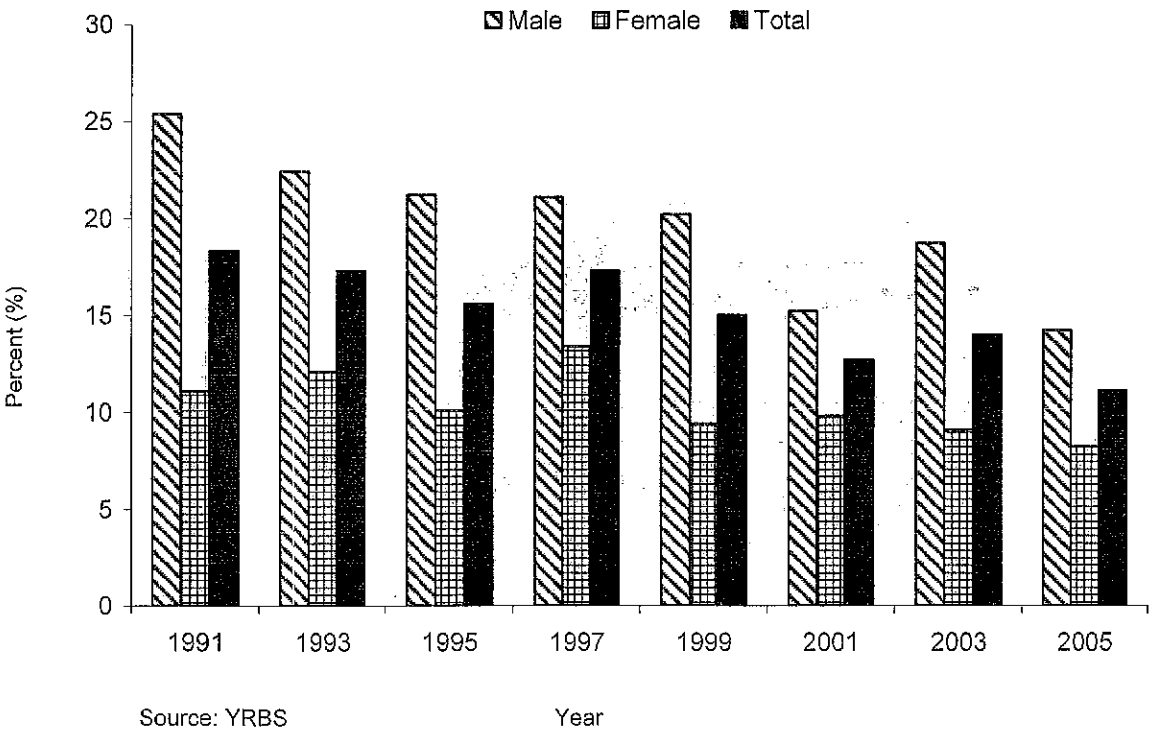
Youth—Drinking and Driving

- Alcohol use is associated with risky behaviors, such as drinking and driving.[13,14]
- In 2005, 11.1% of 9th-12th grade students in Alabama drove a car or other vehicle after drinking at least once in the past 30 days. More males (14.2%) reported drinking and driving than females (8.2%), which was a significant decline from 1991 (25.4% for males and 11.1% for females) (Figure 21).

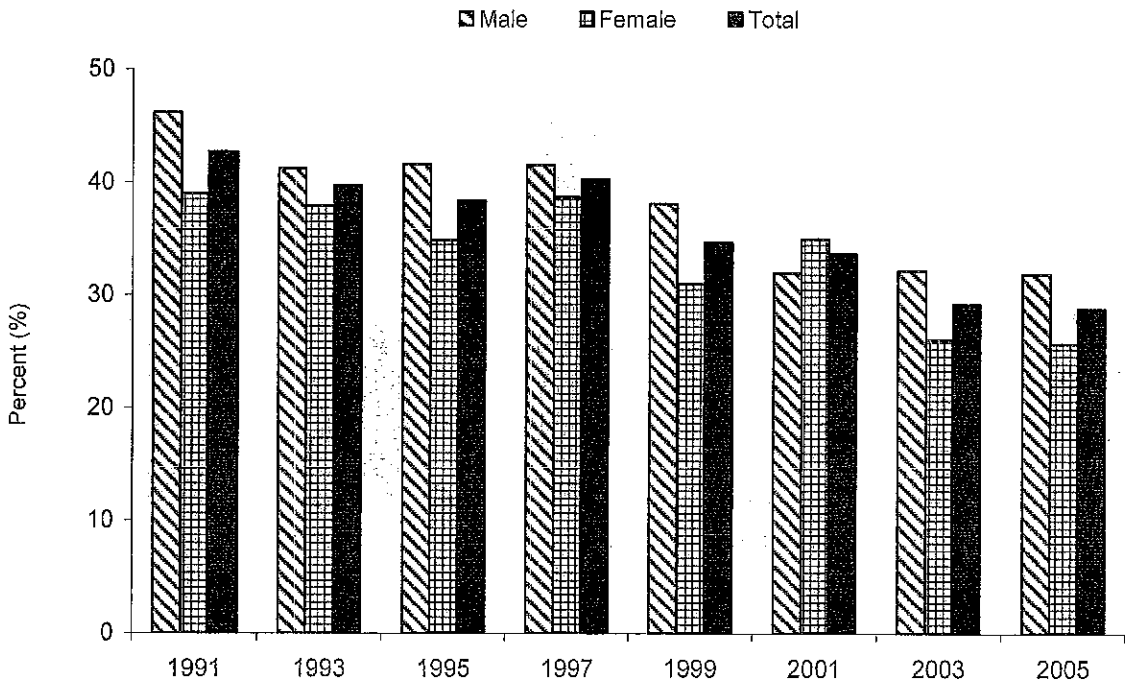
Figure 21—Percent of youth who drove a car or other vehicle when they had been drinking alcohol one or more times during the past 30 days, 1991-2005



Source: YRBS

- More Alabama youth reported riding in a vehicle with someone who had been drinking rather than drinking and driving themselves.
- In 2005, 28.8% of youth reported riding in a car or other vehicle driven by someone who had been drinking, which was a significant decline from 1991 (38.4%) (Figure 22).
- No significant gender difference was noted in 2005 for Alabama youths who reported riding in a car or other vehicle driven by someone who had been drinking (males: 31.9%; females: 25.7%).

Figure 22—Percent of youth who rode in a car or other vehicle driven by someone who had been drinking at least once in the previous 30 days, 1991-2005

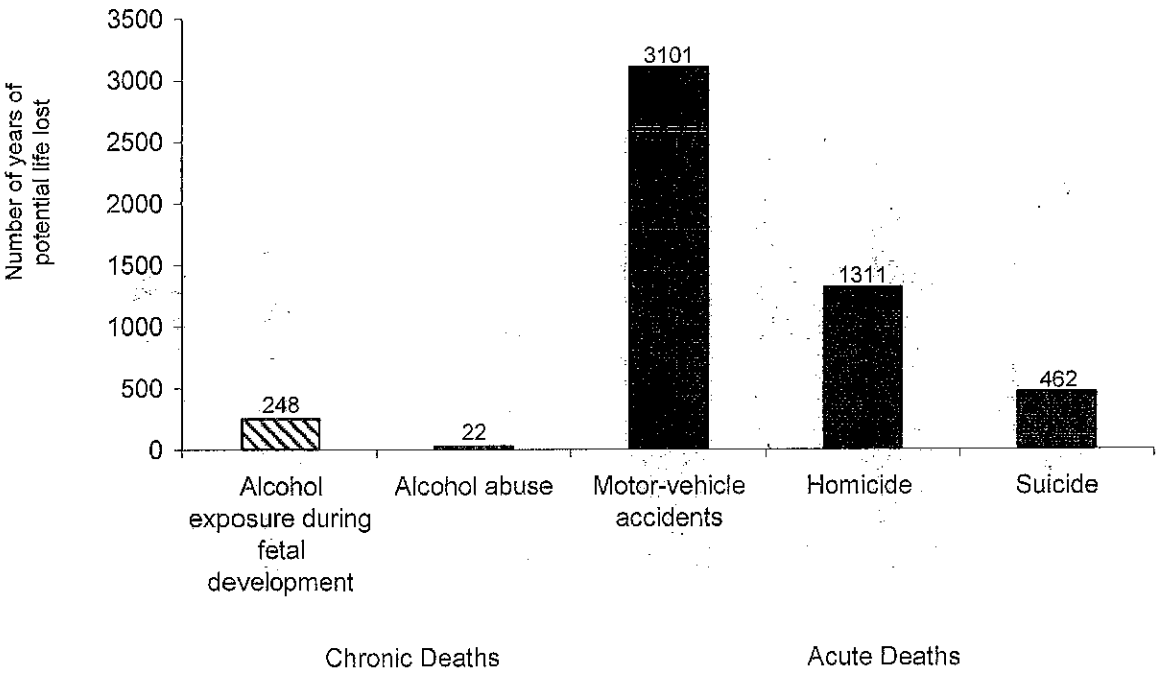


Source: YRBS

Youth—Alcohol-Related Mortality

- Years of potential life lost (YPLL) due to alcohol-related premature mortality among youth may be due to alcohol exposure directly, e.g. their own consumption, or indirectly, e.g. *in utero* or riding in a car driven by someone who had been drinking.
- In 2001, the leading contributors to YPLL among youth in Alabama were acute causes, specifically motor-vehicle accidents, homicide, and suicide (Figure 23).

Figure 23—Years of potential life lost due to alcohol-related premature deaths for youth, 2001

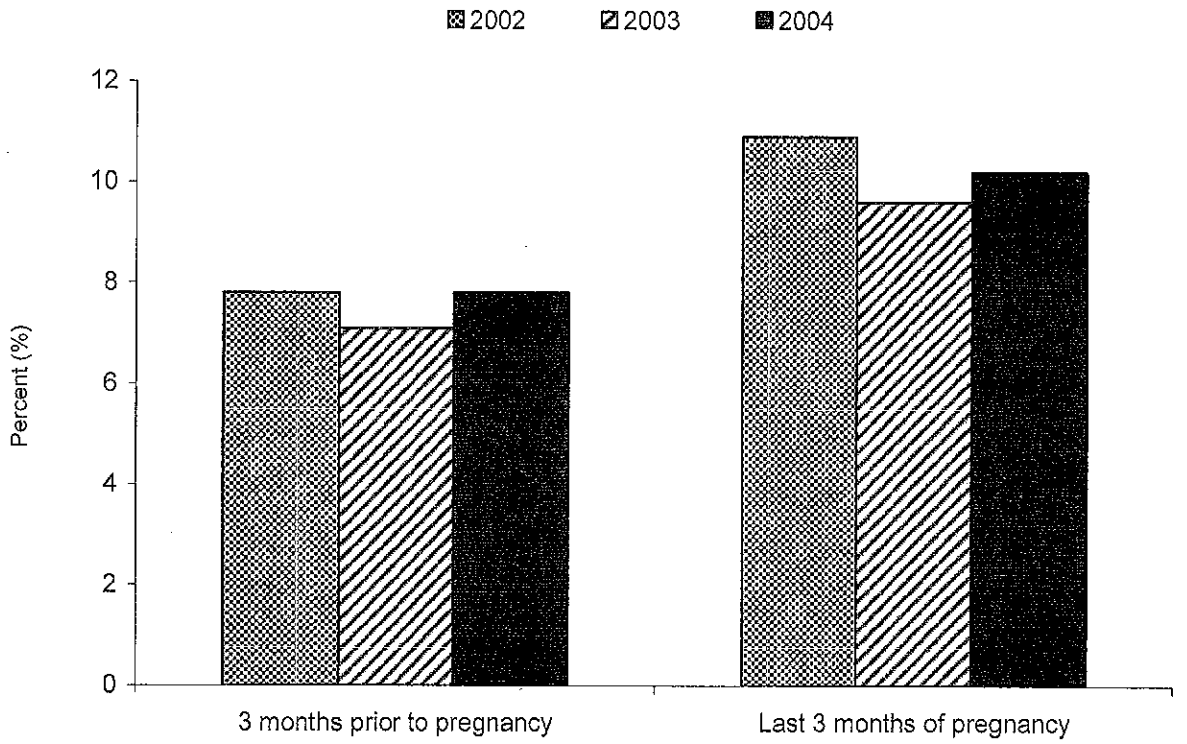


Source: ARDI

Pregnant Women

- Alcohol consumption during pregnancy, particularly in combination with tobacco and other drug use, has been associated with adverse perinatal outcomes such as low birth weight (< 2500 grams or 5.5 pounds).[15]
- In 2004, 7.8% of mothers who reported drinking during the 3 months prior to their pregnancy and 10.2% of mothers who reported drinking during the last 3 months of their pregnancy had low birth weight babies (Figure 24); however, this difference was not statistically significant.

Figure 24—Percent of mothers who reported drinking during the 3 months prior or last 3 months of their pregnancy and who gave birth to low birth weight birth babies, 2002-2004

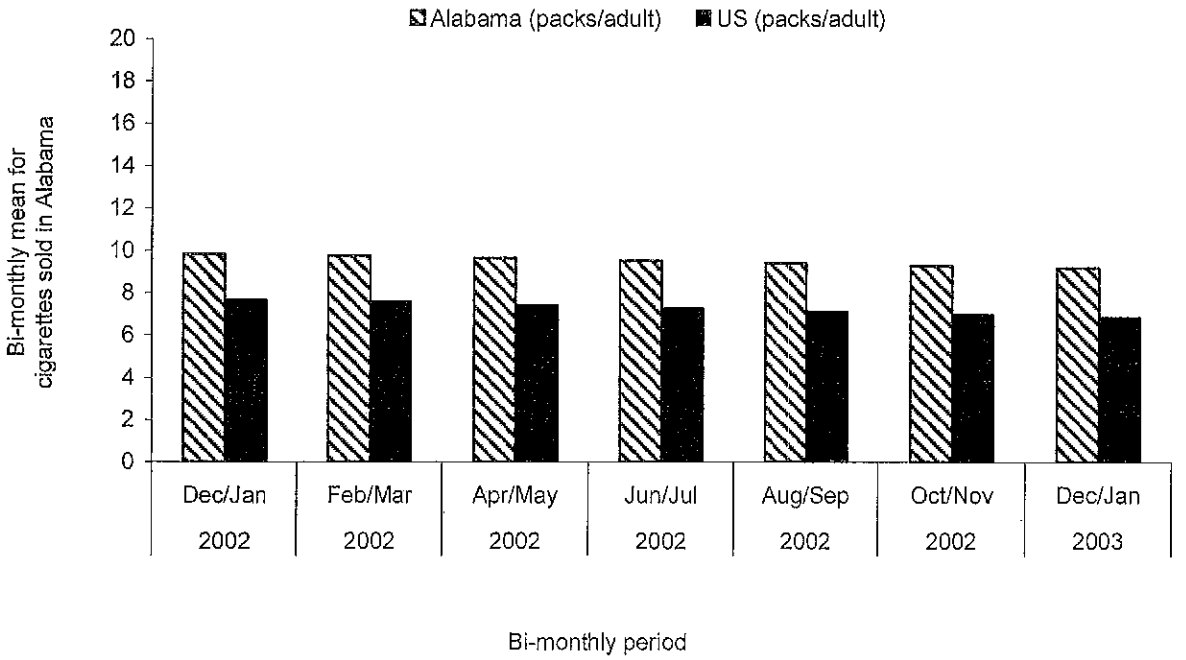


Tobacco

Tobacco

- The minimum legal age to purchase, use, possess, or transport tobacco products in Alabama is 19 years.
- Alabama ranks 40th out of all 50 states plus the District of Columbia for its tax rate on cigarettes, which is 42.5¢ per pack; however, cities and counties may impose an additional tax of 1 to 6¢ per pack.[16]
- The tax rate on cigars varies between 4-40.5¢ per 10 cigars and the tax rate on tobacco/snuff products varies between 0.6-5.25¢ per ounce.[16]
- The seasonally adjusted bi-monthly mean for tobacco sales in Alabama has been stable (Figure 25); although it has consistently exceeded the national mean since the early 1990s.

Figure 25—Bi-monthly mean (seasonally adjusted) for tobacco sales in Alabama (packs/adult), 2002-2003

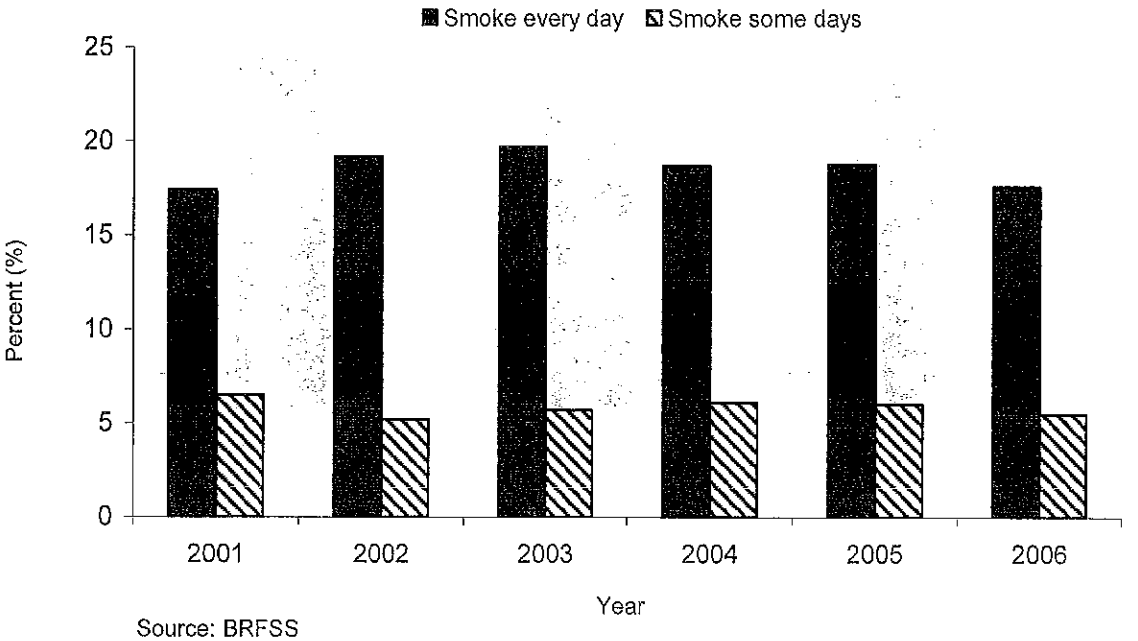


Tobacco Consumption

Adults—Current Use

- During 2003-2006, Alabama ranked above the national median for the percent of current smokers.
- In 2006, 23.2% of Alabama adults were current smokers, with 17.6% smoking every day and 5.5% smoking on some days (Figure 26).

Figure 26—Percent of current smokers in Alabama by smoking frequency, 2001-2006



Source: BRFSS

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- In 1997, the most recent data available that evaluated smokeless tobacco only, 19.7% of Alabama adults reported ever using smokeless tobacco, with significant differences between men (36.7%) and women (4.5%) (Figure 27).

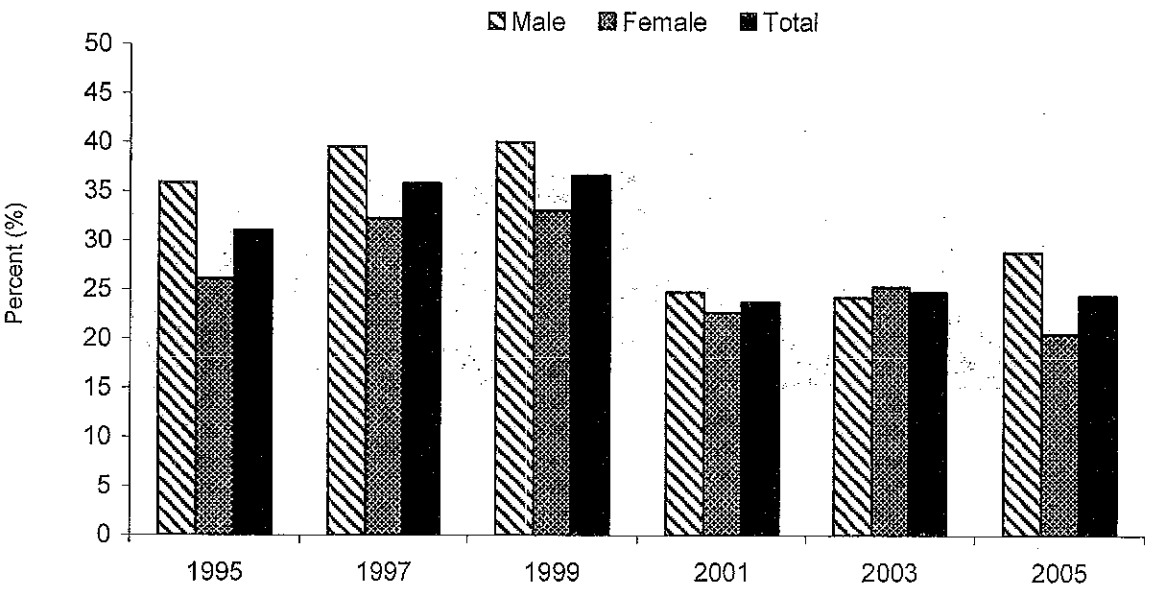
Figure 27—Percent of adults in Alabama who reported ever using smokeless tobacco by gender, 1995-1997

Source: BRFSS

Youth—Current Tobacco Use

- In 2005, 24.4% of youth in 9th-12th grades in Alabama reported smoking cigarettes on one or more of the previous 30 days(Figure 28).

Figure 28—Percent of youth who smoked cigarettes on one or more of the previous 30 days, 1995-2005



Source: YRBS

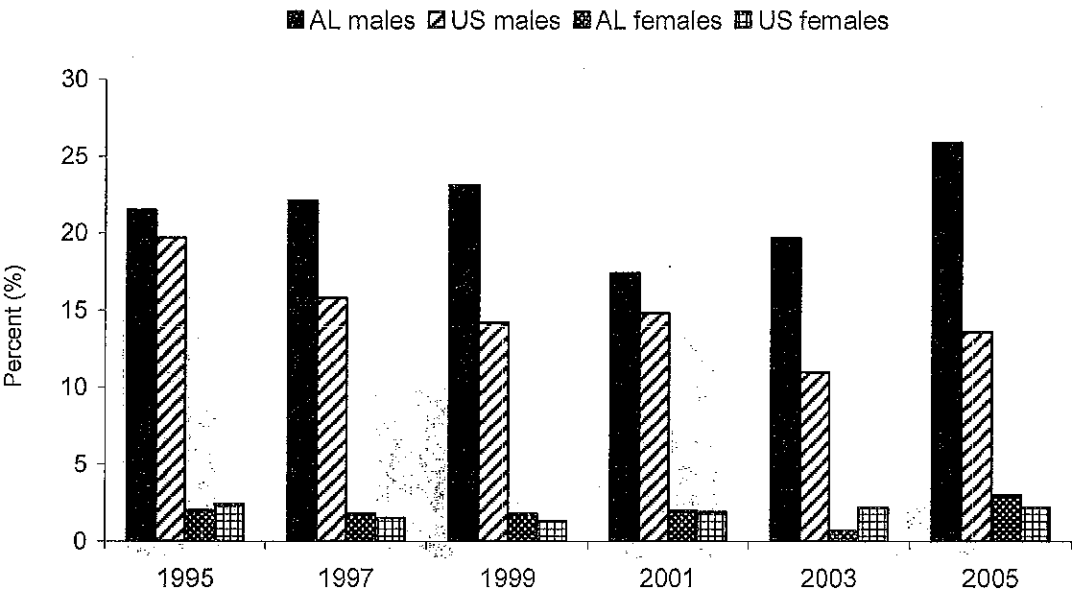
- The percent of youth in 9th-12th grades in Alabama who smoked regularly (20 or more days out of the previous 30 days) declined from 17.0% in 1999 to 10.2% in 2005. No significant differences were noted by gender for regular cigarette smoking among youth (Figure 29).

Figure 29—Percent of youth who smoked cigarettes on 20 or more of the previous 30 days, 1995-2005

Source: YRBS

- The percent of Alabama youth who reported current use of chewing tobacco, snuff, or dip was 14.1% compared to 8.0% nationwide in 2005.
- There was a significant gender difference at both the state- and national-levels for chewing tobacco use with more male youth reporting current use than female youth during 1995-2005.
- The percent of Alabama males who used chewing tobacco was greater than national estimates for each study year and was nearly 2-fold greater in 2005 (25.9% vs. 13.6%) (Figure 30).

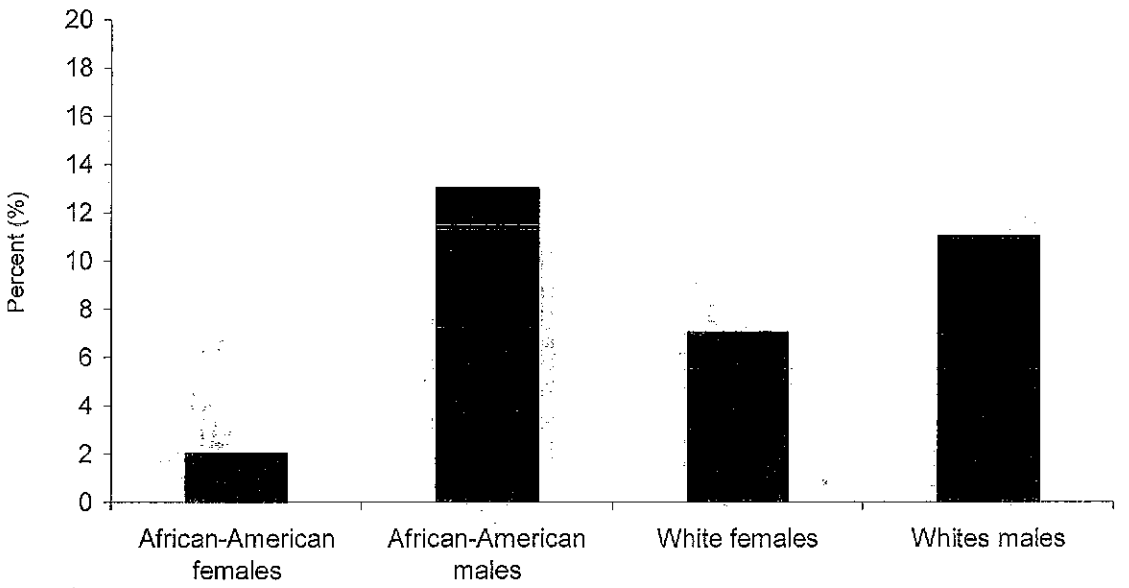
Figure 30—Percent of youth who used chewing tobacco, snuff, or dip on one or more of the previous 30 days by gender for Alabama and United States, 1995-2005



Source: YRBS

- In addition to traditional cigarettes and smokeless tobacco products, youth reported using bidis and kreteks, imported cigarettes that may be flavored or unflavored and have more nicotine, tar, and carbon monoxide than traditional cigarettes.[17,18]
- In 2004, more male youth (13% African-American males; 11% white males) in Alabama reported ever trying bidis or kreteks than female youth (2% African-American females; 7% white females) (Figure 31).

Figure 31—Percent of youth who have tried bidis and/or kreteks, 2004

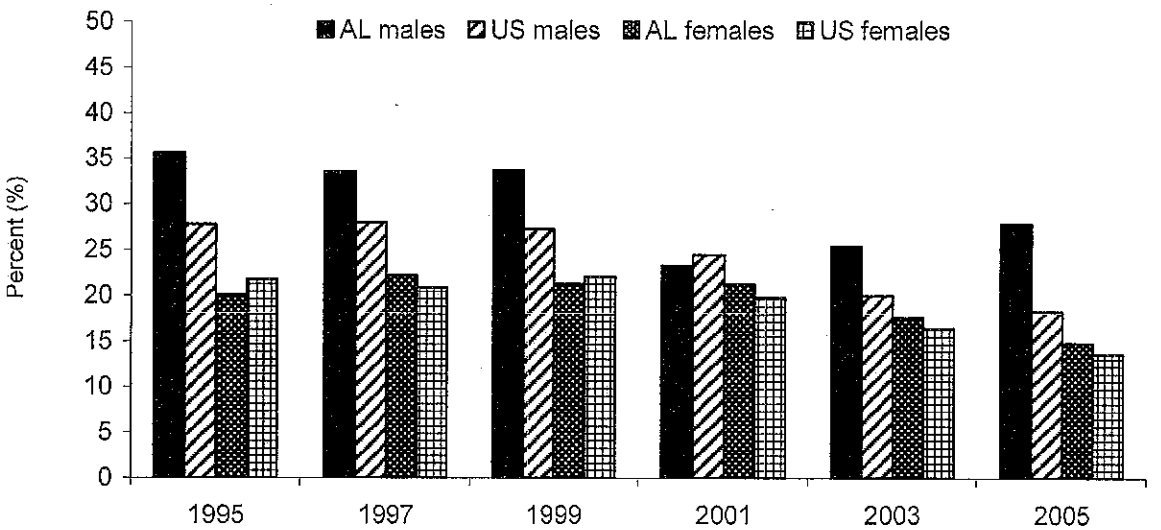


Source: AYTS Year

Youth—Age at First Use

- The age at first use of cigarettes is associated with an increased risk of nicotine dependence and smoking-related cancers.[19]
- In 2005, 21.2% of Alabama youth in 9th-12th grades reported smoking their first whole cigarette before age 13 compared to 16% of youth nationwide.
- More Alabama males (27.9%) reported smoking cigarettes before age 13 than males nationwide (18.3%) in 2005; however, there was no significant difference between state and national estimates for female youth (Figure 32).

Figure 32—Percent of youth who smoked a whole cigarette for the first time before 13 years of age by gender for Alabama and United States, 1995-2005

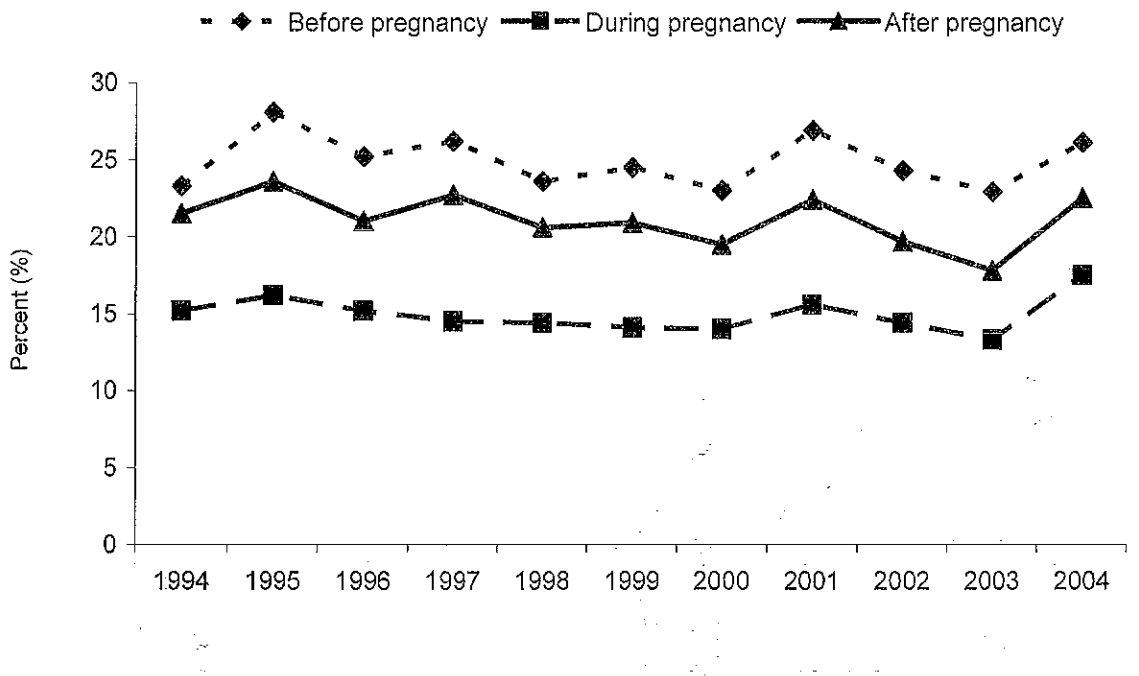


Source: YRBS

Pregnant Women

- Smoking during pregnancy has been associated with an increased risk of preterm birth, low birthweight, placental complications, and sudden infant death syndrome.[20]
- In 2004, 26.1% of Alabama mothers who had recently given birth reported smoking before pregnancy, 17.5% during pregnancy, and 22.5% after pregnancy (Figure 33).

Figure 33—Percent of Alabama mothers who recently gave birth who reported smoking before, during, or after pregnancy, 1994-2004



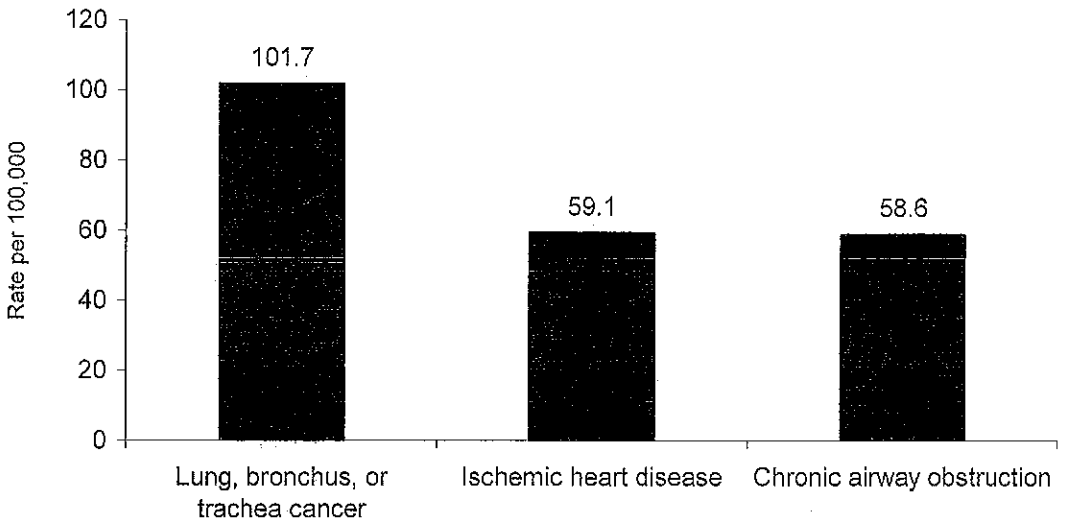
Source: PRAMS

Tobacco Consequences

Tobacco-Related Mortality

- Tobacco consumption is associated with an increased risk of morbidity and mortality.
- In Alabama, the smoking-attributable mortality rate (per 100,000) was greatest for cancer of the lung, bronchus, or trachea, ischemic heart disease, and chronic airway obstruction (Figure 34).

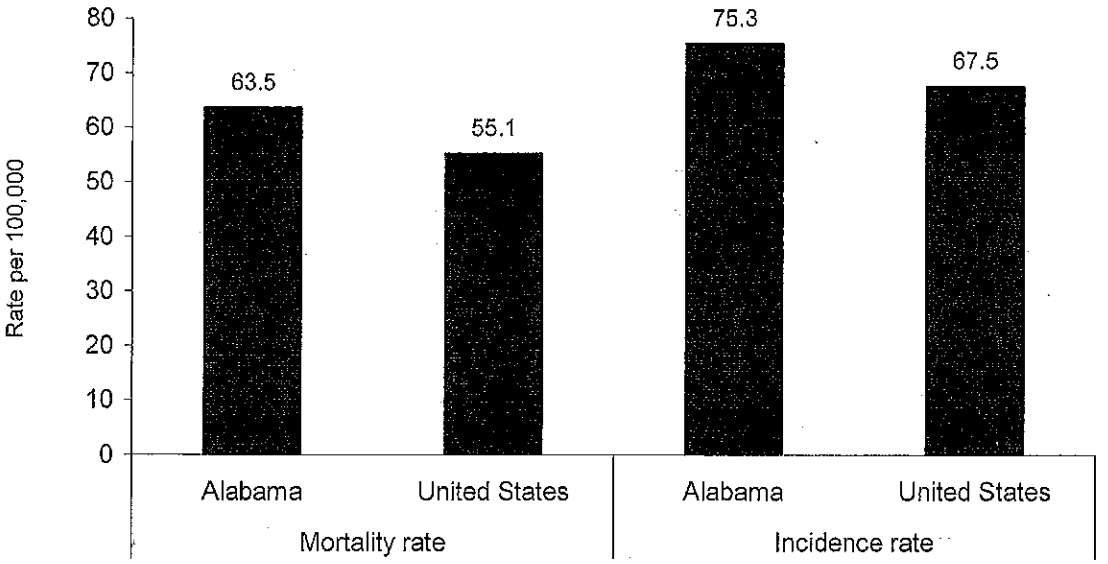
Figure 34—Average annual age-adjusted smoking-attributable mortality rate (per 100,000) in Alabama, 1997-2001



Source: SAMMEC

- The mortality and incidence rates for cancer of the lung, bronchus, or trachea were significantly greater in Alabama than in the United States (Figure 35).

Figure 35—Age-adjusted mortality rate (1999-2003) and incidence rate (2002) per 100,000 in Alabama and United States for cancer of the lung, bronchus, or trachea



Source: SEER

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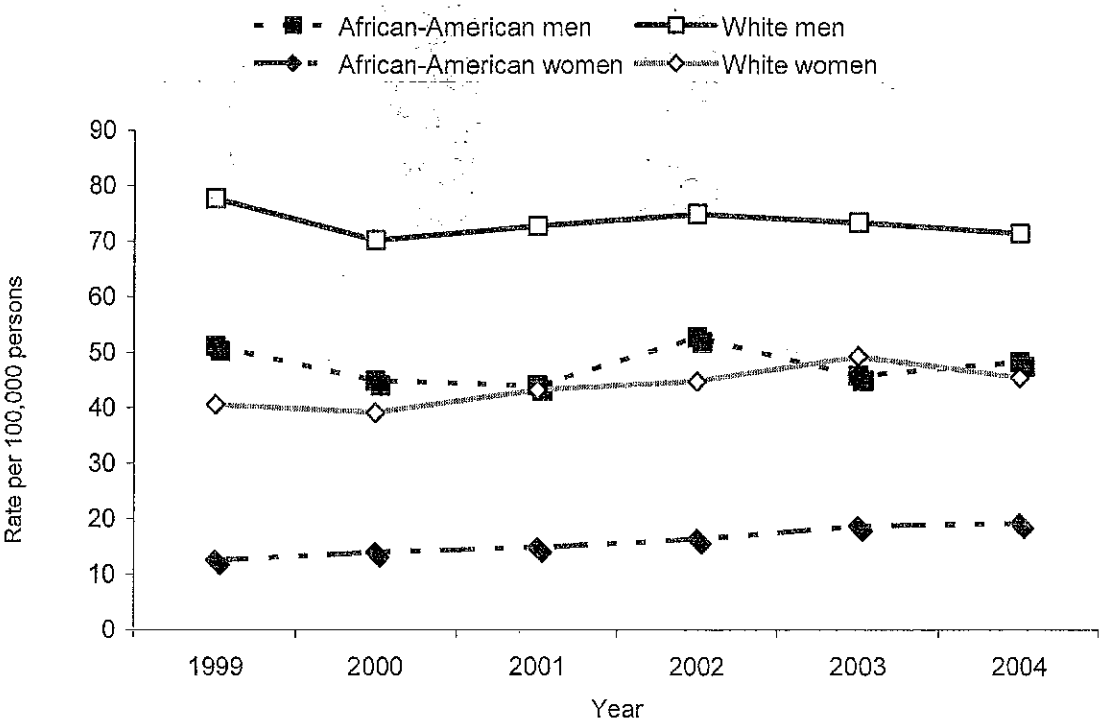
- The mortality rate for chronic lower respiratory diseases (CLRD), which includes bronchitis, asthma, emphysema, and other chronic obstructive pulmonary diseases, was highest for white men, followed by African-American men, white women, and African-American women in Alabama (Figure 36).
- In 2005, the mortality rate for CLRD for white men in Alabama (71.4 per 100,000) was higher than the national rate (51.1 per 100,000) while the state rates for the other groups were comparable to national rates.

Figure 36—Age-adjusted mortality rate (per 100,000) for chronic lower respiratory diseases in Alabama by race and gender, 1999-2004

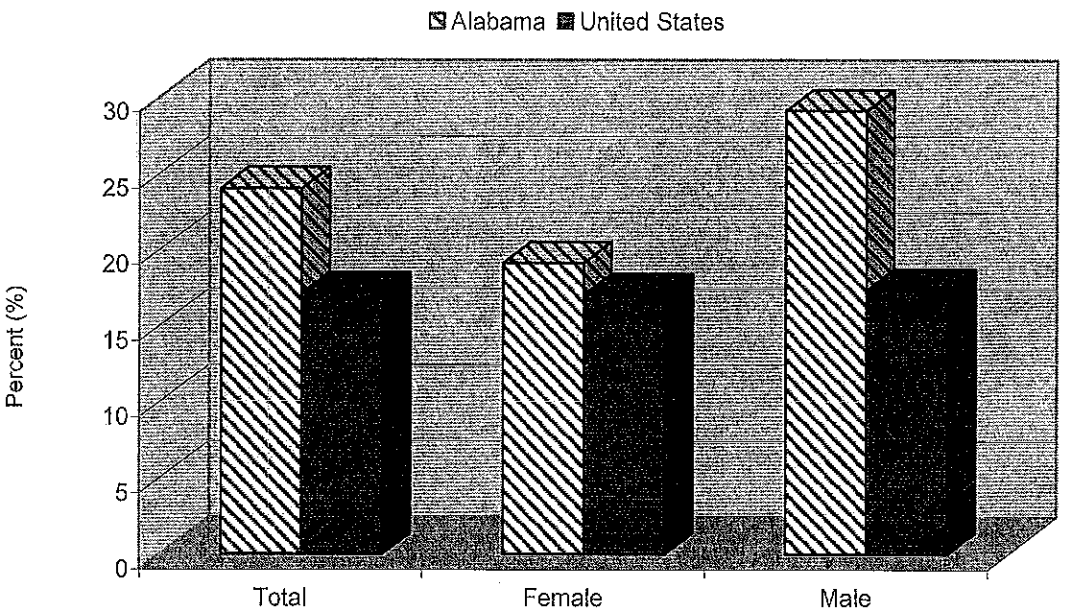


Source: CDC Wonder

Tobacco-Related Morbidity

- While most of the adverse health effects of tobacco are not manifest until adulthood, there is a growing concern about the prevalence of asthma among youth and the ensuing symptoms triggered by tobacco smoke.[21,22]
- In Alabama, 29.1% of male youth and 19.1% of female youth reported being told by a doctor or nurse that they had asthma (Figure 37). The percent of male youth in Alabama who reported being told that they had asthma was significantly higher than male youth nationwide, while there was no difference between state and national estimates for female youth.

Figure 37—Percent of students in Alabama and United States who had ever been told by a doctor or nurse that they had asthma, 2005

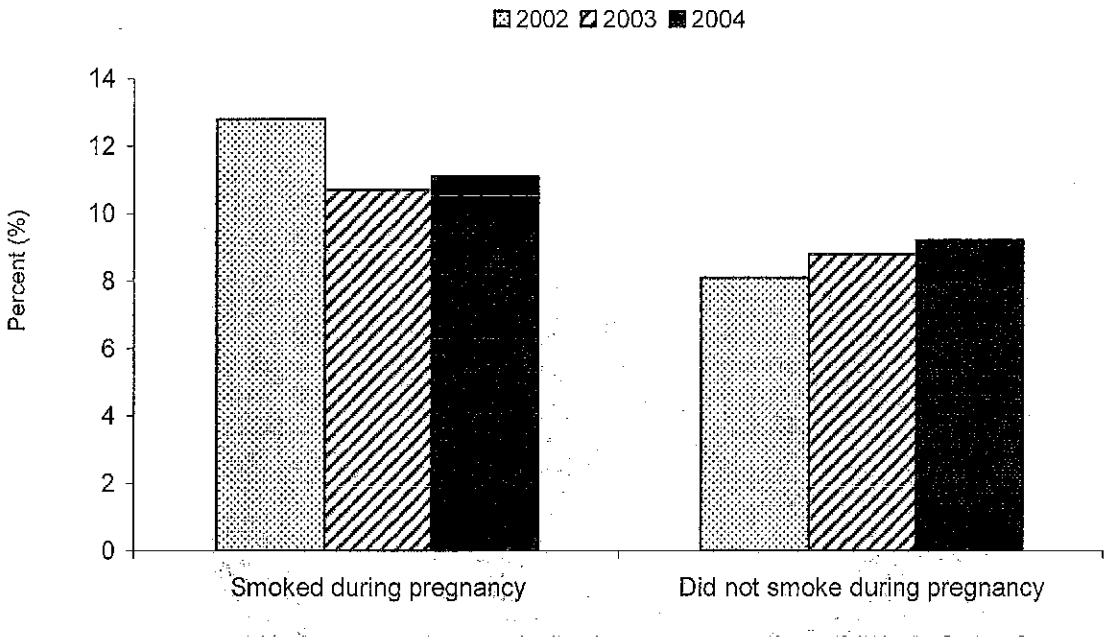


Source: YRBS

Pregnant Women

- Smoking during pregnancy is associated with various health problems including premature births and low birth weight babies.[20,21]
- In 2004, there was not a statistically significant difference by smoking status during pregnancy, with 11.1% of women who smoked during pregnancy and 9.2% of women who did not smoke during pregnancy giving birth to low birth weight babies (Figure 38).

Figure 38—Percent of mothers who reported smoking during their pregnancy and who gave birth to low birth weight birth babies, 2002-2004



Source: PRAMS

Other Drugs

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Other Drugs

- The Controlled Substances Act of 1970 established 5 schedules of drugs to regulate the manufacture and distribution of these drugs in the United States based on potential for abuse and accepted medical uses (21 Code of Federal Regulations Part 1308). Commonly abused drugs by schedule are presented in Table 2.
    - Schedule I: No approved medical uses
    - Schedule II: Requires a non-refillable prescription and order form
    - Schedule III, IV: Requires a prescription; limited refills are allowed; prescriptions may be called-in by the physician
    - Schedule V: Some availability over the counter

Table 2—Commonly abused drugs by category and schedule

Category	Name	Schedule
Cannabinoids	Hashish	I
	Marijuana	I
Depressants	Barbituates	II, III
	Benzodiazepines	IV
	Flunitrazepam	IV
	GHB (gamma-hydroxybutyrate)	I
	Methaqualone	I
Dissociative Anesthetics	Ketamine	III
	PCP (phencyclidine)	I, II
Hallucinogens	LSD (lysergic acid diethylamide)	I
	Mescaline	I
	Psilocybin	I
Opioids and morphine derivatives	Codeine	II, III, IV, V
	Fentanyl	I, II
	Heroin	I
	Morphine	II, III
	Opium	II, III, V
	Oxycodone HCL	II
	Hydrocodone bitartrate, acetaminophen	II
Stimulants	Amphetamine	II
	Cocaine	II
	MDMA (methylenedioxymethamphetamine)	I
	Methamphetamine	II
	Methylphenidate	II
	Nicotine	Not scheduled
Other compounds	Anabolic steroids	III
	DXM (dextromethorphan)	Not scheduled
	Inhalants	Not scheduled

Source: National Institute of Drug Abuse http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html

- In 2004, Alabama enacted a Prescription Drug Monitoring Program to collect data on drugs in Schedules II-V that were dispensed throughout the state. Mandatory reporting for this program began in April 2006.
    - Prescription data for drugs in schedules II-V that are dispensed in Alabama are required to be reported to a central database.
        - Drugs provided by samples, during inpatient care, during physician office visits (injection, oral, topical, or suppository administration), or through assistance programs are not subject to the regulations of the monitoring program.
    - The goal of the program is to identify any potential problems with prescription abuse early and to prevent people from filling multiple prescriptions from multiple physicians at multiple pharmacies, i.e. "doctor shopping."
    - Alabama ranks in the top quartile for the distribution of two prescription pain relievers, meperidine and hydrocodone.
        - In 2005, Alabama ranked 2nd in the distribution of meperidine with 4,452.07 grams/100,000 and 5th in the distribution of hydrocodone with 17,999.39 grams/100,000 persons (Table 3).

Table 3—Cumulative distribution in grams per 100,000 persons in Alabama, 2005

Drug name	Drug code	Grams/100,000 persons	Rank*
Buprenorpine	9064	73.63	12
D-Amphetamine base	1100D	2043.19	6
DL-Amphetamine base	1100B	1659.46	6
Hydrocodone	9193	17,999.39	5
Meperidine	9230	4,452.07	2
Methadone	9250B	3881.14	7

*Ranking is based on 50 states plus the District of Columbia and selected US territories.

Source: DEA http://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/2005/05_rpt4.pdf

Other Drugs Consumption

Consumption

- During 2002-2004, 38% of persons ages 12 years and older in Alabama reported use of other illicit drugs (marijuana/hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically) at some point during their lifetime, with 12.6% reporting use in the past year, and 6.9% reporting use in the past month (Table 4).
- The leading illicit drug used during each time period was marijuana followed by the non-medical use of psychotherapeutics, particularly pain relievers.

Table 4—Percent of Alabama residents ages 12 years and older who reported illicit drug use by drug type and time period used, 2002-2004

Drug	Time Period		
	Lifetime	Past Year	Past Month
Illicit Drug	38.0	12.6	6.9
Marijuana/Hashish	32.6	8.7	4.4
Cocaine	8.8	2.0	0.8
Crack	2.4	0.7	0.3
Heroin	0.8	0.2	0.1
Hallucinogens	8.3	1.2	0.3
LSD	5.8	0.3	0.1
PCP	1.2	0.0	0.0
Ecstasy	4.5	0.9	0.2
Inhalants	7.4	0.7	0.2
Non-medical use of psychotherapeutics[1]	19.0	6.5	3.3
Pain Relievers	13.0	5.0	2.4
OxyContin®[2]	2.0	0.8	0.2
Tranquilizers	8.8	2.8	1.1
Stimulants	6.7	1.5	0.7
Methamphetamine	3.2	0.8	0.4
Sedatives	4.0	0.5	0.2

Source: NSDUH

[1] Non-medical use of prescription-type pain relievers, tranquilizers, stimulants, or sedatives; does not include over-the-counter drugs.
[2] OxyContin® use estimates are based on 2004 data only.

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Adults—Current Use

- The percent of Alabama adults who reported using marijuana was relatively stable between 2002 and 2005, with more people in the 18-25 year age group reporting use than the 26 and older age group (Table 5).
- The proportion of Alabama adults who reported using marijuana was lower than national estimates for both age groups.

Table 5—Percent of marijuana users in past month by age group and year, 2002-2005

	Age Group					
	18-25 years			26 and older		
	2002-03	2003-04	2004-05	2002-03	2003-04	2004-05
United States	17.2	16.6	16.4	4.0	4.0	4.1
Alabama	12.5	13.8	13.9	2.6	2.9	3.1

Source: NSDUH

- The percent of Alabama adults using illicit drugs other than marijuana (cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically) was also relatively stable between 2002 and 2005, with more persons in the 18-25 year age group reporting use than the 26 and older age group (Table 6).
- The proportion of Alabama adults who reported using illicit drugs other than marijuana was comparable to national estimates for both age groups.

Table 6—Percent of illicit drug users (other than marijuana) in past month by age group and year, 2002-2005

	Age Group					
	18-25 years			26 and older		
	2002-03	2003-04	2004-05	2002-03	2003-04	2004-05
United States	8.2	8.3	8.5	2.7	2.5	2.5
Alabama	8.1	8.4	9.9	2.7	2.5	2.7

Source: NSDUH

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- The non-medical use of prescription pain medications has not changed significantly between 2002 and 2005, although the estimates for Alabama are slightly higher than national estimates for the 18-25 year age group (Table 7).

Table 7—Percent of adults who reported non-medical use of prescription pain relievers in past month by age group and year, 2002-2005

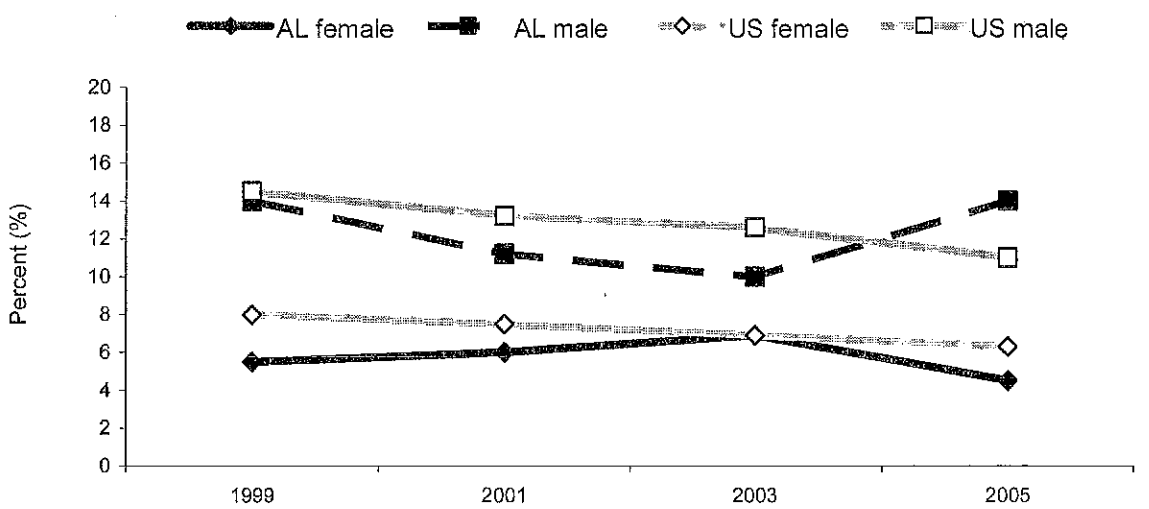
	Age Group					
	18-25 years			26 and older		
	2002-03	2003-04	2004-05	2002-03	2003-04	2004-05
United States	11.7	11.9	12.2	3.2	3.2	3.1
Alabama	13.0	13.7	14.0	3.0	3.2	3.0

Source: NSDUH

Youth—Current Use

- More male youth in 9th-12th grades reported trying marijuana before age 13 years than female youth at both the state and national levels (Figure 39).
- The estimates for Alabama youth were comparable to or slightly less than national estimates on average, with the exception of a non-significant increase in 2005 for Alabama males.

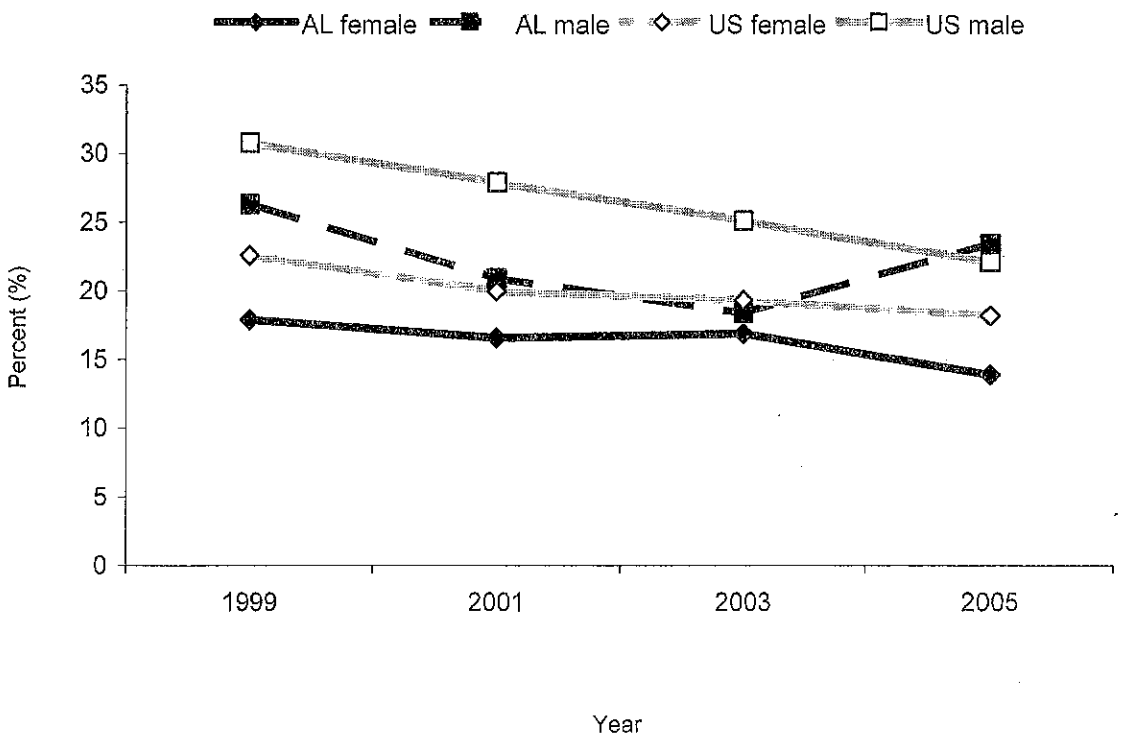
Figure 39—Percent of youths in 9th-12th grades who tried marijuana before age 13 years by gender and year for Alabama and United States, 1999-2005



Source: YRBS

- The percent of Alabama youth who reported using marijuana during the previous 30 days declined between 1999 and 2005, with the exception of male youth in 2005 (Figure 40). In 2005, 13.9% of females and 23.4% of males in Alabama reported current use of marijuana although these estimates were not significantly different from 2003.
- Current marijuana use was lower among Alabama youth compared to national estimates on average, with the exception of a non-significant increase in 2005 for Alabama males.

Figure 40—Percent of youth in 9th-12th grades who reported marijuana use in past month by gender and year for Alabama and United States, 1999-2005



Source: YRBS

- Between 1999 and 2005, the percent of males in 9th-12th grades reporting use of cocaine, ecstasy, heroin, inhalants, or methamphetamines was relatively stable with no statistically significant changes during this period (Table 8).
- The percent of female youth who reported use of cocaine, ecstasy, and heroin also did not change significantly between 1999 and 2005, although inhalant use (1999 and 2003) and methamphetamine use (1999 and 2005) significantly decreased.

Table 8—Percent of youths in 9th-12th grades who reported use of drugs during lifetime by gender and year, 1999-2005

Drug		1999	2001	2003	2005
Cocaine	*Males*	9.6	6.9	7.1	10.1
	Females	6.8	6.2	7.0	5.0
Ecstasy	*Males*	N/A	N/A	8.8	11.9
	Females	N/A	N/A	6.9	5.1
Heroin	*Males*	4.7	3.7	4.3	8.5
	Females	1.5	1.1	0.8	2.0
Inhalants	*Males*	16.1	12.8	11.5	17.9
	Females	15.9	14.2	9.5	13.3
Methamphetamines	*Males*	11.0	6.9	8.9	10.3
	Females	10.7	7.9	8.2	4.4

Source: YRBS

*Note: The estimates for 2005 are less precise than previous years. So, while there appears to be a substantial change in the percent of youths reporting use between 2003 and 2005, there was not a statistically significant increase or decrease for male or female youth.

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- Overall, the non-medical use of pain relievers was higher among Alabama youth than national estimates between 2002 and 2005.
- The percent of youth ages 12-17 years who reported non-medical use of pain relievers during the past year significantly decreased nationally during this period, while there was a slight, non-significant increase in Alabama (Table 9).

Table 9—Percent of youth ages 12-17 years who reported non-medical use of pain relievers in past year for Alabama and United States, 2002-2005

	2002-2003	2003-2004	2004-2005
United States	7.6	7.5	7.1
Alabama	8.0	8.6	8.7

Source: NSDUH

- The percent of youth in 9th-12th grades who reported using a needle to inject illegal drugs into their body was significantly higher for males than females in 1999, 2003, and 2005 (Table 10).
- Between 1999 and 2005, the percent of youth reporting needle use was relatively stable for females, while the estimates for males fluctuated but with no statistically significant changes.

Table 10—Percent of Alabama youth in 9th-12th grades who reported using a needle to inject illegal drugs into their body one or more times during their life, 1999-2005

	1999	2001	2003	2005
Male youth	4.5	2.1	2.8	6.6
Female youth	1.2	1.5	0.5	1.8

Source: YRBS

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Other Drugs Consequences

Adults—Abuse or Dependence

- Illicit drug use, including recreational and experimental use, can result in dependence or abuse.
- In 2004-2005, 8.4% of adults in Alabama ages 18-25 years were dependent or abused illicit drugs in the past year compared to 1.8% of adults ages 26 years and older (Table 11).
- The national and state-level percents were comparable for both age groups and there were no statistically significant changes between 2002 and 2005.

Table 11—Percent of adults who are dependent or abuse[†] illicit drugs[‡] in the United States and Alabama by age group, 2002-2005

	Age Group					
	18-25 years			26 and older		
	2002-03	2003-04	2004-05	2002-03	2003-04	2004-05
United States	8.0	8.1	8.4	1.7	1.7	1.7
Alabama	6.5	7.5	8.4	1.7	1.8	1.8

Source: NSDUH

[†] Dependence or abuse is based on definitions in the DSM-IV.
[‡] Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Adults—Needing Treatment

- Treatment and after-care services are needed to combat the effects of drug dependence or abuse.
- In 2004-2005, 7.1% of adults in Alabama ages 18-25 years needed but did not receive treatment for illicit drug use compared to 1.4% of adults ages 26 years and older (Table 12).
- The national and state-level percents were comparable for both age groups and there were no statistically significant changes between 2002 and 2005.

Table 12—Percent of adults who needed but did not receive treatment[†] for illicit drug[‡] use in the United States and Alabama by age group, 2002-2005

	Age Group					
	18-25 years			26 and older		
	2002-03	2003-04	2004-05	2002-03	2003-04	2004-05
United States	7.5	7.5	7.7	1.5	1.5	1.5
Alabama	5.9	6.8	7.1	1.3	1.4	1.4

Source: NSDUH

[†] Defined as no treatment at a specialty facility (i.e., drug and alcohol rehabilitation facilities, hospitals [inpatient only], and mental health centers).

[‡] Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

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Youth—Abuse or Dependence

- In 2004-2005, 5.0% of youth in Alabama ages 12-17 years were dependent or abused illicit drugs in the past year (Table 13).
- The national and state-level percents were comparable and there were no statistically significant changes between 2002 and 2005.

Table 13—Percent of youth who are dependent or abuse[†] illicit drugs[‡] in the United States and Alabama, 2002-2005

	Age Group		
	12-17 years		
	2002-03	2003-04	2004-05
United States	5.4	5.3	5.0
Alabama	4.7	5.2	5.0

Source: NSDUH

[†] Dependence or abuse is based on definitions in the DSM-IV.

[‡] Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Youth—Needing Treatment

- In 2004-2005, 4.6% of youth in Alabama ages 12-17 years needed but did not receive treatment for illicit drug use (Table 14).
- The national and state-level percents were comparable for both age groups and there were no statistically significant changes between 2002 and 2005.

Table 14—Percent of adults who needed but did not receive treatment[†] for illicit drug[‡] use in the United States and Alabama by age group, 2002-2005

	Age Group		
	12-17 years		
	2002-03	2003-04	2004-05
United States	5.0	4.9	4.7
Alabama	4.3	4.8	4.6

Source: NSDUH

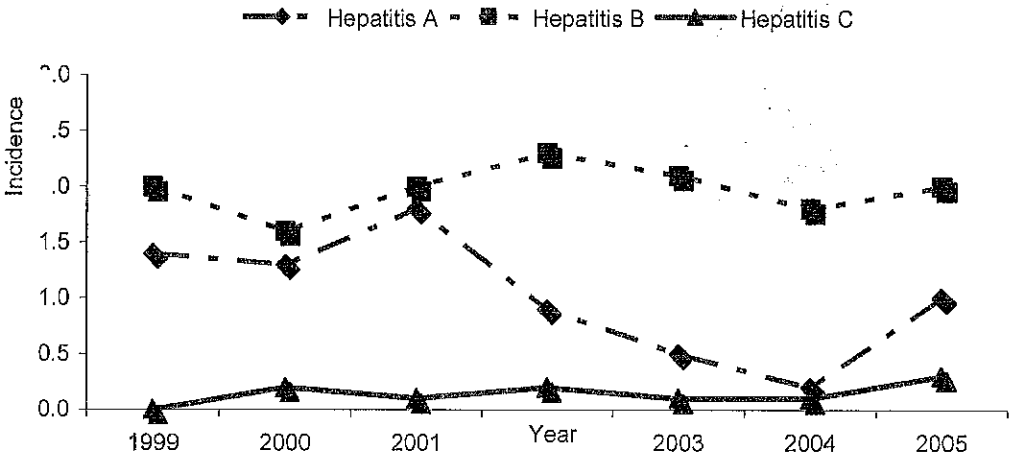
[†] Defined as no treatment at a specialty facility (i.e., drug and alcohol rehabilitation facilities, hospitals [inpatient only], and mental health centers).

[‡] Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Drug-Related Morbidity

- Illicit drug use, particularly injection drug use, may contribute to serious health infections including hepatitis and HIV/AIDS.
- The most common hepatitis infections in the United States are Hepatitis A, Hepatitis B, and Hepatitis C, for which vaccines are currently only available for Hepatitis A and Hepatitis B.[23]
- In Alabama, the incidence for hepatitis B and Hepatitis C has been relatively stable since 1999, while the incidence for Hepatitis A declined between 2001 and 2004 before increasing in 2005 (Figure 41).

Figure 41—Incidence (per 100,000) for hepatitis in Alabama, 1999-2005

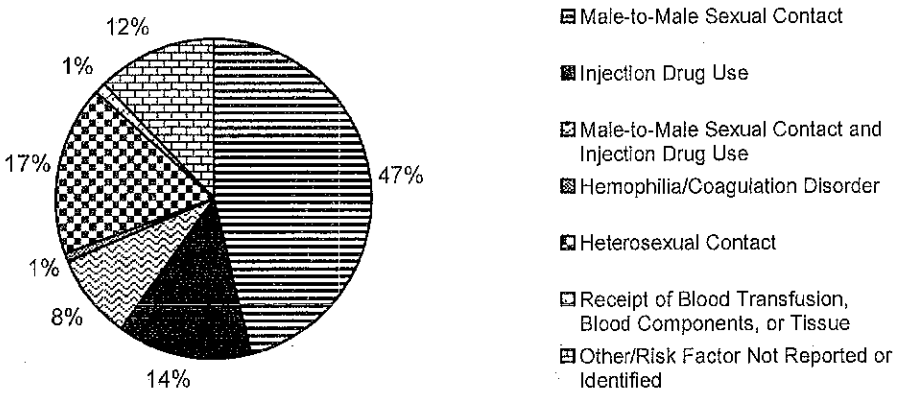


Source: Centers for Disease Control and Prevention. Surveillance for Acute Viral Hepatitis—United States, 2005. Surveillance Summaries, March 16, 2007. MMWR 2007;56(No. SS-3).

- According to national surveillance data, injection drug use was reported as a risk factor in 50% of Hepatitis C cases, 15% of Hepatitis B cases, and 5% of Hepatitis A cases in 2005. Note: Risk factors were identified by assessing exposures during the 6 weeks to 6 months before illness onset and calculated as the percent of cases in which the risk factor was reported divided by the total number of cases in which any exposure information was reported.

- Injection drug use is also a contributing factor in the transmission of HIV/AIDS.
- For all reported cases in Alabama through 2005, injection drug use accounted for 14% of AIDS cases and male-to-male sexual contact and injection drug use combined accounted for 8% of AIDS cases (Figure 42).

Figure 42—Percent of reported AIDS cases in Alabama by transmission category, cumulative through 2005



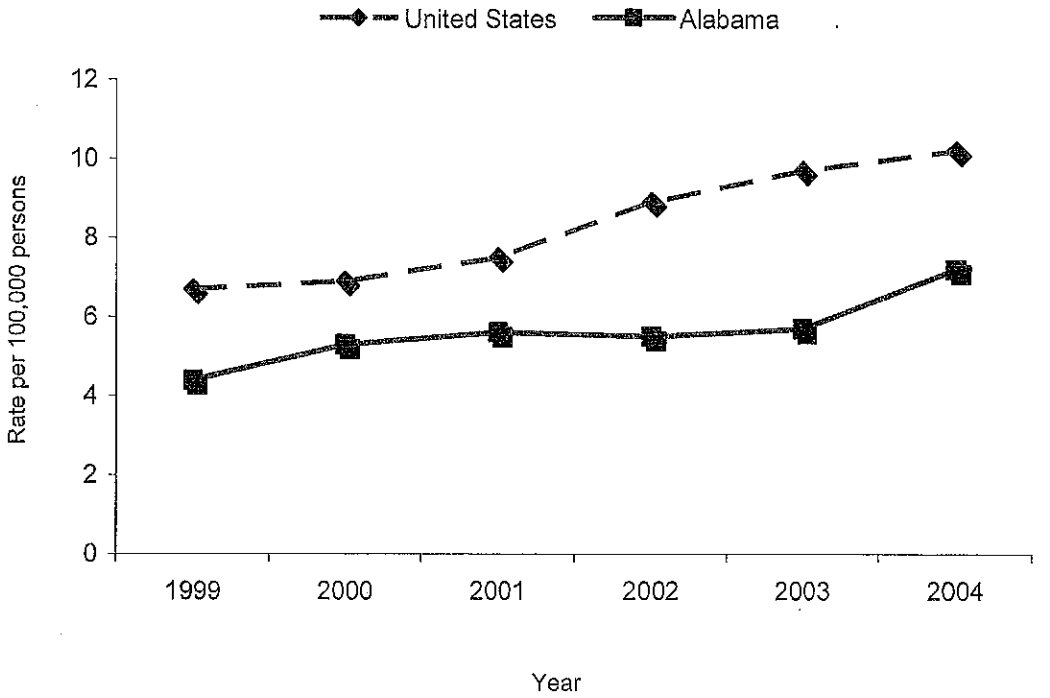
Note: Categories are in clockwise order according to legend.

Source: Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention-Surveillance and Epidemiology, Special Data Request, November 2006. http://www.statehealthfacts.org/profileind.jsp?ind=507&cat=11&rgn=2

Drug-Related Mortality

- Illicit drug use can result in drug overdose fatalities and contribute to homicides and suicides.
- The age-adjusted mortality rate for drug-induced deaths has increased for both Alabama and the United States since 1999, although the rate for Alabama remains lower than the national rate (Figure 43).

Figure 43—Age-adjusted mortality rate (per 100,000) for drug-induced deaths[†], 1999-2004

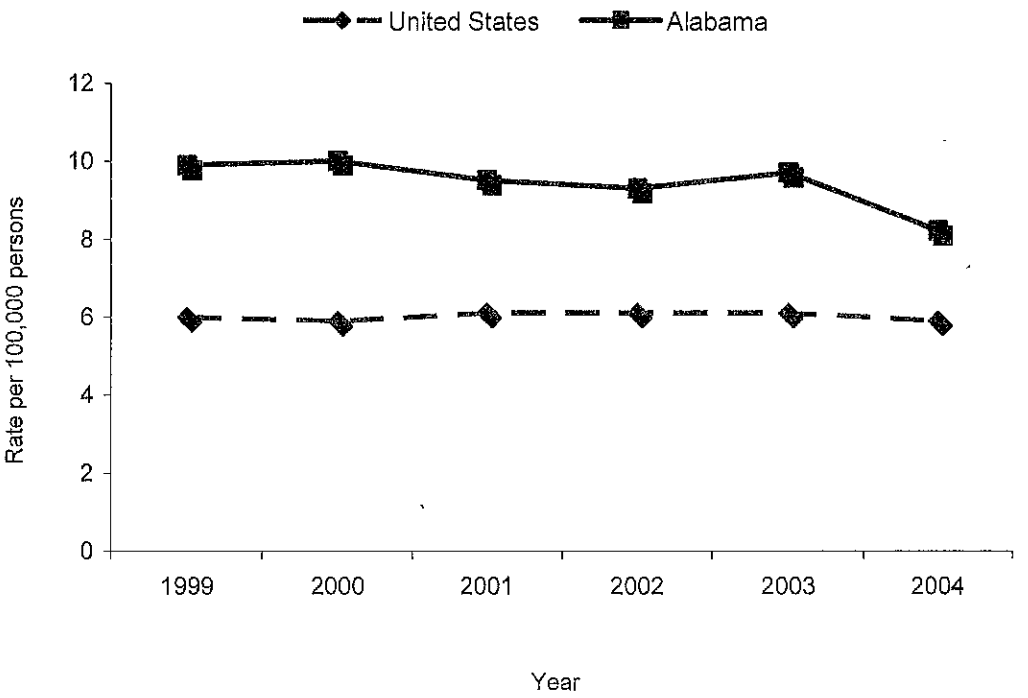


Source: CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2004 Series 20 No. 2J, 2007. Accessed at http://wonder.cdc.gov/cmf-icd10.html.

[†]Drug-induced deaths identified using ICD-10 codes F11-F16, F18, F19, X40-X44, X46, X60-X64, Y10-Y14, and Y16.

- The age-adjusted mortality rate for homicides has remained relatively stable for both Alabama and the United States since 1999, although the rate for Alabama continues to be higher than the national rate (Figure 44).

Figure 44—Age-adjusted mortality rate (per 100,000) for homicides, 1999-2004

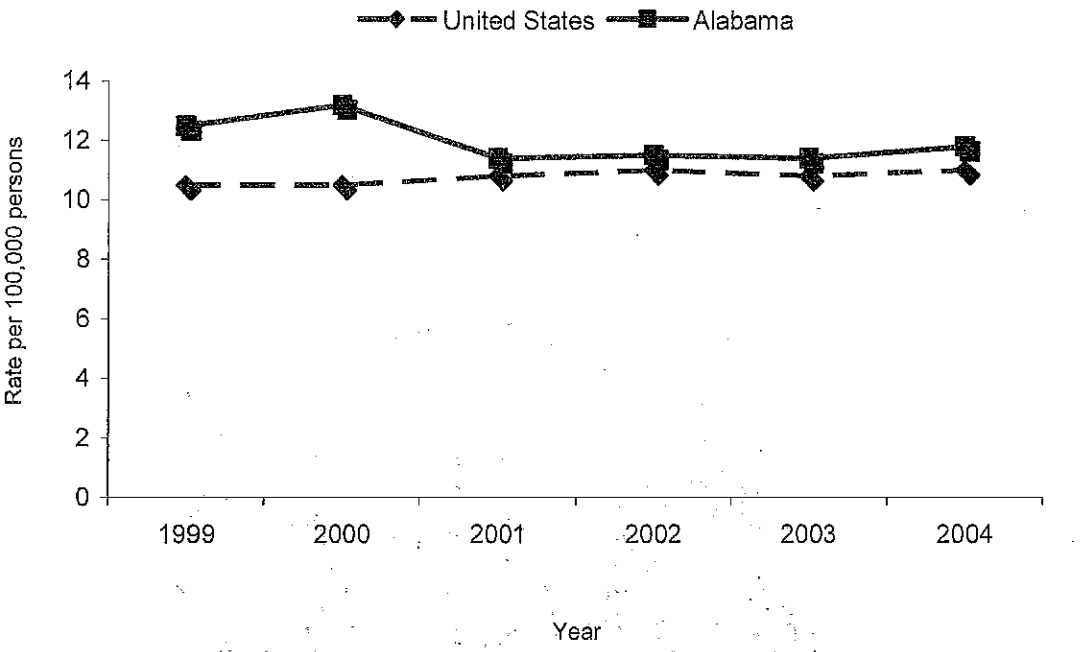


Source: CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2004 Series 20 No. 2J, 2007. Accessed at http://wonder.cdc.gov/cmf-icd10.html.

[†]Homicides identified using ICD-10 codes X85-Y09, and Y87.1.

- Similarly, the age-adjusted mortality rate for suicides has remained relatively stable for both Alabama and the United States since 1999, although the rate for Alabama has been slightly higher than the national rate (Figure 45).

Figure 45—Age-adjusted mortality rate for suicides, 1999-2004



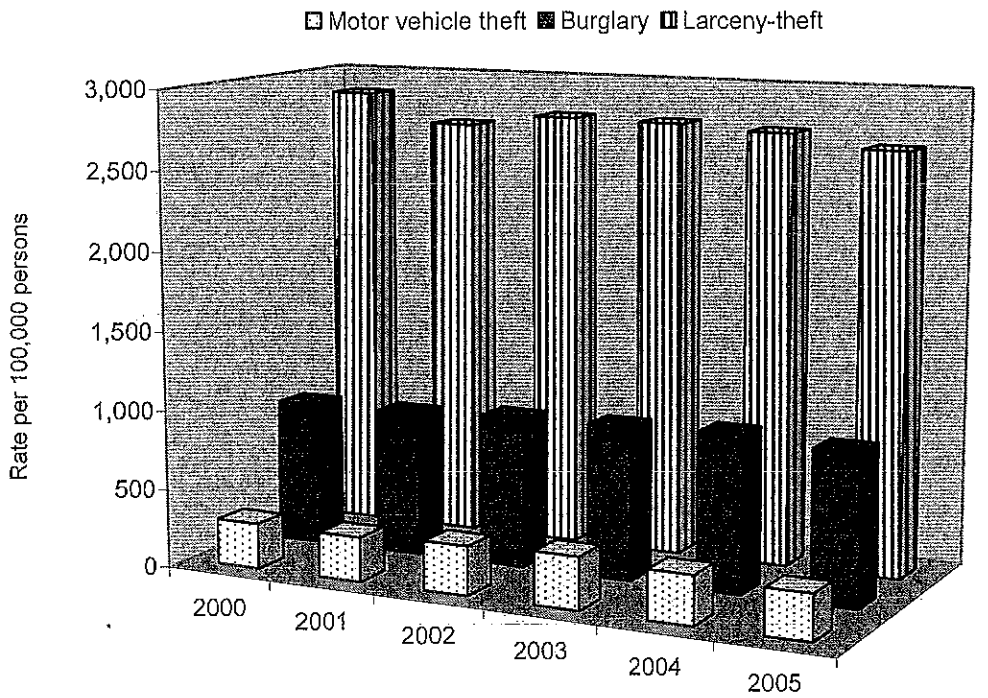
Source: CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2004 Series 20 No. 2J, 2007. Accessed at http://wonder.cdc.gov/cmf-icd10.html.

†Suicides identified using ICD-10 codes X60-X84 and Y87.0.

Drug-Related Crimes

- Another possible consequence of illicit drug use is property crime, such as motor vehicle theft, burglary, and larceny-theft, although the proportion due to illicit drug use is unknown.
- In 2005, the rate per 100,000 Alabama residents was 288.3 for motor vehicle theft, 953.8 for burglary, and 2,650.0 for larceny-theft, which was comparable to rates for previous years (Figure 46).

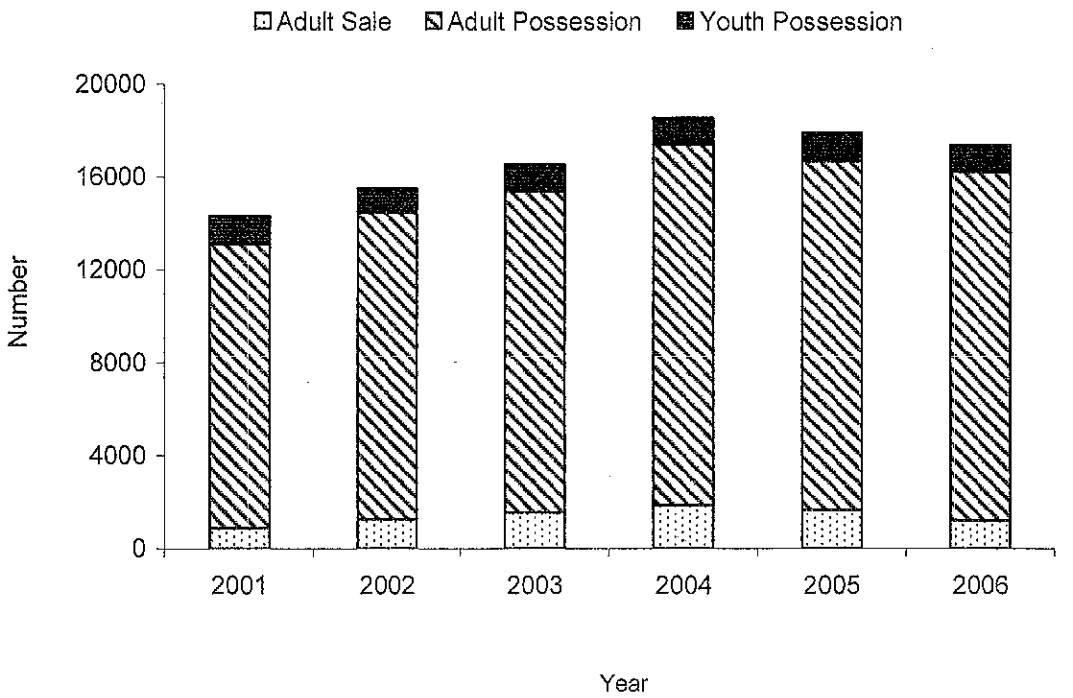
Figure 46—Rate per 100,000 for motor vehicle theft, burglary, and larceny-theft in Alabama, 2000-2005



Source: UCR

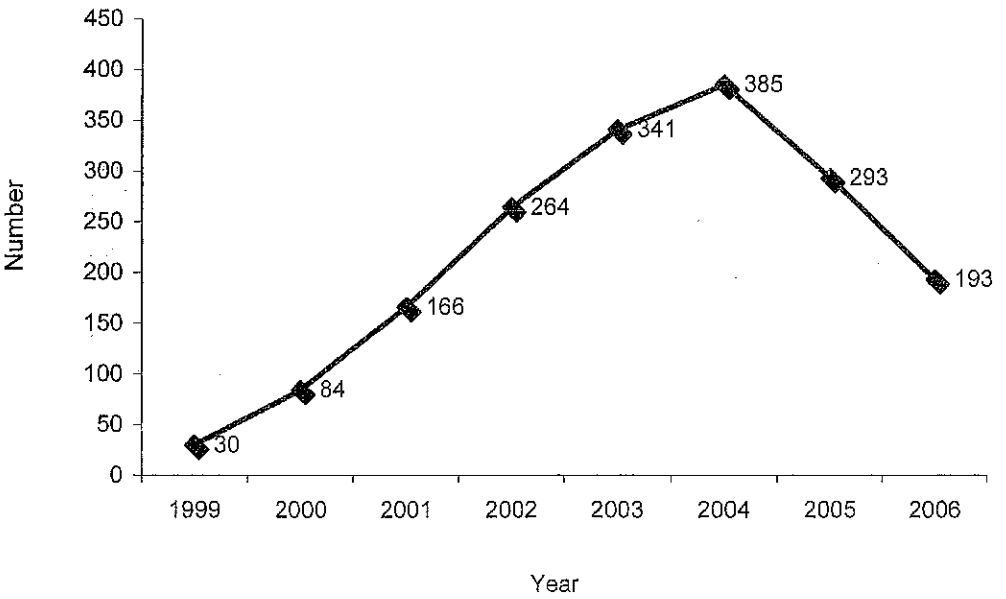
- Criminal arrests for the sale or possession of drugs are also possible consequences.
- In 2006, 16,198 adults and 1,167 youth were arrested for the sale or possession of drugs, with 53% of adult arrests and 79% of youth arrests due to the sale or possession of marijuana. Note: Arrests for youth drug sales were low (< 55 in a given calendar year) and are not visible in Figure 47 but are included in overall totals.

Figure 47—Number of arrests for the sale or possession of drugs in Alabama, 2001-2006



- Clandestine laboratories used to manufacture illicit drugs, particularly methamphetamine, may result in serious injury from explosions, fires, chemical burns, and toxic fumes and create environmental hazards.[24]
- The number of clandestine methamphetamine laboratory incidents in Alabama increased from 1999 to 2004, but then declined in 2005 and 2006 (Figure 48).
- This decline may be partially due to the enactment of Code of Alabama 1975, § 20-2-190 in 2004, which restricted the sale of products containing pseudoephedrine or ephedrine, ingredients used to make methamphetamine. The law requires products with those ingredients to be placed behind the counter or in a locked display; buyers to be ages 18 years or older; presentation of photo identification; and a signature.

Figure 48—Number of clandestine methamphetamine laboratory incidents in Alabama, 1999-2006



Source: DEA

State Resources

Selected State Resources

- In fiscal year 2004-2005, 25,319 clients received treatment for an alcohol and/or drug problem in a publicly funded facility in Alabama, an increase of 7,487 from 2003-2004 (Table 15).

Table 15—Number of clients treated in publicly funded† facilities in Alabama by fiscal year

	Fiscal Year (October 1 to September 30)	
	2003-04	2004-05
Total	17,832	25,319

†Funding provided by federal block grant and/or state sources. There were 43 and 45 publicly funded facilities in Alabama in 2003-04 and 2004-05, respectively.

Source: Alabama DMH/MR website http://www.mh.alabama.gov/SA/StatisticsAndPublications.aspx?sm=d_c

- Between fiscal years 2003-04 and 2004-05, the amount of federal Substance Abuse Prevention and Treatment (SAPT) block grant funds spent on prevention and treatment decreased, while the amount of Medicaid funds spent increased (Table 16).
- The amount of state funds spent on prevention and treatment also increased between fiscal years 2003-04 and 2004-05 although there was no state funding provided for primary prevention in either fiscal year (Table 16).

Table 16—Amount of money spent on prevention and treatment services in Alabama, by source and fiscal year

	Fiscal Year (October 1 to September 30)	
	2003-04	2004-05
SAPT Federal Block Grant		
Prevention† and Treatment	$17,152,741	$16,810,026
Primary Prevention	$4,930,210	$4,811,204
State Funds		
Prevention† and Treatment	$4,518,640	$6,691,266
Primary Prevention	$0	$0
Medicaid Funds		
Prevention† and Treatment	$2,458,051	$2,769,551

†Prevention other than primary prevention

Source: Alabama Block Grant Applications for 2006 and 2007

- The Department of Youth Services manages court and other referrals for youth with substance abuse problems. In 2006-07, most of the referrals were boys (Table 17).

Table 17—Number of youths referred to DYS for alcohol and/or drug use in Alabama

	July 1, 2006 to June 30, 2007	
	Males	**Females**
General referral	609	68

Source: DYS

- DYS also operates facilities that provide a comprehensive Chemical Addiction Program, particularly for serious or repeat juvenile offenders. In 2006, 301 males and 89 females were referred to these facilities for chemical addiction treatment (Table 18).

Table 18—Number of youths referred for chemical addiction treatment at a DYS facility (Chalkville or Mount Meigs) in Alabama

	January 1, 2006 to December 31, 2006	
	Males	**Females**
Facility referral	89	301

Source: DYS

- The Department of Human Resources investigates allegations of child abuse and neglect. In fiscal year 2006-2007 (as of July 31, 2007), there were 26 indicated allegations for fetal alcohol syndrome/drug withdrawal and 391 positive tests for alcohol/drugs at birth (Table 19).

Table 19—Number of allegations investigated by DHR for child neglect or abuse among newborns in Alabama

	Fiscal Year (October 1 to September 30)	
	2005-06	**2006-07***
Fetal Alcohol Syndrome/ Drug Withdrawal	15	26
Positive Test for Alcohol/ Drugs at Birth	353	391

Source: DHR
* The final count for FY 2007 was not available so data is current as of 7/31/07.

- The Department of Corrections maintains facilities to incarcerate persons convicted of crimes. In fiscal year 2006, drug-related crimes were the 3rd leading factor for incarceration among incarcerated persons in Alabama (Figure 49).

Figure 49—Reason for incarceration among incarcerated persons in Alabama, FY 2006

Source: DOC

- In 2005-2006, there were 8,492 convictions for drug offenses, with 56.4% of those convictions due to possession of a controlled substance (Table 20).

Table 20—Most frequent offense at conviction for drug offenses in Alabama

	June 1, 2005 to May 31, 2006
Possession of Controlled Substance	4787
Felony DUI	984
Distribution of Controlled Substance	953
Possession of Marijuana 1st	906
Manufacturing of Controlled Substance 2nd	299
Trafficking Drugs	297
Manufacturing of Controlled Substance 1st	195
Other Drug Offenses	71
Total	8492

Source: Sentencing Commission

References

1. Department of Archives and History. State of Alabama. All about Alabama. http://www.alabamainteractive.org/alabamainteractive_shell/Welcome.do?url=http://www.archives.state.al.us/aaa.html. Accessed October 25, 2007.
2. Center for Business and Economic Research. University of Alabama. Alabama Maps. http://cber.cba.ua.edu/edata/maps/AlabamaMaps1.html. Accessed October 25, 2007.
3. U.S. Department of Agriculture. Economic Research Service. State fact sheets: Alabama. http://www.ers.usda.gov/StateFacts/AL.htm. Accessed October 25, 2007.
4. Lakins NE, Williams GD, and Yi H. Surveillance Report #78--Apparent per capita alcohol consumption: national, state, and regional trends 1977-2004. National Institute on Alcohol Abuse and Alcoholism, Alcohol Epidemiologic Data System (AEDS). http://pubs.niaaa.nih.gov/publications/surveillance78/CONS04.htm#top
5. O'Keefe JH, Bybee KA, Lavie CJ. Alcohol and cardiovascular health: the razor-sharp double-edged sword. J Am Coll Cardiol. 2007; 50(11):1009-14.
6. Guo J, Collins LM, Hill KG, Hawkins JD. Developmental pathways to alcohol abuse and dependence in young adulthood. J Stud Alcohol. 2000; 61(6):799-808.
7. Miller JW, Naimi TS, Brewer RD, Jones SE. Binge drinking and associated health risk behaviors among high school students. Pediatrics. 2007; 119(1):76-85.
8. Floyd RL, O'Connor MJ, Sokol RJ, Bertrand J, Cordero JF. Recognition and prevention of fetal alcohol syndrome. Obstet Gynecol. 2005; 106(5 part 1): 1059-64.
9. Sokol RJ, Janisse JJ, Louis JM, Bailey BN, Ager J, Jacobson SW, Jacobson JL. Extreme prematurity: an alcohol-related birth effect. Alcohol Clin Exp Res. 2007; 31(6):1031-7.
10. U.S. Department of Health and Human Services. *Surgeon General's Advisory on Alcohol Use in Pregnancy.* Department of Health and Human Services, Office of the Surgeon General, 2005.
11. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR.* Washington, DC: American Psychiatric Association, 2005.
12. Room R, Babor T, Rehm J. Alcohol and public health. Lancet. 2005; 365 (9458):519-30.
13. Faden VB, Fay MP. Trends in drinking among Americans age 18 and younger: 1975-2002. Alcohol Clin Exp Res. 2004; 28(9):1388-95.
14. Eaton DK, Kann L, Kinchen S, Ross J, Hawkins J, Harris WA, Lowry R, McManus T, Chyen D, Shanklin S, Lim C, Grunbaurm JA, Wechsler H. Youth risk behavior surveillance—United States, 2005. MMWR Surveill Summ. 2006; 55(5): 1-108.
15. Okah FA, Cai J, Hoff GL. Term-gestation low birth weight and health-compromising behaviors during pregnancy. Obstet Gynecol. 2005; 105(3):543-50.
16. Federation of Tax Administrators. State cigarette excise tax rates. http://www.taxadmin.org/fta/rate/tax_stru.html#Excise. Accessed October 25, 2007.
17. Watson CH, Polzin GM, Calafat AM, Ashley DL. Determination of the tar, nicotine, and carbon monoxide yields in the smoke of bidi cigarettes. Nicotine Tob Res. 2003; 5(5);747–753.
18. Malson JL, Lee EM, Murty R, Moolchan ET, Pickworth WB. Clove cigarette smoking: biochemical, physiological, and subjective effects. Pharmacol Biochem Behav. 2003; 74:739–745.

19. National Cancer Institute, U.S. Department of Health and Human Services. *Cancer Trends Progress Report - 2005 Update*. Bethesda, MD; December 2005, http://progressreport.cancer.gov. Accessed October 25, 2007.

20. U.S. Department of Health and Human Services. Women and smoking. A report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2001.

21. U.S. Department of Health and Human Services. The health consequences of smoking: A report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

22. Stoddard JJ, Miller T. Impact of parental smoking on the prevalence of wheezing respiratory illness in children. Am J Epidemiol. 1995; 141(2):96-102.

23. Centers for Disease Control and Prevention. Surveillance for Acute Viral Hepatitis—United States, 2005. Surveillance Summaries, March 16, 2007. MMWR 2007;56(No. SS-3).

24. Scott MS, Dedel K. Clandestine methamphetamine labs, 2nd edition. Office of Community Oriented Policing Services, U.S. Department of Justice, 2006. Problem-Specific Guide Series No. 16. http://www.cops.usdoj.gov/mime/open.pdf?Item=274

Appendix A
Substance Abuse Services in Alabama

The Alabama Department of Mental Health and Mental Retardation is the state agency authorized to supervise, coordinate, and establish standards for all operations and activities related to mental health services in the State of Alabama. The department has three service divisions (Mental Illness, Mental Retardation, and Substance Abuse Services) to address the mental health needs of Alabama residents.

The Substance Abuse Services Division is responsible for contracting with community providers, overseeing services provided, certifying programs, and promoting a continuum of prevention, intervention, treatment, and after-care services for substance abuse in Alabama.

Prevention Services

The Office of Prevention within the Substance Abuse Services Division coordinates and manages all prevention services and programs throughout the state, including the Strategic Prevention Framework, State Incentive Grant, Alabama Epidemiological Outcomes Workgroup, Synar (Tobacco Sales to Minors Program), and Regional Information Clearinghouses. *Currently, 22 prevention providers with locations in 20 counties receive funding from the State of Alabama to deliver substance abuse prevention services.*

Treatment Services

The Office of Treatment within the Substance Abuse Services Division coordinates and manages all treatment services throughout the state, including Adolescent Treatment, Adult Treatment, Co-occurring Disorders, Opiate Replacement Therapy, and Medicaid Services. *Currently, 42 certified community-based providers with locations in 45 counties receive funding from the State of Alabama to provide substance abuse treatment services. An additional 46 community-based providers are certified but are privately funded to deliver substance abuse treatment services.*

Note: All treatment providers in Alabama must be certified according to the standards developed by the Substance Abuse Services Division, with the exception of professionals in private practice.

Appendix B

Members of the Alabama Epidemiological Outcomes Workgroup

Dr. April Carson	Department of Mental Health and Mental Retardation
Ms. Kimberly Desmond	Department of Human Resources
Ms. Sarah Harkless	Department of Mental Health and Mental Retardation
Ms. Joan Leary	Alabama Council of Community Mental Health Boards
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Mr. Chris McInnish	Department of Children's Affairs
Mr. Robert Oakes	Board of Pardons and Paroles
Capt. Vance Patton	Alcoholic Beverage Control Board
Mr. Pat Pendergast	Department of Youth Services
Ms. Sondra Reese	Department of Public Health
Mr. Bill Shanks	Department of Public Safety
Dr. Marcus Vandiver	Department of Education
Mr. Kristopher Vilamaa	Department of Mental Health and Mental Retardation
Mr. Bennet Wright	Alabama Sentencing Commission
Mr. Bob Wynn	Department of Mental Health and Mental Retardation

Appendix C
Methodology

The indicators that were included in this state-level epidemiological profile were selected based on the following criteria:

1. Availability of data;
2. Relevance to ATOD consumption and consequences;
3. Study design and data collection methods;
4. Validity and reliability of data.

Many of the indicators included in this profile are reasonable measures of ATOD consumption and consequences at the state-level for youth and adults in Alabama.

Some measures (e.g. arrests, homicide mortality rate) were included as consequence indicators in this profile, but these measures are widely influenced by enforcement policies and available resources and may not be representative of the underlying issue of substance use and abuse. Also, these measures may include duplicate counts so that persons may be included more than once.

The indicators included in this profile, the data source, and comments are provided in Table C1. The study description for each data source is provided in Table C2.

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Table C1 — Indicators and data sources included in state epidemiological profile for Alabama.

Indicator	Source	Comments
Alcohol Consequences		
% adults meeting DSM-IV criteria for alcohol abuse or dependence	NSDUH	Reasonable measure of alcohol abuse/dependence.
% adults needing but not receiving treatment for alcohol use	NSDUH	Reasonable measure of treatment need.
% of motor vehicle accidents that involved alcohol	DPS	Reasonable measure of alcohol-related MVA. May not include some alcohol-related accidents because alcohol involvement determined by officer report at the accident scene and any requested lab tests.
% of motor vehicle fatal accidents that were alcohol-related	FARS	Reasonable measure of alcohol-related fatal MVA. May not include some alcohol-related MVA because alcohol involvement determined by officer report at the accident scene and any requested lab tests.
% of drivers in fatal MVA with a BAC≥0.8	FARS	Reasonable measure of BAC of drivers involved in fatal MVA.
Alcohol-attributable deaths	ARDI	Measure of chronic and acute deaths attributable to alcohol. May be subject to competing causes of death.
Chronic liver disease or cirrhosis mortality	CDC Wonder	Reasonable measure of mortality due to CLD/cirrhosis. May not be entirely attributable to alcohol.
Alcohol-induced mental disorders or dependence syndrome mortality	CDC Wonder	Reasonable measure of mortality due to alcohol-induced causes. May be subject to competing causes of death.
Rate for forcible rape, robbery, and aggravated assault	UCR	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions. Proportion attributable to alcohol unknown.
% youth ages 12-17 years meeting DSM-IV criteria for alcohol abuse or dependence	NSDUH	Reasonable measure of alcohol abuse/dependence.
% youth ages 12-17 needing but not receiving treatment for alcohol use	NSDUH	Reasonable measure of treatment need.
% of youth in 9th-12th grades who drove a car or other vehicle when they had been drinking within the past 30 days	YRBS	Reasonable measure of drinking and driving among youth.
% of youth in 9th-12th grades who rode in a car or other vehicle driven by someone who had been drinking within the past 30 days	YRBS	Reasonable measure of youth endangerment by riding with impaired drivers.
Years of potential life lost due to alcohol-related deaths	ARDI	Reasonable measure of YPLL due to alcohol. May be subject to competing causes of death.
% of mothers who reported drinking during pregnancy and gave birth to low birth weight baby	PRAMS	Measures adverse perinatal outcome by drinking status. LBW may be due to other factors.
Alcohol Consumption		
% of adults reporting use of alcohol in past 30 days	BRFSS	Reasonable measure of alcohol use.
% of adults reporting heavy drinking in past 30 days	BRFSS	Reasonable measure of heavy drinking.
% of adults reporting binge drinking in past 30 days	BRFSS	Reasonable measure of binge drinking.
% of youth in 9th-12th grades reporting use of alcohol in past 30 days	YRBS	Reasonable measure of alcohol use.
% of youth in 9th-12th grades reporting first use of alcohol before age 13	YRBS	Reasonable measure of alcohol initiation.
% of youth in 9th-12th grades reporting binge drinking in past 30 days	YRBS	Reasonable measure of binge drinking.
% of mothers who consumed alcohol during last 3 months of pregnancy	PRAMS	Reasonable measure of alcohol use during pregnancy.
Tobacco Consequences		
Smoking-attributable mortality rate	SAMMEC	Measure of deaths attributable to tobacco. May be subject to competing causes of death.
Incidence and mortality rates for lung, bronchus, or trachea cancer	SEER	Measure of tobacco-related cancer morbidity and mortality. Proportion due to smoking unknown.
Mortality rate for chronic lower respiratory diseases per 100,000 population	CDC Wonder	Measure of tobacco-related mortality from CLRD. Proportion due to smoking unknown.
% of students ever told by doctor or nurse that they had asthma	YRBS	Measure of tobacco-related morbidity. Proportion due to exposure to smoking unknown.
% of mothers who reported smoking during pregnancy and gave birth to low birth weight baby	PRAMS	Measure of adverse perinatal outcome by smoking status.
Tobacco Consumption		
% of adults who are current smokers	BRFSS	Reasonable measure of tobacco use.

% of adults reporting ever use of smokeless tobacco	BRFSS	Reasonable measure of smokeless tobacco use.
% of youth in 9th-12th grades who smoked cigarettes on 1 or more of the previous 30 days	YRBS	Reasonable measure of tobacco use.
% of youth in 9th-12th grades who smoked cigarettes on 20 or more of the previous 30 days	YRBS	Reasonable measure of regular tobacco use.
% of youth in 9th-12th grades who used chewing tobacco, snuff, or dip on 1 or more of the previous 30 days	YRBS	Reasonable measure of use of alternative forms of tobacco.
% of youth who have tried bidis/kreteks	AYTS	Reasonable measure of use of alternative forms of tobacco.
Age of first use of tobacco by youth in 9th-12th grades	YRBS	Reasonable measure of age at first use.
% of mothers who reported smoking during pregnancy	PRAMS	Reasonable measure of tobacco use during pregnancy
Other Drug Consequences		
% adults meeting DSM-IV criteria for illicit drug abuse or dependence	NSDUH	Reasonable measure of illicit drug abuse/dependence.
% adults needing but not receiving treatment for illicit drug use	NSDUH	Reasonable measure of treatment need.
% youth ages 12-17 years meeting DSM-IV criteria for illicit drug abuse or dependence	NSDUH	Reasonable measure of illicit drug abuse/dependence.
% youth ages 12-17 needing but not receiving treatment for illicit drug use	NSDUH	Reasonable measure of treatment need.
Incidence rate for hepatitis	CDC	May be subject to other transmission modes so proportion due to illicit drug use unknown.
% of reported AIDS cases by transmission category	CDC	May be subject to multiple exposure routes.
Mortality rate for drug-induced deaths	CDC WONDER	Measure of mortality due to drug-induced deaths. May be affected by competing causes of death.
Mortality rate for homicides	CDC WONDER	Measure of mortality due to homicides. Proportion due to illicit drug use unknown.
Mortality rate for suicides	CDC WONDER	Measure of mortality due to suicides. Proportion due to illicit drug use unknown.
Rate for motor vehicle theft, burglary, and larceny-theft	UCR	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions. Proportion attributable to illicit drug use unknown.
Number of arrests for drug possession or sale per 100,000 population	ACJIC	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions.
Number of clandestine methamphetamine laboratory incidents	DEA	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions.
Other Drug Consumption		
% of persons 12 years and older who reported illicit drug use during the past month, past year, and lifetime	NSDUH	Reasonable measure of illicit drug use.
% of adults who used marijuana in past month	NSDUH	Reasonable measure of marijuana use.
% of adults who used illicit drugs (other than marijuana) in past month	NSDUH	Reasonable measure of other drug use (excluding marijuana).
% of adults who reported non-medical use of prescription pain relievers in past month	NSDUH	Reasonable measure of non-medical use of prescription pain relievers.
% of youth in 9th-12th grades who tried marijuana before age 13	YRBS	Reasonable measure of age at initiation for marijuana use.
% of youth in 9th-12th grades who reported marijuana use in past month	YRBS	Reasonable measure of youth marijuana use.
% of youth in 9th-12th grades who reported use of drugs during lifetime	YRBS	Reasonable measure of youth drug use during lifetime.
% of youth ages 12-17 who reported non-medical use of prescription pain relievers in past month	NSDUH	Reasonable measure of youth non-medical use of prescription pain relievers.
% of youth in 9th-12th grades who reported using a needle to inject drugs into their body during their lifetime	YRBS	Reasonable measure of youth use of needles for drug injection.

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Table C2—Study descriptions for data sources included in state epidemiological profile for Alabama.

Study Name	Type of Study	Year(s)	Participants	Data Collected	Citation
Alabama Accident Summary	N/A	Annually	statewide	accidents involving alcohol/drugs	Alabama Department of Public Safety. Alabama Accident Summary--Statewide Accidents 2006. http://dps.alabama.gov/Administrative/accidentsummary.aspx
Alabama Accident Summary	N/A	2006	statewide-rural	accidents involving alcohol/drugs	Alabama Department of Public Safety. Alabama Accident Summary--Statewide Rural Accidents 2006. http://dps.alabama.gov/Administrative/accidentsummary.aspx
Alabama Criminal Justice Information Center	reporting system	Annually	statewide	collects data on crimes in AL	Alabama Criminal Justice Information Center. http://www.acjic.alabama.gov/cia/2005_cia.pdf
Alabama Pride Survey	Cross-sectional survey in public schools	Every school yr since 2002	6th-12th grade students	extensive data on ATOD	http://www.pridesurveys.com/Reports/index.html#state
Alabama Youth Tobacco Survey	Cross-sectional survey	Biennially since 2000	6th-12th grade students	collects data on tobacco use	http://www.adph.org/tobacco/assets/alabamayouthtobaccosurvey.pdf
Alcohol Epidemiologic Data System (AEDS)	reporting system	Annually	14 years and older	estimate of per capita consumption based on alcohol sales and census population counts	Lakins NE, Williams GD, and Yi H. Surveillance Report #78--Apparent per capita alcohol consumption: national, state, and regional trends 1977-2004. National Institute on Alcohol Abuse and Alcoholism, Alcohol Epidemiologic Data System (AEDS). http://pubs.niaaa.nih.gov/publications/surveillance78/CONS04.htm#top
Alcohol Related Disease Impact (ARDI)	online computational application	N/A	statewide	alcohol-attributable mortality; years of potential life lost	http://apps.nccd.cdc.gov/ARDI/HomePage.aspx
Automation of Reports and Consolidated Orders System (ARCOS)	reporting system	N/A	statewide	monitors sale of controlled substances	www.deadiversion.usdoj.gov/arcos/index.html
Behavioral Risk Factor Surveillance System (BRFSS)	Cross-sectional survey	Annually since 1984	18 years and older	alchohol consumption; binge drinking: preventive counseling (module); tobacco use; secondhand smoke policies	Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/brfss/

Centers for Disease Control and Prevention Wide-ranging OnLine Data for Epidemiologic Research (CDC Wonder)	reporting system	Annually	statewide	mortality data by cause of death	http://wonder.cdc.gov/
Fatality Analysis Reporting System (FARS)	reporting system	Annually	statewide	collects data on motor vehicle accidents	National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Washington, DC. http://www-fars.nhtsa.dot.gov/Main/index.aspx
Federation of Tax Administrators (FTA)	reporting system	Annually	N/A	monitors tax rates for cigarettes	http://www.taxadmin.org/fta/rate/tax_stru.html#Excise
HIV/AIDS in the state of Alabama	surveillance report	N/A	statewide	AIDS diagnoses; modes of transmission	State of Alabama Department of Public Health, Bureau of Communicable Diseases. Division of HIV/AIDS prevention and control. 2005. http://www.adph.org/aids/assets/SurveillanceReport2005.pdf
National Survey on Drug Use and Health (NSDUH)	Cross-sectional survey	Annually since 1971	12 years and older	ATOD use, perceptions, and consequences	Substance Abuse and Mental Health Services, Office of Applied Studies. National Survey on Drug Use and Health. U.S. Department of Health and Human Services. http://www.oas.samhsa.gov/states.htm
Pregnancy Risk Assessment Monitoring System (PRAMS)	Surveillance study; nationwide	1993 to present	women with recent live births in AL	health behaviors of pregnant mothers	Alabama Department of Public Health, Center for Health Statistics. PRAMS Surveillance Report. http://www.adph.org/healthstats/index.asp?ID=1518
Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)	online computational application	N/A	statewide	smoking-attributable mortality, YPLL, medical expenditures, productivity losses; smoking-attributable infant mortality; excess neonatal costs	http://apps.nccd.cdc.gov/sammec/
Tax Burden on Tobacco	reporting system	N/A	18 years and older	per capita sales of tobacco	The Tobacco Institute. Monthly State Cigarette Tax Reports. February 1983 through May 1998. 1875 I Street, N.W. Washington, DC 20006. Orzechowski & Walker. The Tax Burden on Tobacco. Historical Compilation, Vol. 37, 2002. Arlington, VA: 2003. http://ssdc.ucsd.edu/tobacco/sales/
Treatment Episode Data Set (TEDS)	Admission-based data reporting system	Annually	statewide	collects data on admissions for SA treatment	Substance Abuse and Mental Health Services Administration, Office of Applied Studies. http://wwwdasis.samhsa.gov/webt/tedsweb/tab_year.choose_year?t_state=AL
Uniform Crime Reports (UCR)	reporting system	Annually	statewide	collects data on crimes	Federal Bureau of Investigation. Uniform crime reports. http://www.fbi.gov/ucr/ucr.htm

Youth Risk Behavior Surveillance System (YRBSS)	Cross-sectional survey in schools	Biennially since 1991	9th-12th grade students	alchohol consumption; tobacco use	Centers for Disease Control and Prevention. Youth Risk Behavior Survey. http://www.cdc.gov/yrbss.

Appendix D
Glossary

Acute —Describes a disease, illness, or injury that is characterized by a rapid onset, short duration, and symptom presentation. Examples include colds and influenza.

Age-adjusted rate — A weighted average of age-specific rates where the weights are the proportions of persons in the corresponding age groups of a standard population. A standard population is used (2000 U.S. standard population) to allow for comparisons among counties, states, and national estimates by taking into account differences in the age composition of different areas.

Age-specific rate — A rate determined by the number of cases or events that occur within a specific age group divided by the population of that age group. Example: age-specific mortality rates can be calculated for youth 11-14 years and 15-17 years or any other age group of interest.

Chronic — Describes a disease, illness, or injury that is characterized by a long duration and may be asymptomatic. Examples include coronary heart disease, cancer, and diabetes.

Crude rate — An unadjusted rate based on the total number of cases or events divided by the population.

Epidemiology —The study of the distribution and determinants of health-related states and events in populations and the application of this study to control health problems.

ICD-10 codes — The International Classification of Diseases, 10th Revision, is a classification system published by the World Health Organization that is used to classify causes of death.

Incidence — The number of new cases of a disease, illness, or injury that occurs in a population.

Morbidity — The effects of disease, illness, or injury in a population. Typical measures of morbidity are incidence rates and prevalence rates.

Mortality — The total number of deaths due to a particular disease, illness, or injury in a population.

Prevalence — The total number of cases (existing and new) of a disease, illness, or injury that occurs in a population.

Years of potential life lost — A measure of the relative impact of a disease on a population that is determined by calculating the loss of expected years of life due to early deaths from the particular disease.

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Alcohol, Tobacco, and Other Drugs Consumption and Consequences in Alabama Communities

Substance Abuse Planning Regions

Alabama Epidemiological Outcomes Workgroup
Department of Mental Health
Substance Abuse Services Division
Office of Prevention
2009

Contact information:

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http://www.mh.alabama.gov/

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List of Tables

List of Abbreviations

ACJIC	Alabama Criminal Justice Information Center
ATOD	Alcohol, Tobacco, and Other Drugs
BAC	Blood Alcohol Concentration
CDC WONDER	Centers for Disease Control and Prevention Wide-ranging OnLine Data for Epidemiologic Research
CLRD	Chronic Lower Respiratory Diseases
DMH	Alabama Department of Mental Health
DOE	Alabama Department of Education
DPS	Alabama Department of Public Safety
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th edition
DUI	Driving under the influence
DYS	Alabama Department of Youth Services
FARS	Fatality Analysis Reporting System
ICD-10	International Classification of Diseases, 10th Revision
NSDUH	National Survey on Drug Use and Health
SEER	Surveillance, Epidemiology, and End Results
UCR	Uniform Crime Reports

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Executive Summary

This 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 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.

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- 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.

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Methodology

The sources for ATOD consumption and consequence data at the regional level are the Alabama Pride Survey (2008-2009), the National Survey on Drug Use and Health (NSDUH) (2004-2006), and state agencies. Additional information on indicators and inclusion criteria is presented in Appendix C.

The Alabama Pride Survey is a census-based survey of students in grades 6-12 that is conducted annually in public schools in Alabama. The survey collects data from approximately 300,000 students every year to identify patterns of alcohol, tobacco, and other drug use among youth in Alabama. The substate estimates in this profile reflect data collected for the 2008-2009 school year.

Table 1—Sample size for Alabama Pride Survey by grade and planning region, 2008-2009

	Grade							
	6th	**7th**	**8th**	**9th**	**10th**	**11th**	**12th**	**Total**
Region 1	14319	13940	13849	12872	11455	10021	7958	84414
Region 2	15216	14933	14766	12492	11712	10359	8425	87903
Region 3	8094	7677	7580	6883	6255	5366	4175	46030
Region 4	10052	10192	9947	8981	7999	6893	5335	59399
	Grand Total							277746

The NSDUH is a nationwide survey conducted annually that involves computerized interviews with approximately 70,000 randomly selected individuals aged 12 and older. Data from NSDUH is used to provide national and state-level estimates of past month, past year, and lifetime use of alcohol, tobacco, other drugs, and non-medical use of prescription drugs. NSDUH uses survey-weighted hierarchical Bayes methodology to produce substate estimates by planning region in Alabama. This methodology is described in detail by Folsom, Shah, and Vaish (1999)[1] and provides small area estimates that are design consistent (i.e., for substates with large sample sizes, the small area estimates are close to the robust design-based estimates). The substate estimates in this profile reflect data combined from 2004-2006.

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Alabama

The State of Alabama, named after a southern Indian tribe, has been a central figure in the historical events that have shaped the modern-day United States. Alabama was admitted to the Union as the 22nd state in 1819, seceded in 1861 during which time Montgomery, Alabama was named as the capital of the Confederacy, and was re-admitted in 1868 following the end of the Civil War. Almost a century later, defining moments of the Civil Rights Movement would take place in Alabama, specifically the Montgomery Bus Boycott in 1955, Dr. Martin Luther King's Letter from a Birmingham Jail in 1963, and the Selma to Montgomery "Bloody Sunday" March in 1965[2].

Alabama is located in the southeastern United States, bordered by the states of Florida, Georgia, Mississippi, and Tennessee. The capital city of Alabama is Montgomery (located in Montgomery County) and the largest city is Birmingham (located in Jefferson County). Alabama is the 30th largest state based on total land area and 23rd most populous with an estimated population of 4,708,708 in 2009. It consists of 67 counties, of which 51 have greater than 50% of their population residing in rural areas.

The median age in Alabama is 35.8 years. The majority of Alabama residents are white (71%) and African-Americans represent the largest minority group in the state (26.4%). Urban and rural areas of Alabama have different socio-demographic profiles, with rural areas being less advantaged than urban areas. In 2008, the state's overall poverty level was 15.9% with rural areas having a higher poverty level (18.6%) than urban areas (14.8%). Similarly, rural areas had fewer residents with a college degree (12.8%) and a higher unemployment rate (4.1%) compared to urban Alabama at 21.7% and 3.4% respectively[3].

Approximately 29% of Alabama residents live in rural areas. Alabama's Black Belt, its name originating from its agricultural history and rich soil but now indicative of its majority African-American presence, is a predominately rural region concentrated in the southwest and central areas of the state that consists of 19 counties: Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Hale, Lowndes, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, and Wilcox. Similar to other rural counties in Alabama, these counties are less advantaged than urban areas; however, these counties have even harsher economic conditions characterized by declining populations, lack of health care access, high unemployment rates, and high poverty rates as they are among the poorest counties in the state[4].

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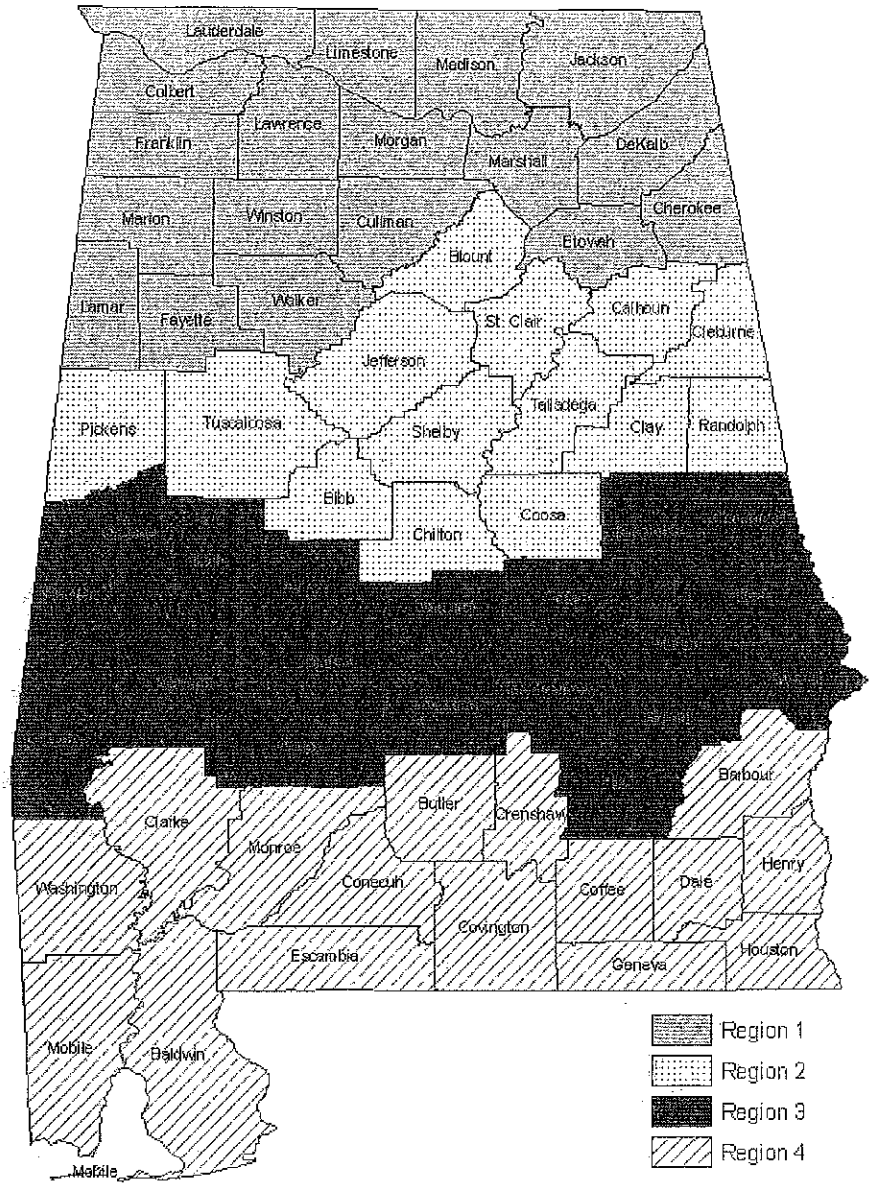
Figure 1—Alabama Department of Mental Health Planning Regions



Region 1

Region 1 includes 18 counties located in the northern part of the state: Cherokee, Colbert, Cullman, DeKalb, Etowah, Fayette, Franklin, Jackson, Lamar, Lauderdale, Lawrence, Limestone, Madison, Marion, Marshall, Morgan, Walker, and Winston. Madison County is the most populous county in Region 1 and is home to Redstone Arsenal and Marshall Space Flight Center.

Table 2—County populations for Region 1, Alabama

County	Population, 2007 Estimate
Alabama	4,708,708
Cherokee County	24,448
Colbert County	54,639
Cullman County	81,778
DeKalb County	69,380
Etowah County	103,645
Fayette County	17,371
Franklin County	31,091
Jackson County	52,838
Lamar County	14,200
Lauderdale County	89,599
Lawrence County	34,106
Limestone County	78,572
Madison County	**327,744**
Marion County	29,116
Marshall County	90,399
Morgan County	117,293
Walker County	68,742
Winston County	23,997

Source: US Census Bureau Alabama Quick Facts[5]

Region 2

Region 2 includes 14 counties located in the north-central part of the state: Bibb, Blount, Calhoun, Chilton, Clay, Cleburne, Coosa, Jefferson, Pickens, Randolph, St. Clair, Shelby, Talladega, and Tuscaloosa. Jefferson County is the most populous county in the state and its largest employer is the University of Alabama at Birmingham.

Table 3—County populations for Region 2, Alabama

County	Population, 2007 Estimate
Alabama	4,708,708
Bibb County	21,587
Blount County	58,345
Calhoun County	114,081
Chilton County	42,971
Clay County	13,640
Cleburne County	14,759
Coosa County	10,556
Jefferson County	**665,027**
Pickens County	19,218
Randolph County	22,577
St. Clair County	81,895
Shelby County	192,503
Talladega County	80,242
Tuscaloosa County	184,035

Source: US Census Bureau Alabama Quick Facts[5]

Region 3

Region 3 includes 19 counties located in the south-central part of the state: Autauga, Bullock, Chambers, Choctaw, Dallas, Elmore, Greene, Hale, Lowndes, Lee, Macon, Marengo, Montgomery, Pike, Perry, Russell, Sumter, Tallapoosa, and Wilcox. Montgomery County is the most populous county in Region 3 and its largest employers are Maxwell-Gunter Air Force Base and the State of Alabama.

Table 4—County populations for Region 3, Alabama

County	Population, 2007 Estimate
Alabama	4,708,708
Autauga County	50,756
Bullock County	10,985
Chambers County	34,320
Choctaw County	13,990
Dallas County	41,925
Elmore County	79,233
Greene County	8,829
Hale County	17,975
Lee County	135,883
Lowndes County	12,293
Macon County	21,789
Marengo County	20,943
Montgomery County	**224,119**
Perry County	10,623
Pike County	30,461
Russell County	50,846
Sumter County	12,853
Tallapoosa County	41,008
Wilcox County	12,384

Source: US Census Bureau Alabama Quick Facts[5]

Region 4

Region 4 includes 16 counties located in the southern part of the state: Baldwin, Barbour, Butler, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Escambia, Geneva, Henry, Houston, Mobile, Monroe, and Washington. Mobile County is the most populous county in Region 4 and is Alabama's major seaport.

Table 5—County populations for Region 4, Alabama

County	Population, 2007 Estimate
Alabama	4,708,708
Baldwin County	179,878
Barbour County	29,737
Butler County	19,964
Clarke County	26,042
Coffee County	48,635
Conecuh County	12,931
Covington County	36,678
Crenshaw County	13,781
Dale County	48,147
Escambia County	37,434
Geneva County	25,961
Henry County	16,647
Houston County	100,085
Mobile County	**411,721**
Monroe County	22,389
Washington County	17,069

Source: US Census Bureau Alabama Quick Facts[5]

ALCOHOL

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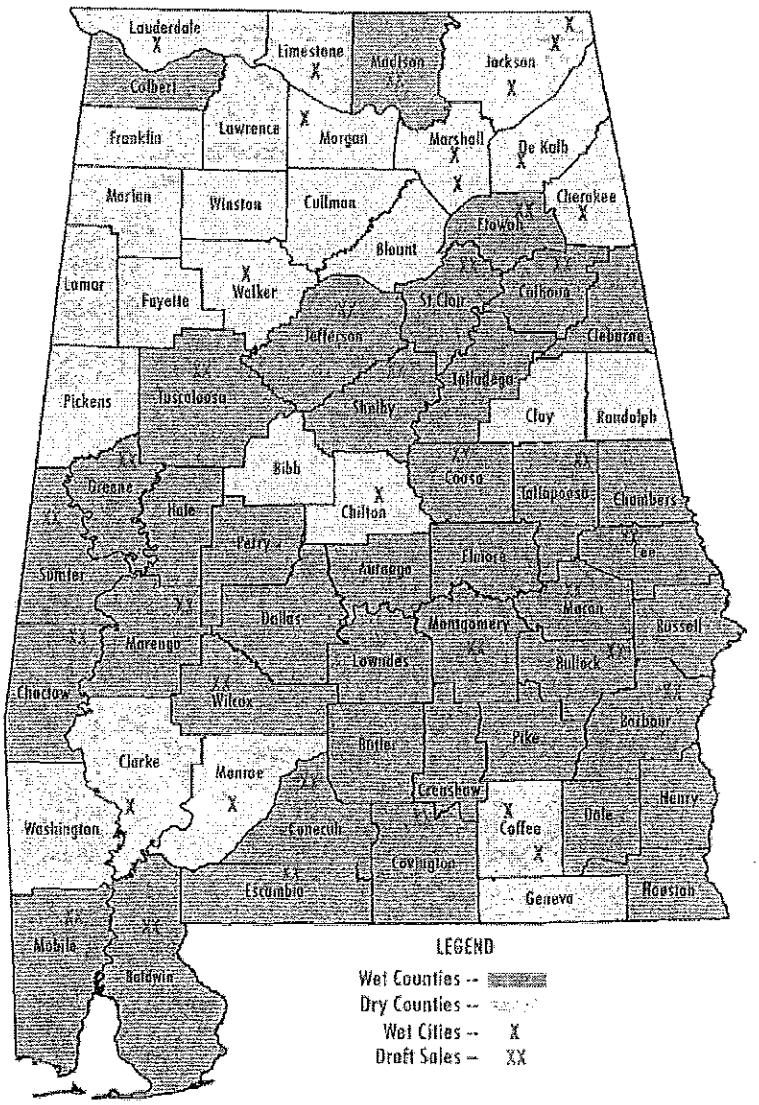
Alcohol

- The minimum legal age to purchase, use, possess, or transport alcoholic beverages in Alabama is 21 years.
- Alcohol sales are regulated by the Alabama Alcoholic Beverage Control Board, which is responsible for the distribution of alcohol, licensing of retail outlets, and enforcement of policies.
- The wet and dry counties are presented in Figure 1. Region 1 has the highest percentage of dry counties (89%), followed by Region 2 (43%) and Region 4 (31%). All of the counties in Region 3 are wet counties.

Figure 2—Wet and dry counties and cities in Alabama



Source: Alabama Alcoholic Beverage Control Board

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ALCOHOL CONSUMPTION

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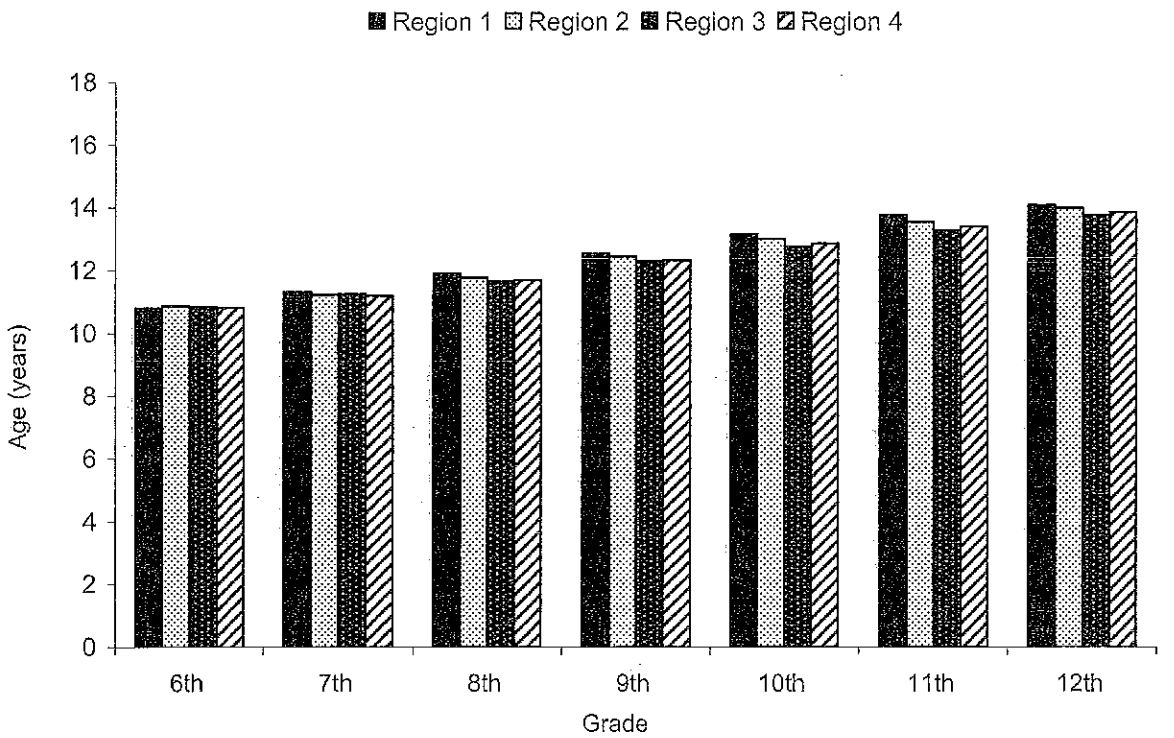
Youth

- The average age of first use of alcohol among Alabama youth was 11 years old for 6th graders and 14 years old for 12th graders.
- Age of first use of alcohol increased as school grade increased, with youth in higher grades having later ages of first use than youth in lower grades for each of the 4 regions (Figure 3).

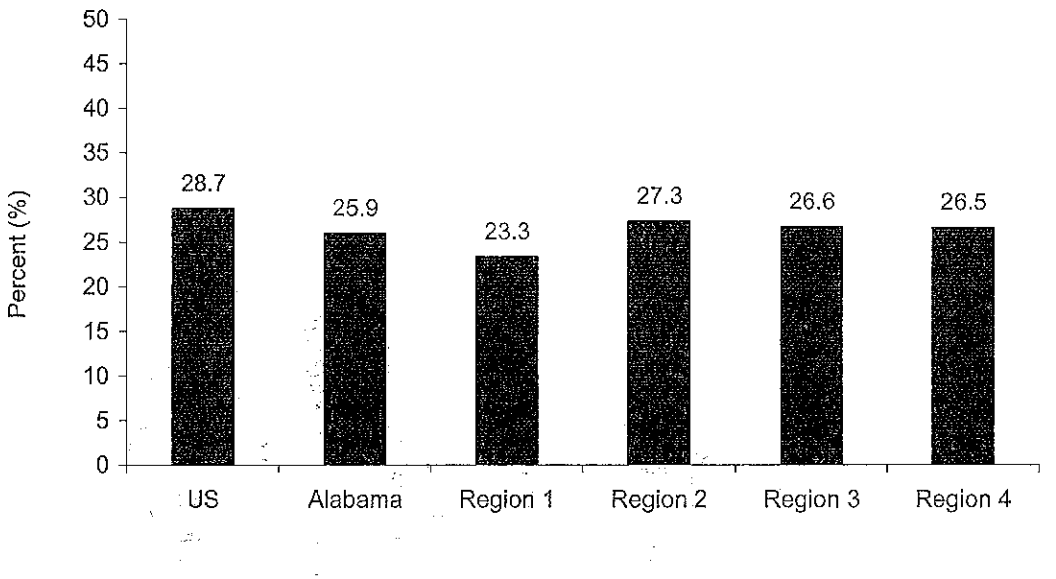
Figure 3—Age of first use of alcohol by grade among students in Alabama, 2008-2009



Source: Alabama Pride Survey

- In 2004-2006, alcohol use among youth in Alabama was slightly lower (25.9%) than the U.S. national average (28.7%) (Figure 4).
- Alcohol use among youth was comparable across regions. Region 2 had the highest percent of youth reporting alcohol use during the past month (27.3%) while Region 1 had the lowest percent (23.3%); however, these differences were not statistically significant (Figure 4).

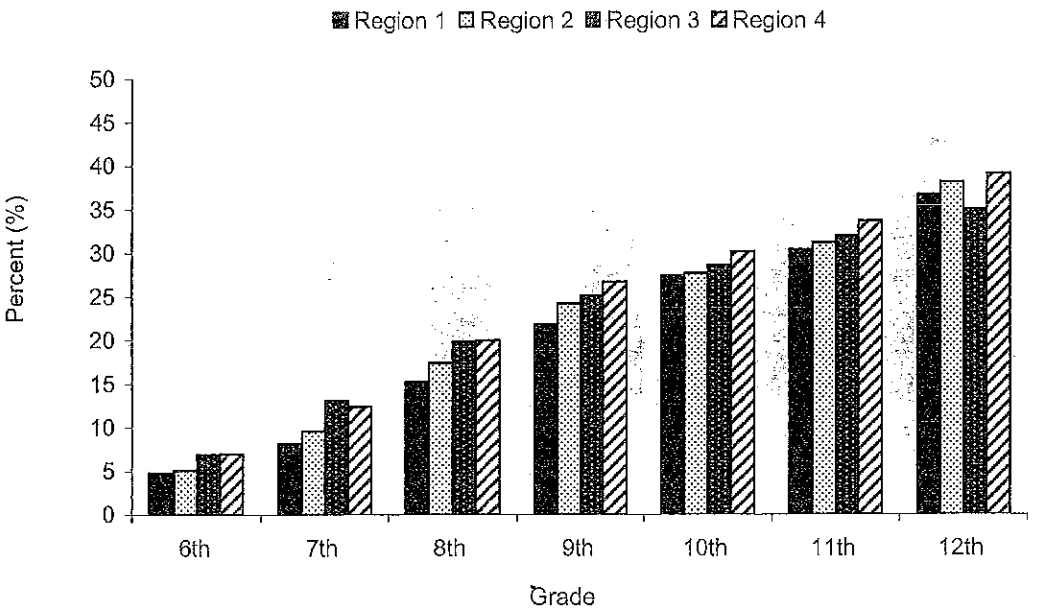
Figure 4—Percent of persons aged 12 to 20 years who reported alcohol use during the past month, 2004-2006



Source: NSDUH

- As school grade increased, the percent of students who reported using alcohol during the past month increased for all regions (Figure 5).
- Alcohol use by school grade was comparable across regions. Region 4 had a greater percent of youth in 8th through 12th grades who reported using alcohol during the past month while Region 1 had a lower percent of youth in 6th through 11th grades who reported using alcohol during the past month (Figure 5).

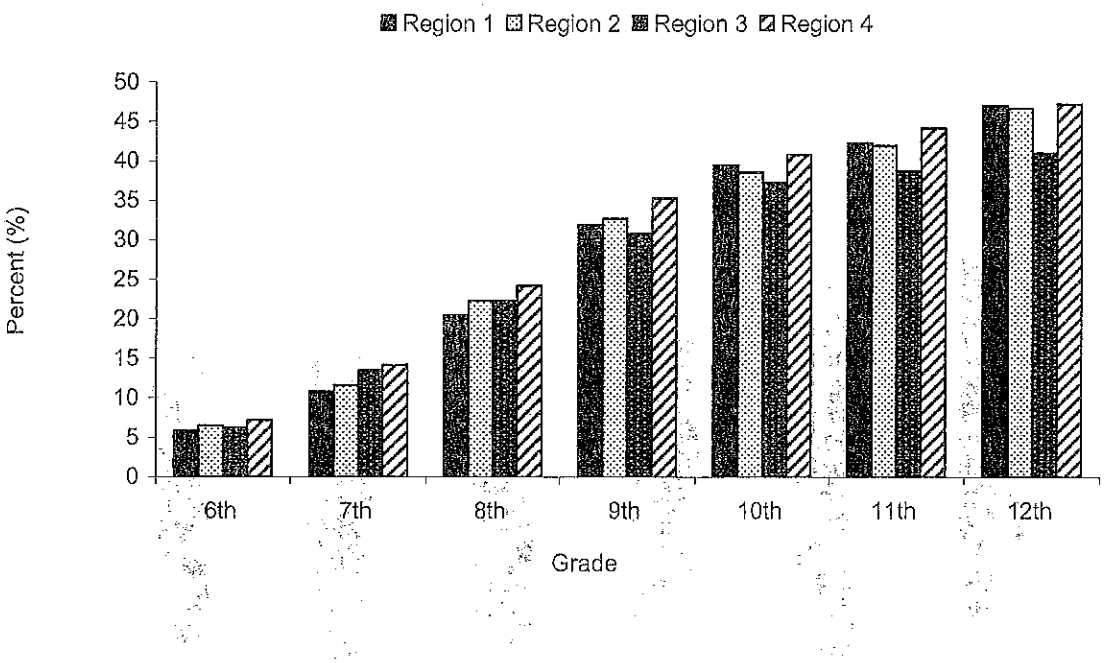
Figure 5—Percent of students in Alabama who reported using alcohol during the past month by grade, 2008-2009



Source: Alabama Pride Survey

- As school grade increased, the percent of students who reported that their friends use alcohol also increased (Figure 6).
- More youth in 6th through 12th grades in Region 4 reported that their friends use alcohol compared to the other regions. Fewer youth in 9th through 12th grades in Region 3 reported that their friends use alcohol compared to the other regions (Figure 6).

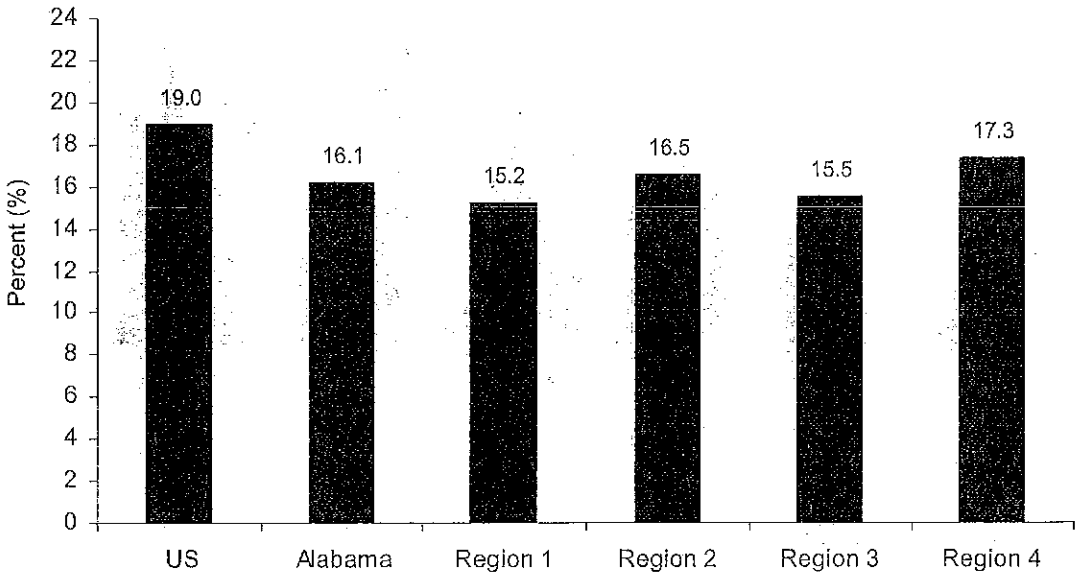
Figure 6—Percent of students in Alabama who reported their friends use alcohol, 2008-2009



Source: Alabama Pride Survey

- In 2004-2006, binge drinking, defined as 5 or more alcoholic beverages within a few hours, among youth in Alabama was slightly lower (16.1%) than the U.S. national average (19.0%) (Figure 7).
- Binge drinking among youth was comparable across regions. Region 4 had the highest percent of youth reporting binge drinking (17.3%) while Region 1 had the lowest percent (15.2%); however, these differences were not statistically significant (Figure 7).

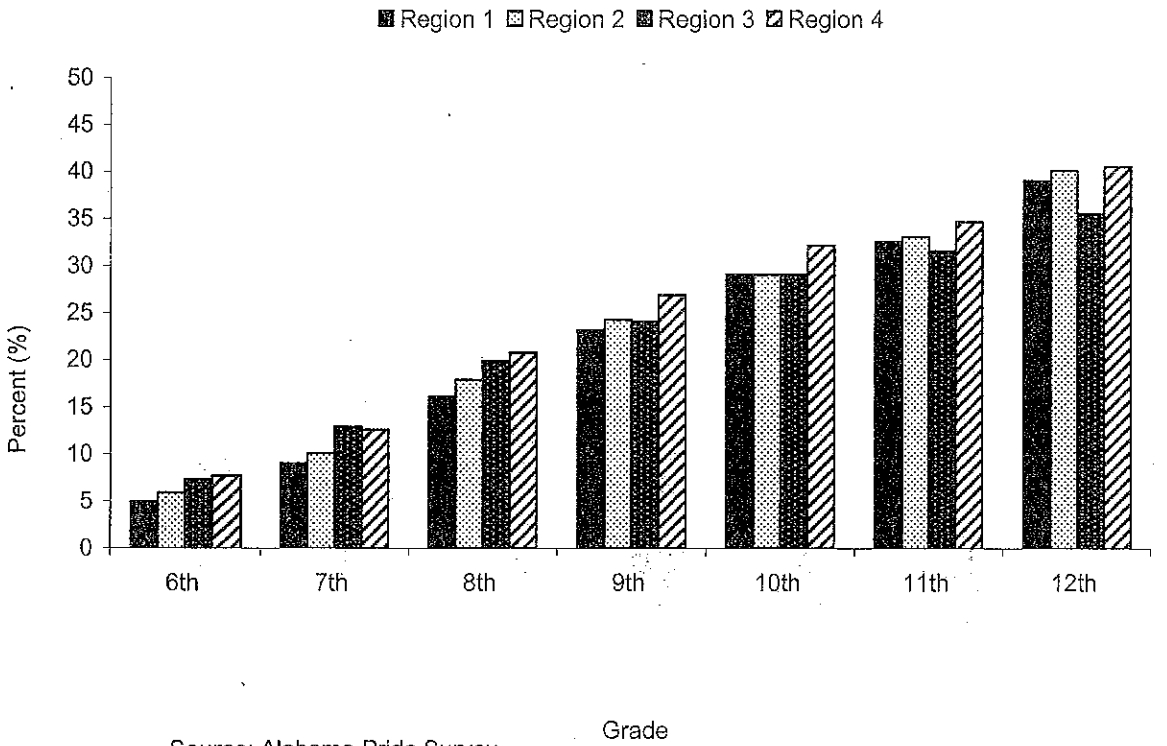
Figure 7—Percent of students who reported binge drinking (5 or more alcoholic beverages within a few hours) by region, 2004-2006



Source: NSDUH

- The percent of students who reported binge drinking increased as school grade increased (Figure 8).
- More youth in 8th through 12th grades in Region 4 reported binge drinking compared to the other regions. Fewer youth in 6th through 10th grades in Region 1 reported binge drinking compared to the other regions (Figure 8).

Figure 8—Percent of students who reported binge drinking (5 or more alcoholic beverages within a few hours) by grade, 2008-2009

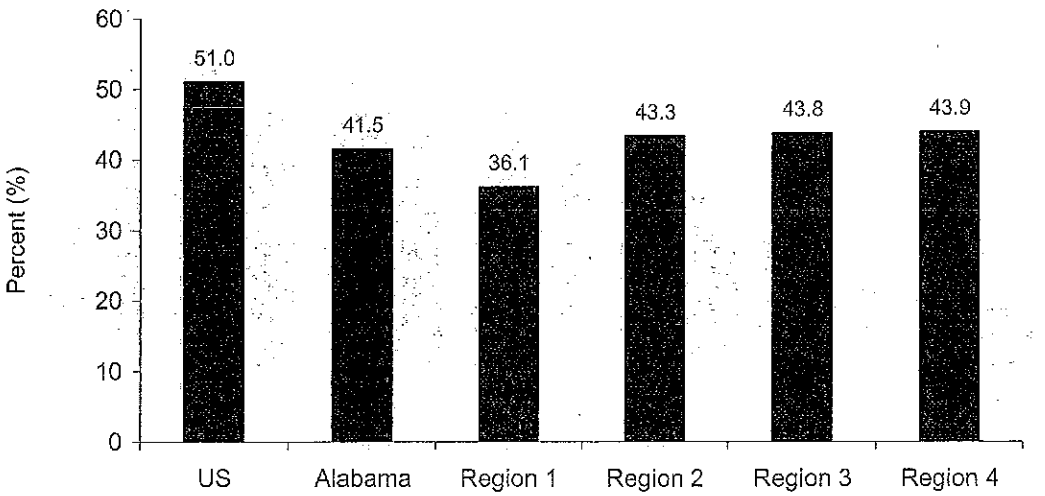


Source: Alabama Pride Survey

Adults and Youth Combined

- Alcohol consumption during the past month among persons 12 years and older in Alabama (41.5%) was less than the U.S. national average (51.0%) (Figure 9).
- Region 1 had the lowest percent of persons who reported consuming alcohol during the past month (36.1%) while slightly more than 43% of persons in Regions 2, 3, and 4 reported consuming alcohol during the past month. The regional differences were not statistically significant (Figure 9).

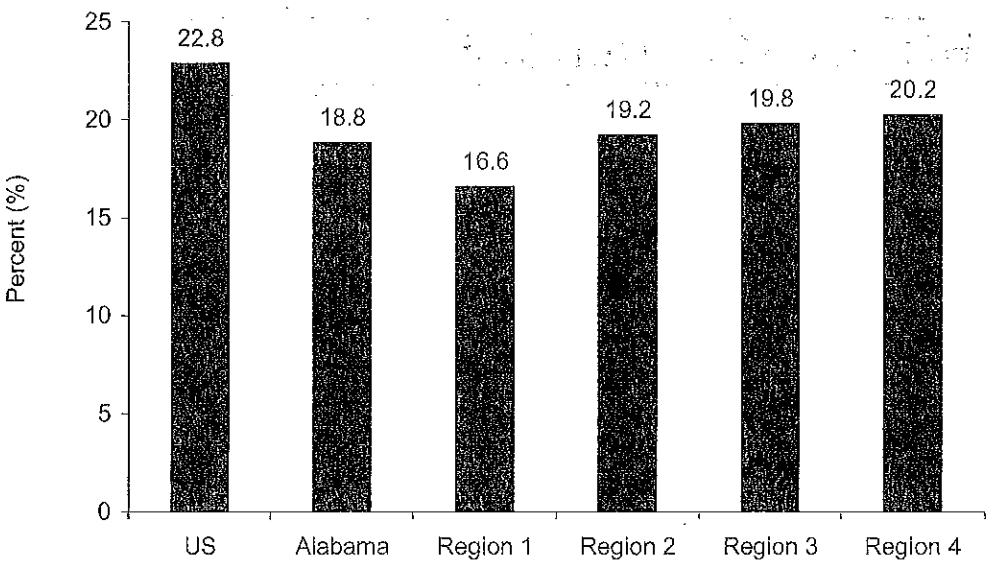
Figure 9—Alcohol use in past month among persons 12 years and older in Alabama, 2004-2006



Source: NSDUH

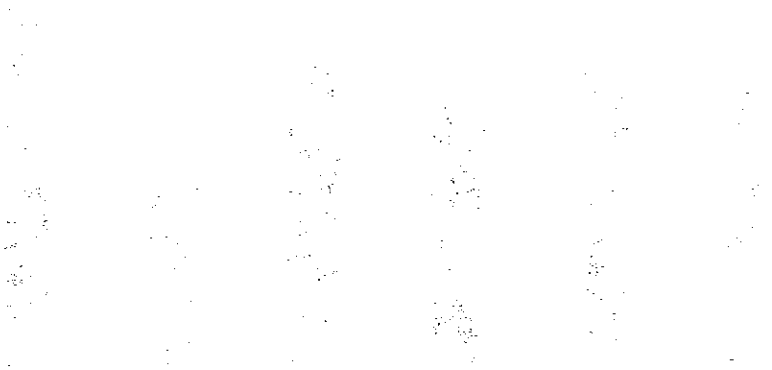
- Binge alcohol drinking during the past month among persons 12 years and older in Alabama (18.8%) was less than the U.S. national average (22.8%) (Figure 10).
- Region 1 had the lowest percent of persons who reported binge alcohol drinking during the past month (16.6%) while Region 4 had the greatest percent of persons who reported binge drinking (20.2%); however, these regional differences were not statistically significant (Figure 10).

Figure 10—Binge drinking (5 or more alcoholic drinks within a couple of hours) during past month among persons 12 years and older in Alabama, 2004-2006



Source: NSDUH

ALCOHOL CONSEQUENCES



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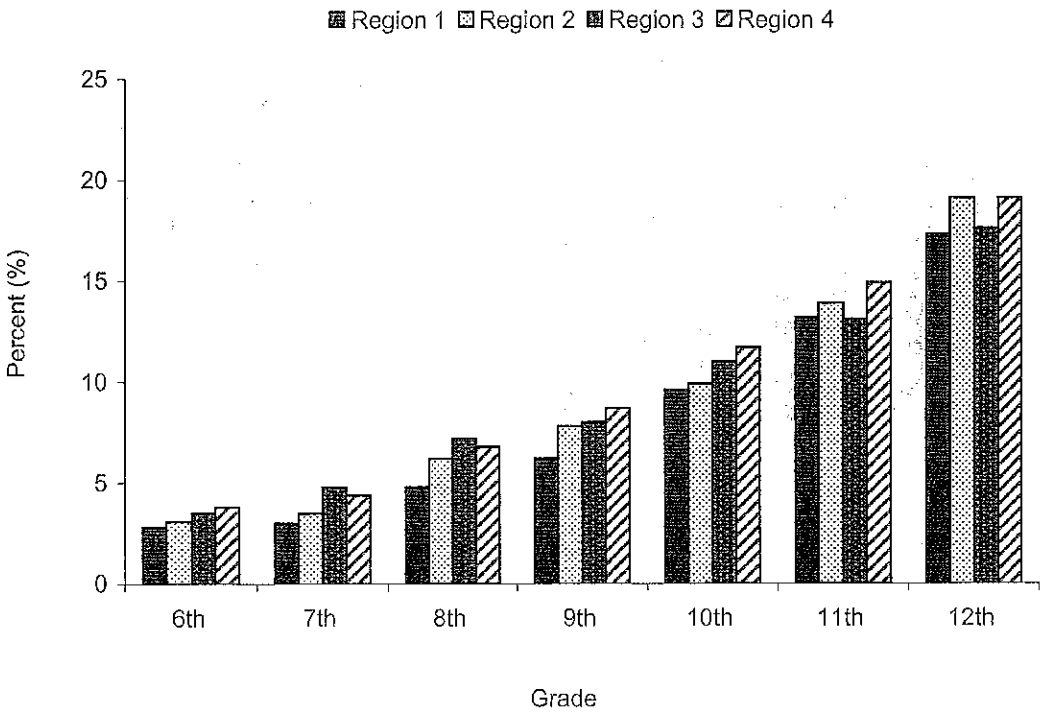
Youth

- The percent of students who reported driving a car after or while drinking increased as school grade increased (Figure 11).
- More youth in 9th through 12th grades in Region 4 reported drinking and driving compared to the other regions. The highest percent of students who reported drinking and driving occurred among 12th graders: 19.1% in Regions 2 and 4 reporting drinking and driving compared to 17.3% in Region 1, and 17.6% in Region 3 (Figure 11).

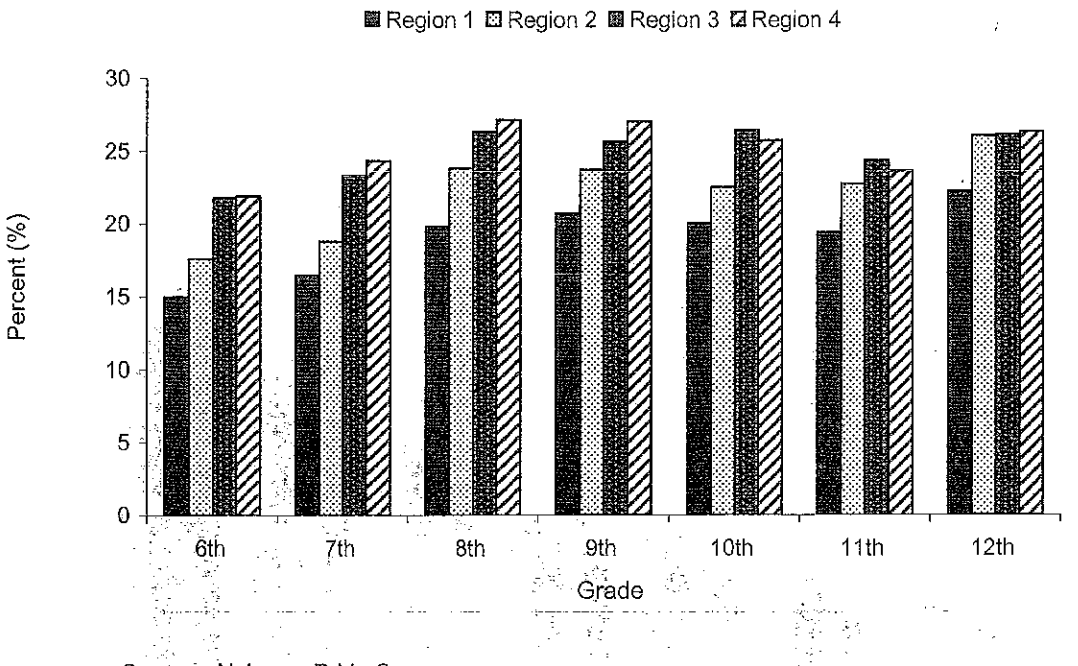
Figure 11—Percent of students who reported driving a car after or while drinking alcohol by grade and county, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported riding in a car with a driver who had been drinking was slightly less among 6th and 7th graders, but was comparable among 8th through 12th graders (Figure 12).
- Overall, the students in Region 1 had the lowest percent reporting riding in a car with a driver who had been drinking. More youth in 6th through 9th grades in Region 4 reported riding in a car with a driver who had been drinking (Figure 12).

Figure 12—Percent of students who reported riding in a car with a driver who had been drinking, 2008-2009

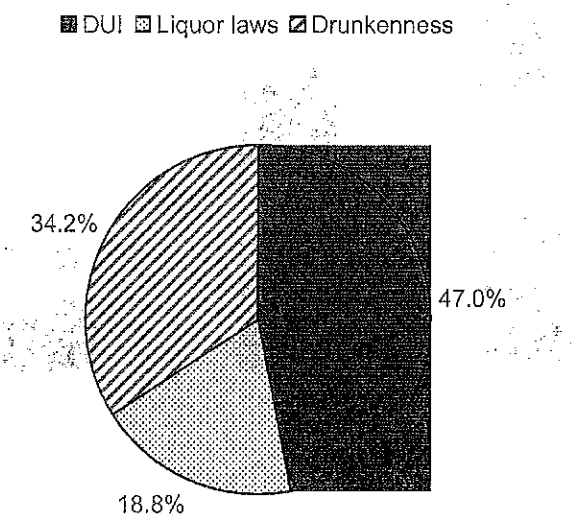


Source: Alabama Pride Survey

Adults and Youth Combined

- Alcohol-related arrests, DUI, liquor law violations (e.g. bootlegging, selling to minors), and public drunkenness, may result from alcohol use and abuse.
- In 2008, there were 34,785 arrests in Alabama for alcohol-related offenses[6]. DUI accounted for 16,337 arrests (47.0%); Public drunkenness accounted for 11,893 arrests (34.2%); and liquor law violations accounted for 6,555 arrests (18.8%) (Figure 13).

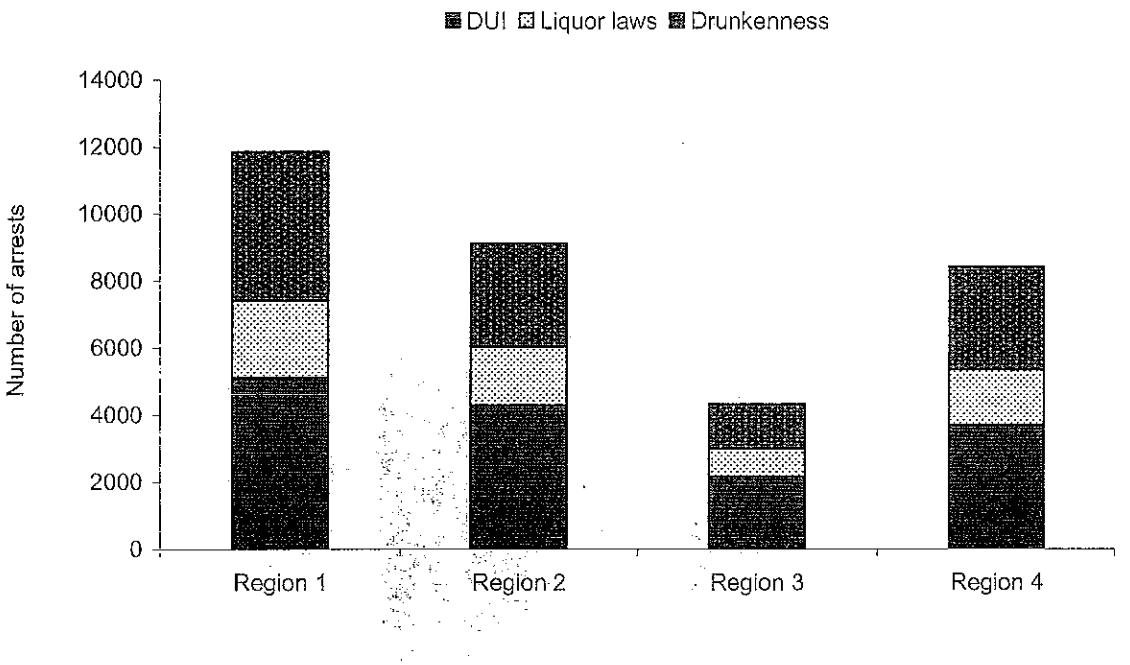
Figure 13—Alcohol-related arrests by type, 2008



Source: ACJIC

- In 2008, the number of alcohol-related arrests varied by region: 11,865 for Region 1; 9,116 for Region 2; 4,322 for Region 3; and 8,408 for Region 4 (Figure 14).
- For all regions, DUI was the most common reason for an alcohol-related arrest followed by public drunkenness and liquor law violations.

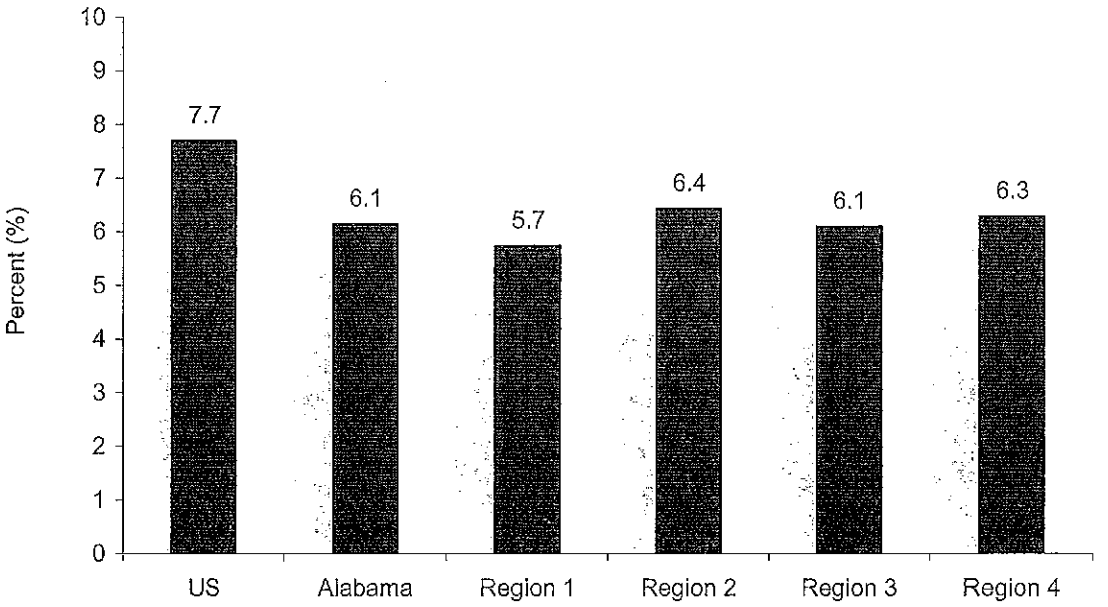
Figure 14—Alcohol-related arrests by region, 2008



Source: ACJIC

- In 2004-2006, the percent of persons 12 years and older in Alabama with alcohol abuse or dependence (6.1%) was less than the U.S. national average (7.7%) (Figure 15).
- Alcohol abuse or dependence was comparable across regions. Region 2 had the highest percent of persons reporting alcohol abuse or dependence (6.4%) while Region 1 had the lowest percent (5.7%); however, these differences were not statistically significant (Figure 15).

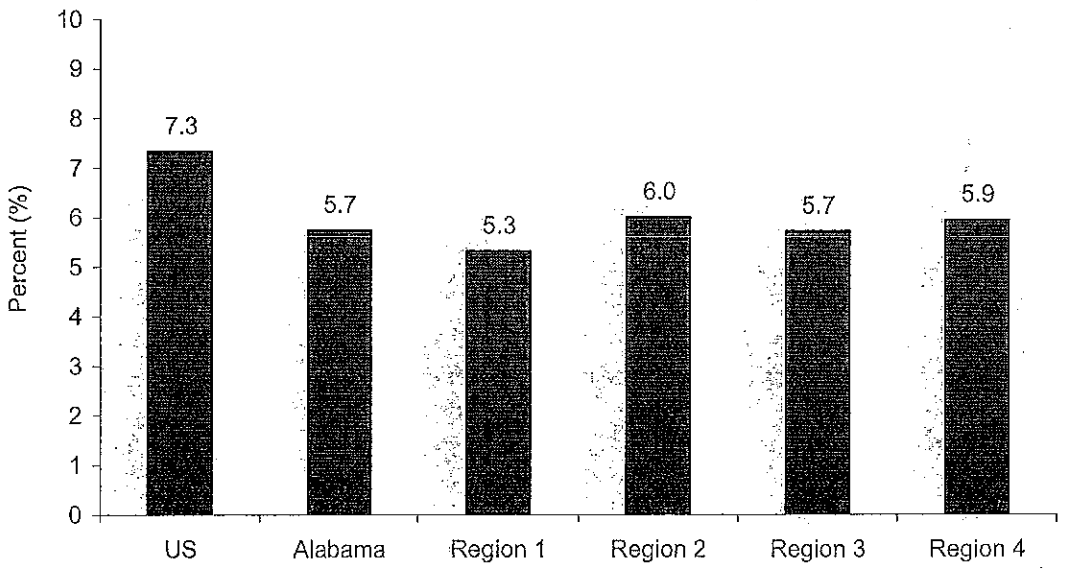
Figure 15—Percent of persons 12 years and older in Alabama with alcohol abuse or dependence, 2004-2006



Source: NSDUH

- In 2004-2006, the percent of persons 12 years and older in Alabama who needed but did not receive treatment for alcohol abuse or dependence (5.7%) was less than the U.S. national average (7.3%) (Figure 16).
- The need for treatment was comparable across regions: 6.0% in Region 2; 5.9% in Region 4; 5.7% in Region 3; and 5.3% in Region 1 (Figure 16).

Figure 16—Percent of persons 12 years and older in Alabama who needed but did not receive treatment for alcohol abuse or dependence, 2004-2006



Source: NSDUH

TOBACCO

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Tobacco

- The minimum legal age to purchase, use, possess, or transport tobacco products in Alabama is 19 years.
- Alabama ranks 40th out of all 50 states plus the District of Columbia for its tax rate on cigarettes, which is 42.5¢ per pack; however, cities and counties may impose an additional tax.
- The Alabama Alcoholic Beverage Control (ABC) Board is responsible for issuing tobacco permits, vendor education programs, and enforcement (Table 6).

Table 6—Number of tobacco inspections, compliance checks, and citations done by the Alabama ABC Board by fiscal year, 2004-2009

	FY 2004-2005	FY 2005-2006	FY 2006-2007	FY 2007-2008	FY 2008-2009
Tobacco inspections	2814	6306	9030	11265	12559
Tobacco compliance checks	2069	2470	3596	3229	3397
Tobacco citations	245	298	388	333	302

Source: Alabama ABC Board

Tobacco Consumption

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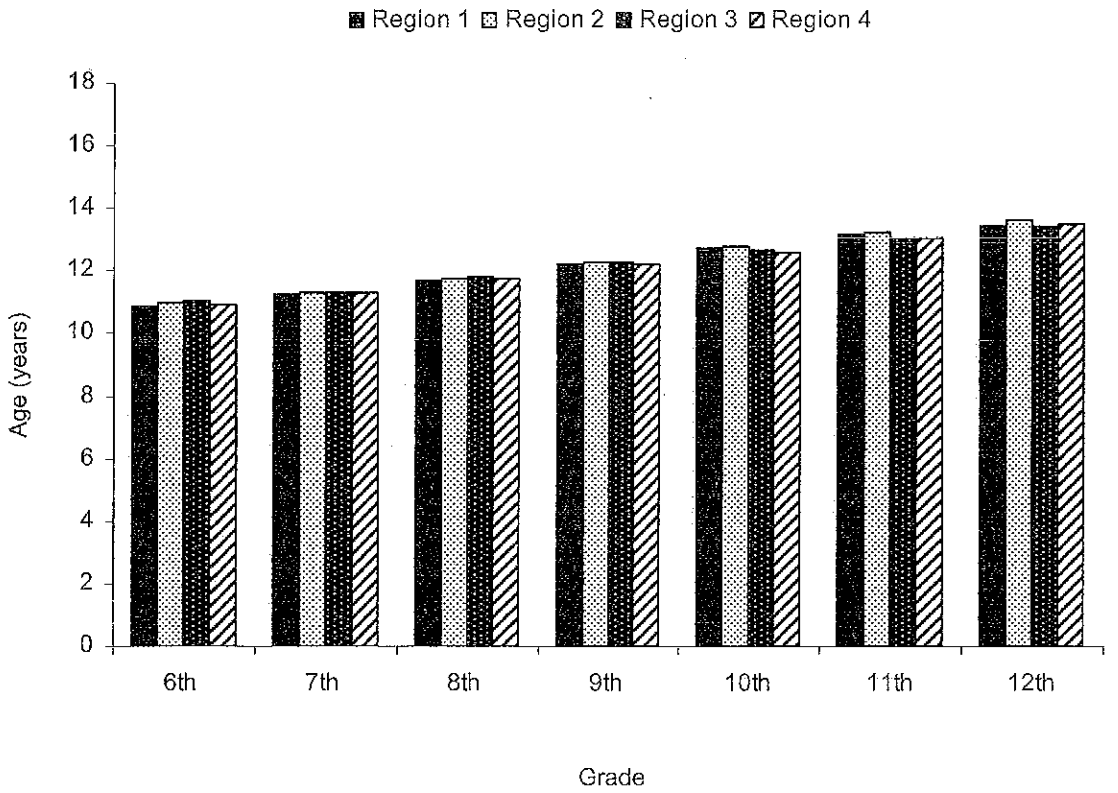
Youth

- During 2008-2009, the average age of first use of tobacco increased as grade increased for each region (Figure 17).
- The average age of first use of tobacco was comparable across regions within each school grade (Figure 17).

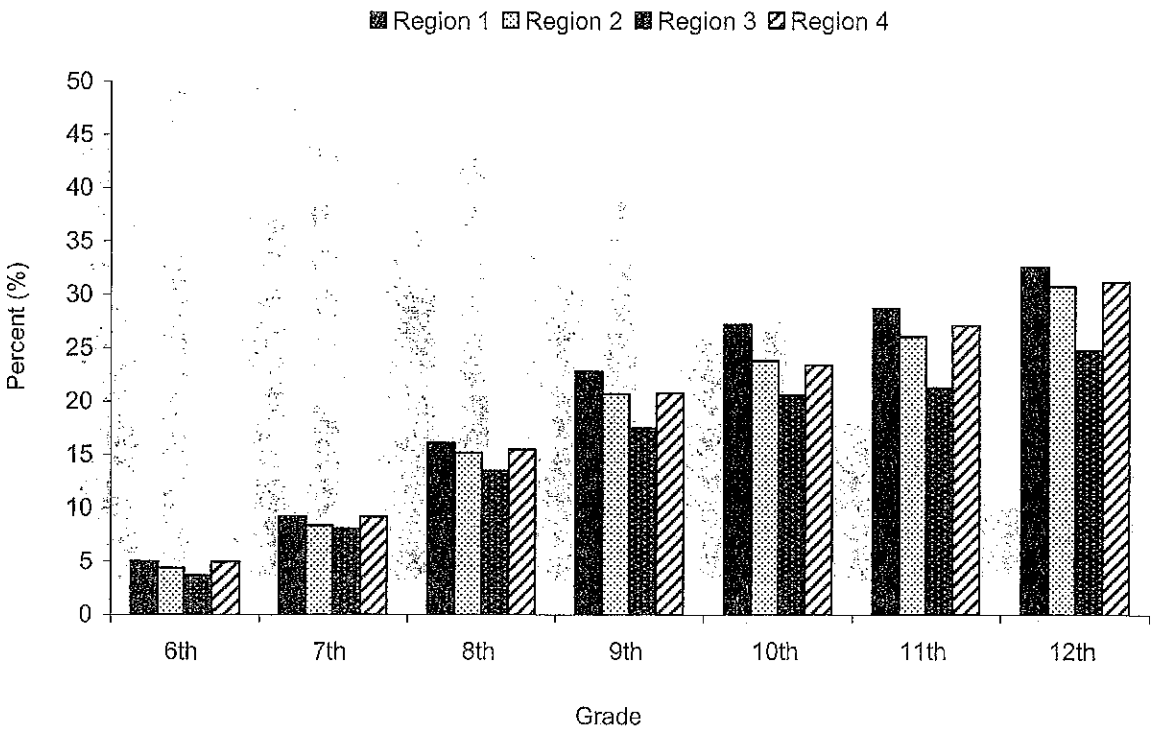
Figure 17—Average age at first use by grade, 2008-2009



Source: Alabama Pride

- The percent of students who reported tobacco use during the past month increased as school grade increased for each region (Figure 18).
- Within each school grade, Region 1 had the highest percent of youth reporting tobacco use during the past month while Region 3 had the lowest percent (Figure 18).

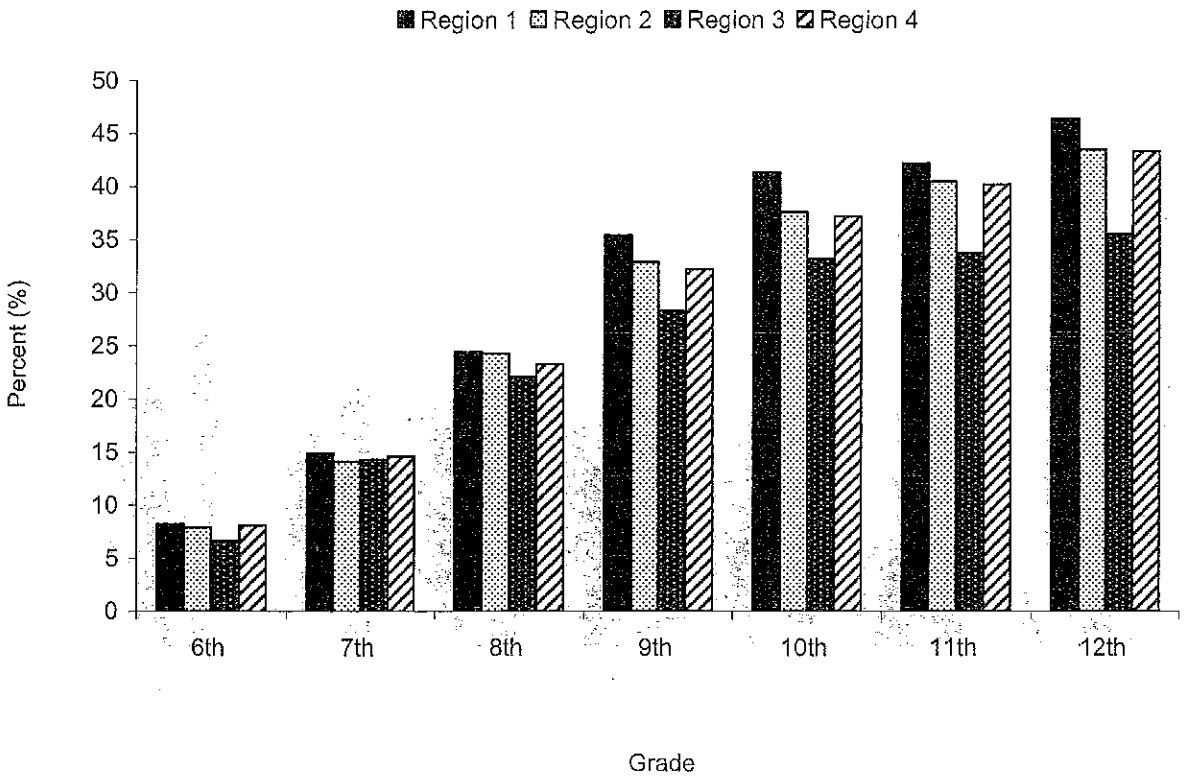
Figure 18—Percent of students who reported tobacco use during the past month by school grade, 2008-2009



Source: Alabama Pride

- The percent of students who reported that their friends use tobacco also increased as grade increased (Figure 19).
- Within each school grade, Region 1 had the highest percent of youth reporting that their friends use tobacco. Region 3 had the lowest percent except the 7th grade. (Figure 19).

Figure 19—Percent of students who reported their friends use tobacco by school grade and region, 2008-2009

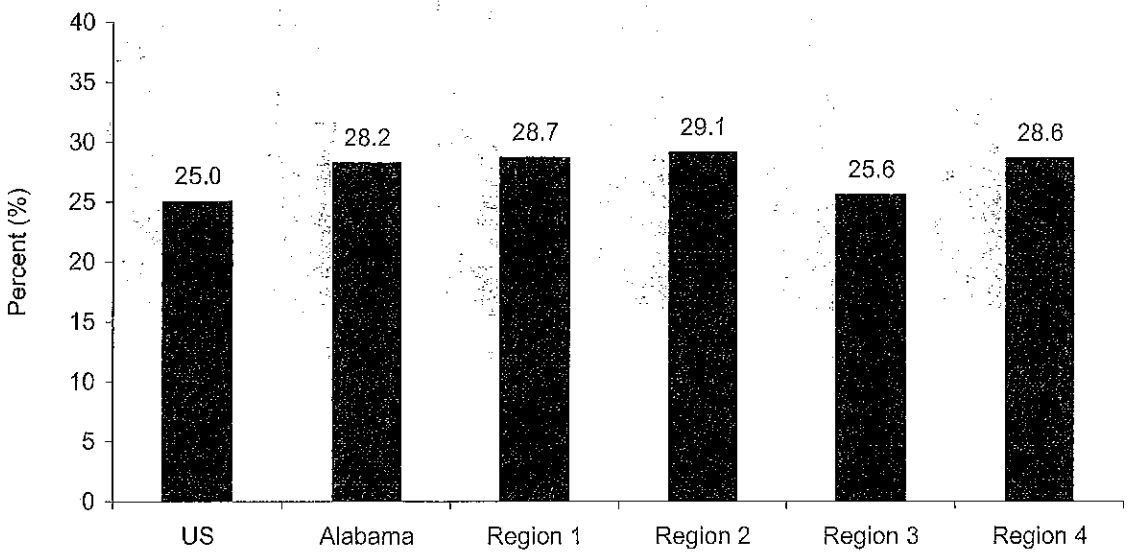


Source: Alabama Pride

Adults and Youth Combined

- Cigarette smoking during the past month among persons 12 years and older in Alabama (28.2%) was higher than the U.S. national average (25.0%) (Figure 20).
- Cigarette smoking was comparable across regions. Region 2 had the highest percent of persons who reported smoking cigarettes during the past month (29.1%) while Region 3 had the lowest percent (25.6%); however, these differences were not statistically significant (Figure 20).

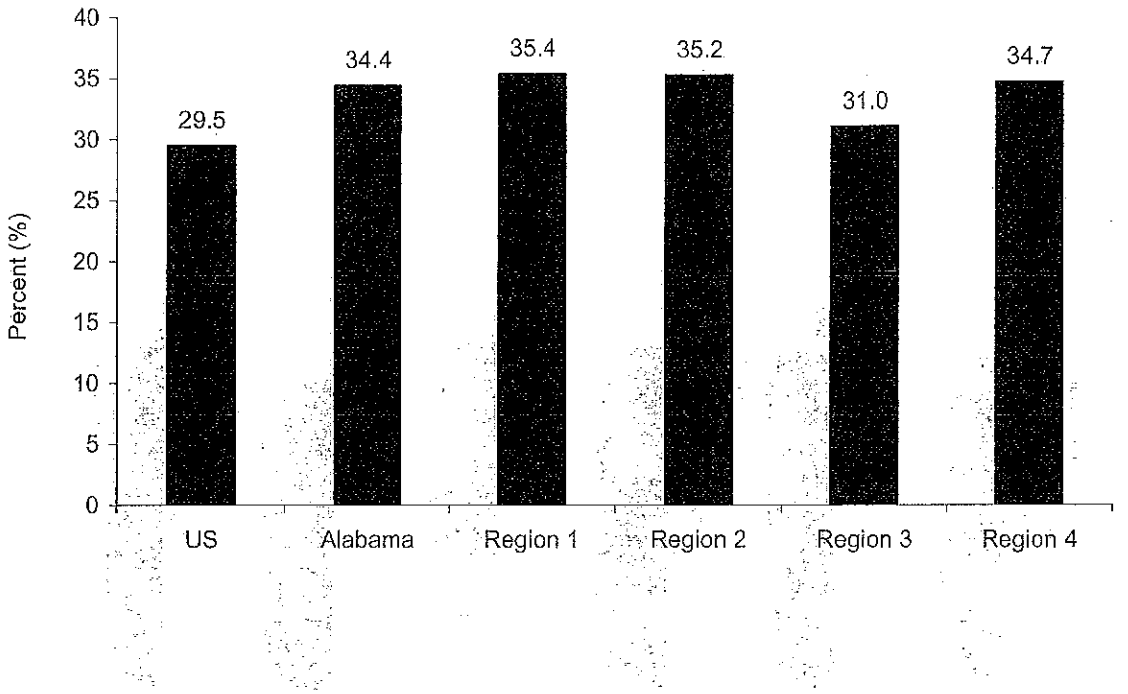
Figure 20—Percent of persons 12 years and older in Alabama who reported smoking cigarettes during the past month, 2004-2006



Source: NSDUH

- Tobacco use during the past month among persons 12 years and older in Alabama (34.4%) was higher than the U.S. national average (29.5%) (Figure 21).
- Tobacco use was comparable across regions. Region 1 had the highest percent of persons who reported any tobacco use during the past month (35.4%) while Region 3 had the lowest percent (31.0%); however, these differences were not statistically significant (Figure 21).

Figure 21—Percent of persons 12 years and older in Alabama who reported using any tobacco products during the past month, 2004-2006

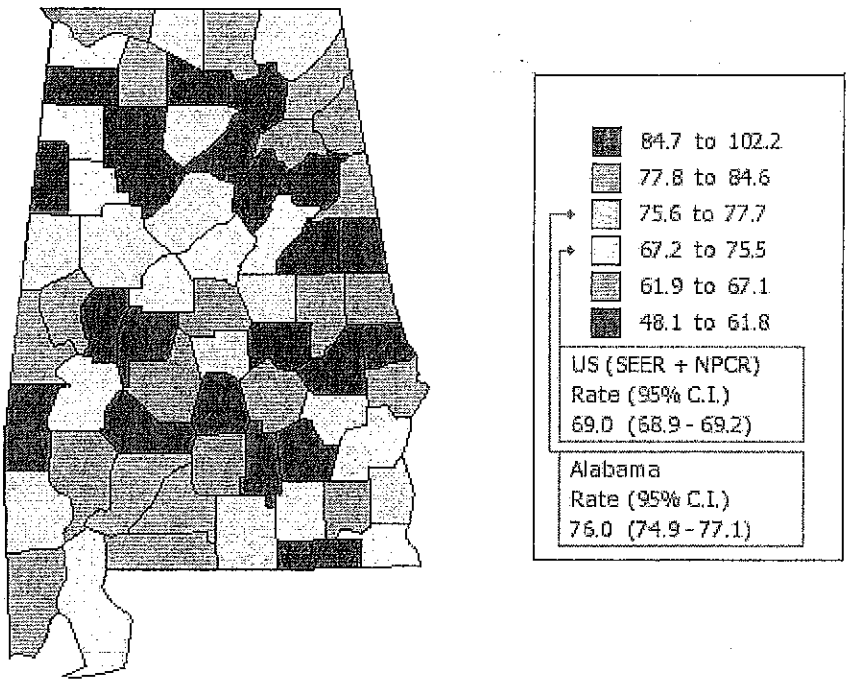


Source: NSDUH

Tobacco Consequences

- Tobacco use is associated with an increased risk of morbidity and mortality.
- In 2002-2006, the age-adjusted incidence rate for lung and bronchus cancers was higher for Alabama (76.0 per 100,000 persons) than the U.S. (69.0 per 100,000 persons) (Figure 22).
- Six of the eleven counties with the highest incidence rates (84.7 to 102.2 per 100,000 persons) were located in Region 1 in Alabama.

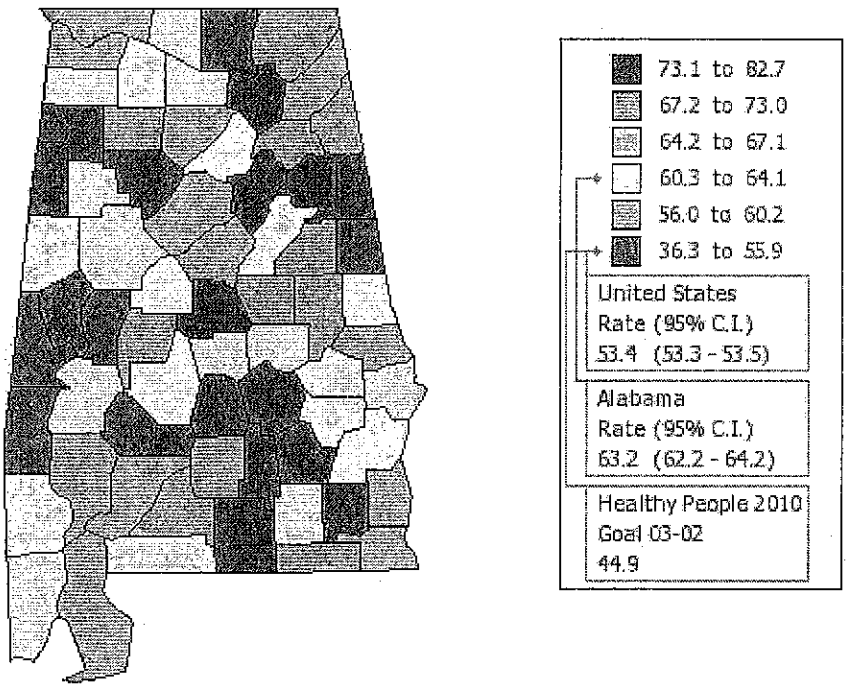
Figure 22—Age-adjusted incidence rate (per 100,000) for lung and bronchus cancers by county, 2002-2006



Source: http://statecancerprofiles.cancer.gov

- In 2002-2006, the age-adjusted mortality rate for lung and bronchus cancers was higher for Alabama (63.2 per 100,000 persons) than the U.S. (53.4 per 100,000 persons) (Figure 23).
- The mortality rate for lung and bronchus cancers was higher in the northern part of the state. Thirteen of the 18 counties in Region 1 had an age-adjusted mortality rate higher than the state average (Figure 23).

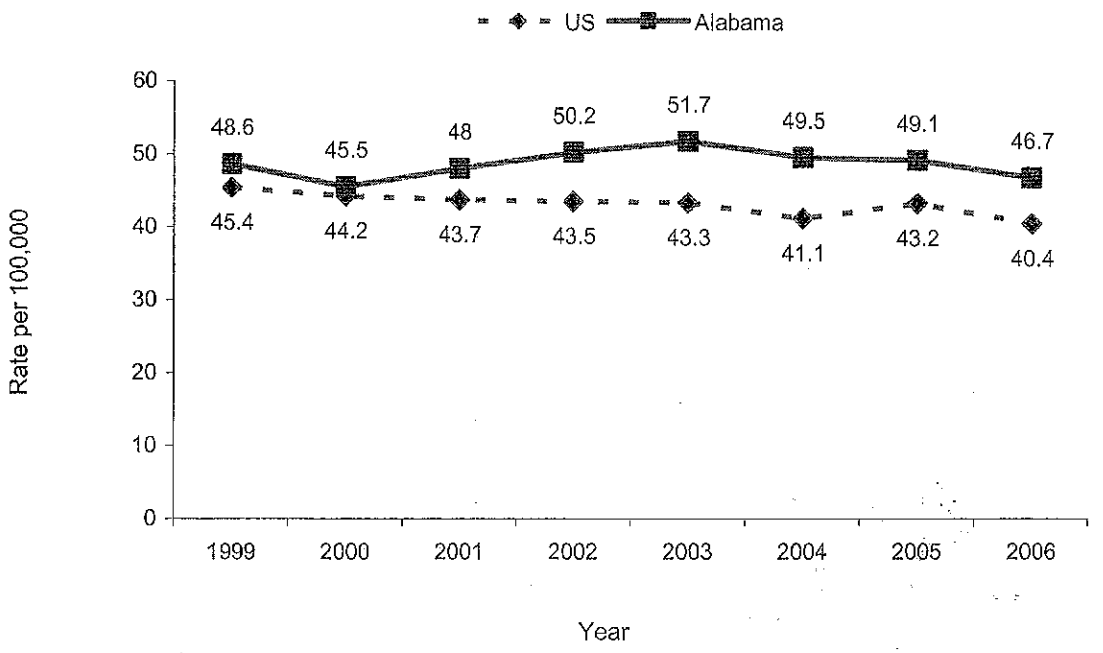
Figure 23—Age-adjusted mortality rate (per 100,000) for lung and bronchus cancers by county, 2002-2006



Source: http://statecancerprofiles.cancer.gov

- During 1999-2006, the age-adjusted mortality rate for chronic lower respiratory diseases, which includes bronchitis, asthma, emphysema, and other chronic obstructive pulmonary diseases, was also higher for Alabama compared to the U.S. (Figure 24).

Figure 24—Age-adjusted mortality rate (per 100,000) for chronic lower respiratory diseases, 1999-2006



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2K, 2009. Accessed at http://wonder.cdc.gov/cmf-icd10.html. ICD-10 codes J40-J47.

OTHER DRUGS

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Other Drugs

- The Controlled Substances Act of 1970 established 5 schedules of drugs to regulate the manufacture and distribution of these drugs in the United States based on potential for abuse and accepted medical uses (21 Code of Federal Regulations Part 1308). Commonly abused drugs by schedule are presented in Table 7.
    - Schedule I: No approved medical uses
    - Schedule II: Requires a non-refillable prescription and order form
    - Schedule III, IV: Requires a prescription; limited refills are allowed; prescriptions may be called-in by the physician
    - Schedule V: Some availability over the counter

Table 7—Commonly abused drugs by category and schedule

Category	Name	Schedule
Cannabinoids	Hashish	I
	Marijuana	I
Depressants	Barbituates	II, III, V
	Benzodiazepines	IV
	Flunitrazepam	IV
	GHB (gamma-hydroxybutyrate)	I
	Methaqualone	I
Dissociative Anesthetics	Ketamine	III
	PCP (phencyclidine)	I, II
Hallucinogens	LSD (lysergic acid diethylamide)	I
	Mescaline	I
	Psilocybin	I
Opioids and morphine derivatives	Codeine	II, III, IV, V
	Fentanyl	I, II
	Heroin	I
	Morphine	II, III
	Opium	II, III, V
	Oxycodone HCL	II
	Hydrocodone bitartrate, acetaminophen	II
Stimulants	Amphetamine	II
	Cocaine	II
	MDMA (methylenedioxymethamphetamine)	I
	Methamphetamine	II
	Methylphenidate	II
	Nicotine	Not scheduled
Other compounds	Anabolic steroids	III
	DXM (dextromethorphan)	Not scheduled
	Inhalants	Not scheduled

Source: National Institute of Drug Abuse http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html

OTHER DRUG CONSUMPTION

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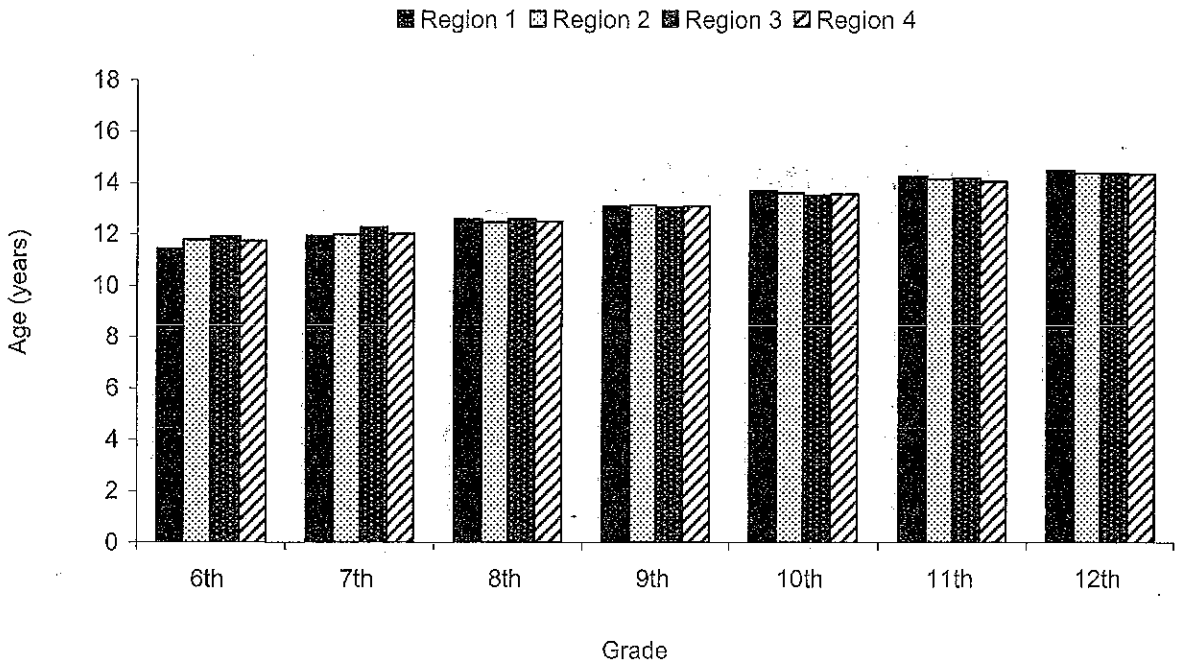
Youth

- During 2008-2009, the average age of first use of marijuana increased as school grade increased, but was comparable across regions (Figure 25). Among 12th grade students in Alabama, the average age of first use of marijuana was 14 years old.

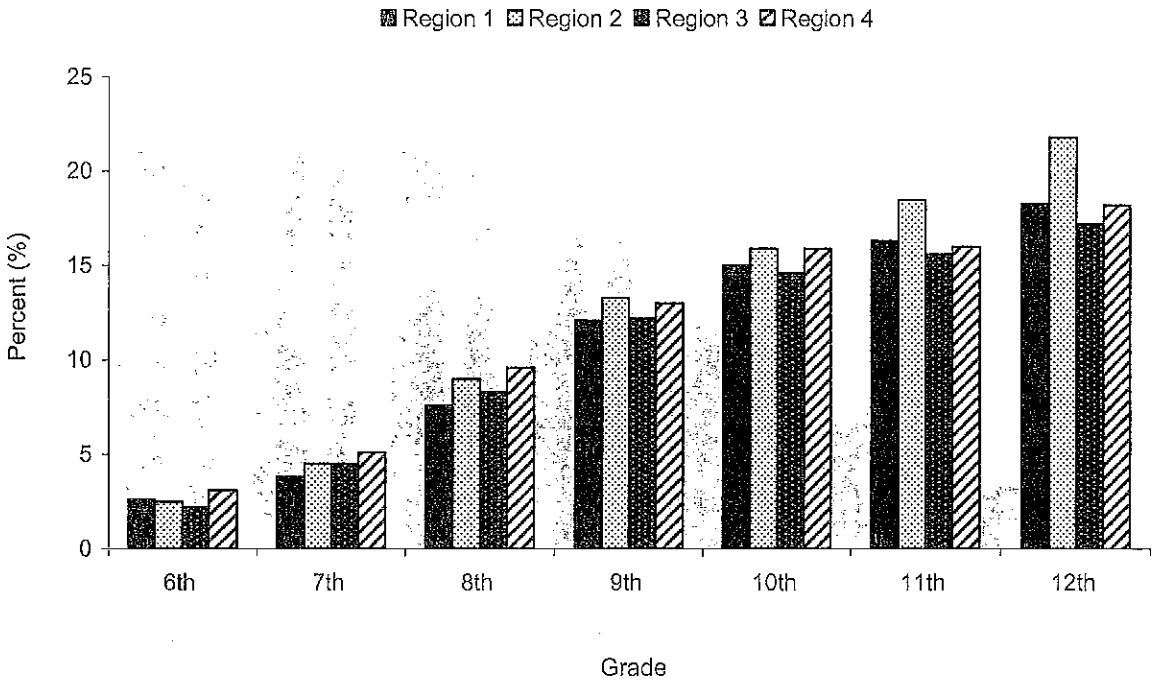
Figure 25—Average age of first use of marijuana, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using marijuana during the past month increased as grade increased (Figure 26).
- Among high school students, a higher percent of students in Region 2 reported marijuana use during the past month, while fewer students in Region 3 reported marijuana use during the past month.

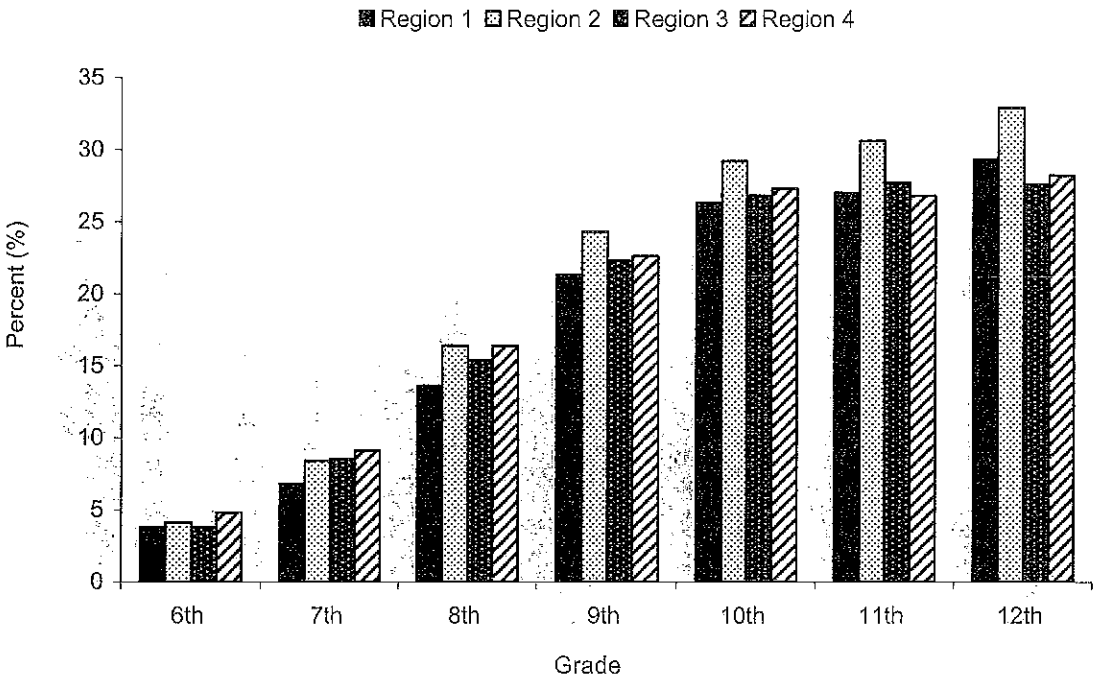
Figure 26—Percent of students reporting marijuana use during the past month by grade, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported that their friends use marijuana increased as grade increased for each region (Figure 27).
- Among high school students, a higher percent of students in Region 2 reported their friends use marijuana. In 6^{th}-10^{th} grades, fewer students in Region 1 reported their friends use marijuana (Figure 27).

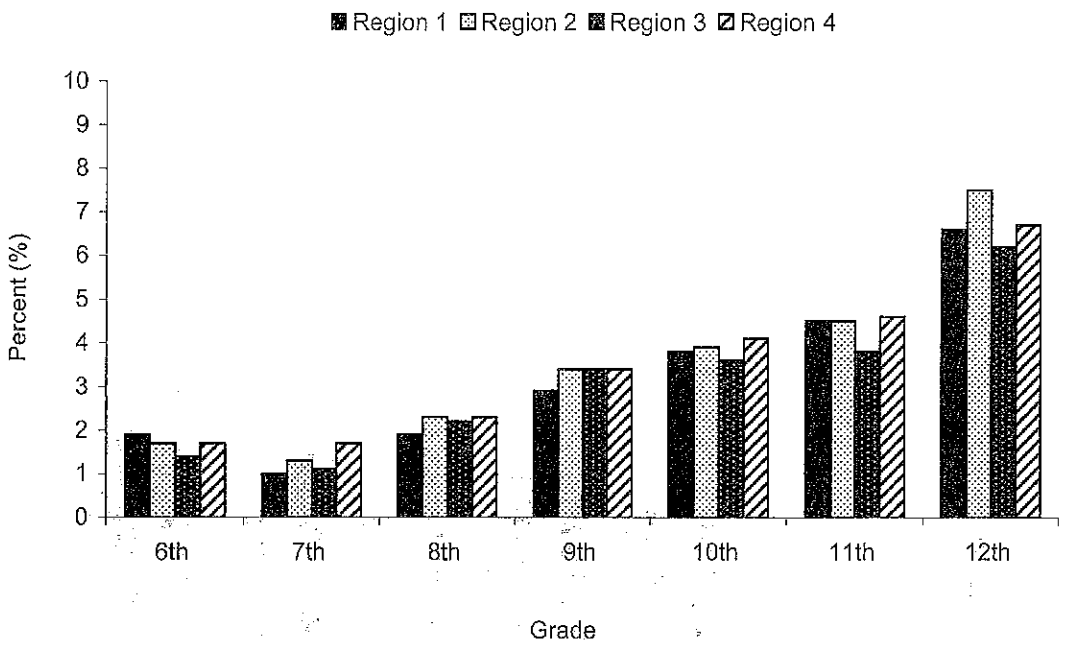
Figure 27—Percent of students who reported that their friends use marijuana by grade, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using cocaine during the past month increased as school grade increased for each region (Figure 28).
- In each region, less than 2% of 6th and 7th graders reported cocaine use during the past month compared to just over 6% of 12th graders (Figure 28).

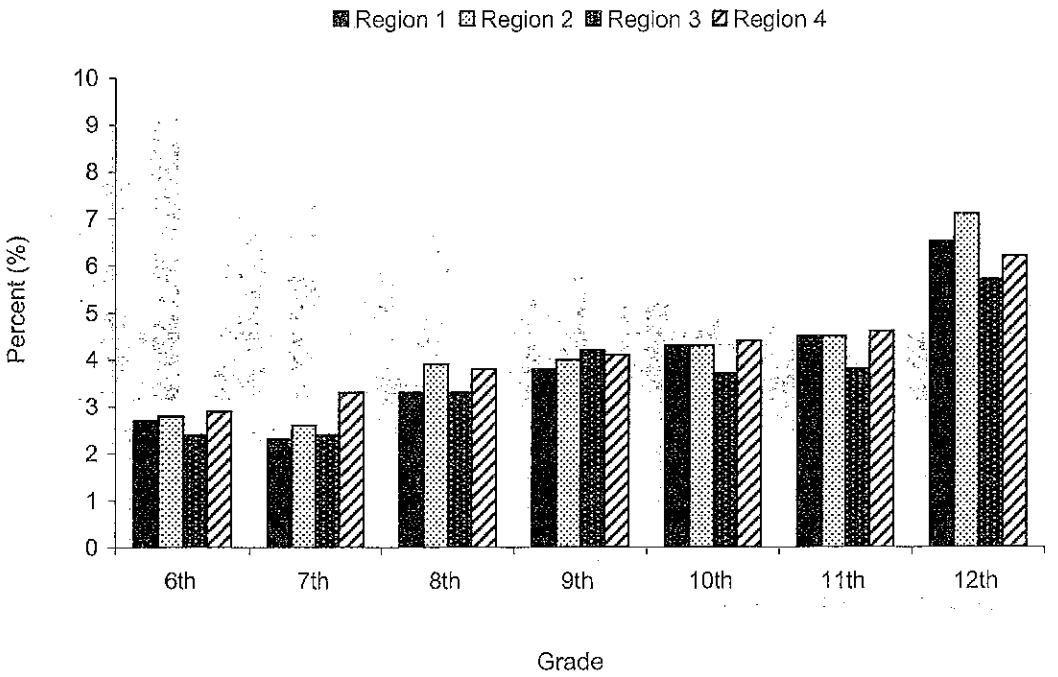
Figure 28—Percent of students reporting cocaine use during the past month by grade and region, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using inhalants during the past month increased as school grade increased for each region (Figure 29).
- In each region, approximately 3% of 6th and 7th graders reported inhalant use during the past month compared to just approximately 6.5% of 12th graders.
- Among 12th grade students, Region 2 had the highest percent of students who reported inhalant use during the past month (7.1%), followed by Region 1 (6.5%), Region 4 (6.2%), and Region 3 (5.7%) (Figure 29).

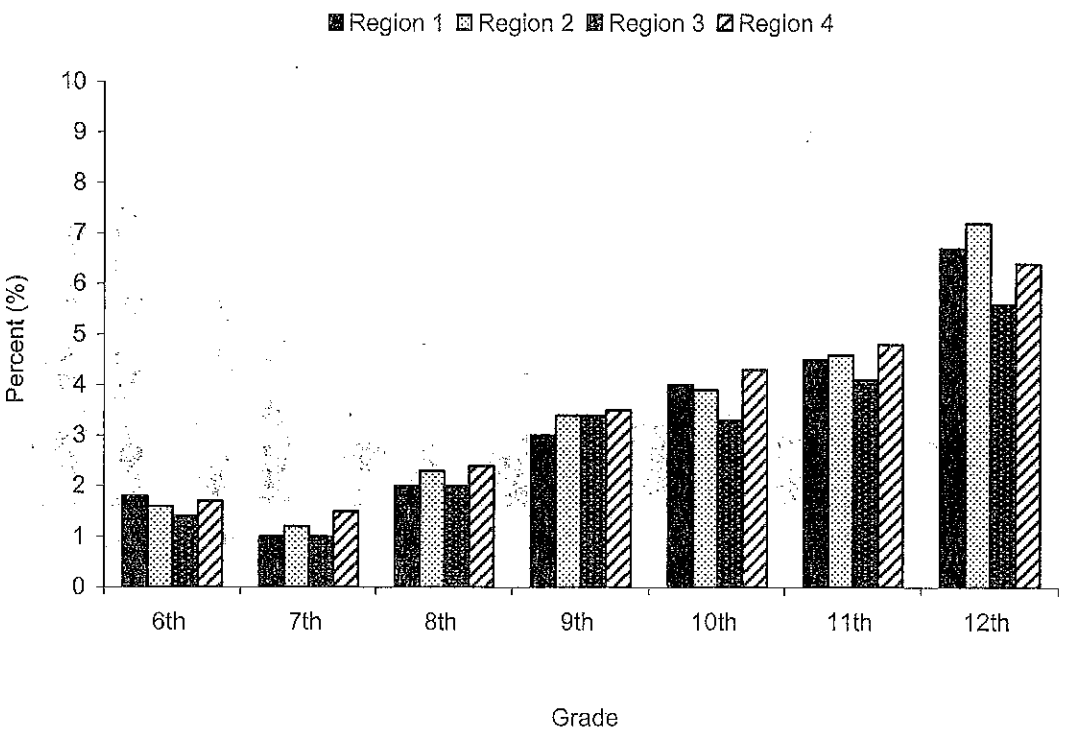
Figure 29—Percent of students reporting using inhalants during the past month by grade and region, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using hallucinogens during the past month increased as school grade increased for each region (Figure 30).
- Among 12th grade students, Region 2 had the highest percent of hallucinogen use during the past month (7.2%), followed by Region 1 (6.7%), Regions 4 (6.4%), and 3 (5.6%) (Figure 30).

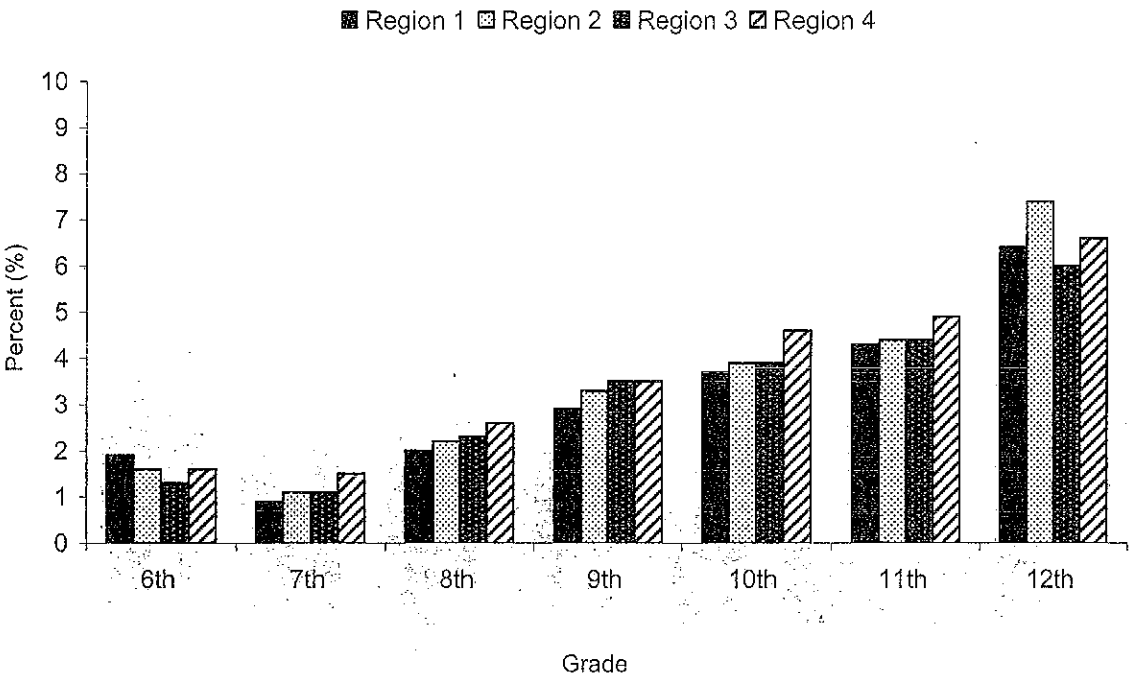
Figure 30—Percent of students reporting hallucinogen use during the past month by grade and region, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using ecstasy during the past month increased as school grade increased for each region (Figure 31).
- Among 12th grade students, Regions 2 had the highest percent of ecstasy use during the past month (7.4%), followed by Region 4 (6.6%), Region 1 (6.4%), and Region 3 (6.0%) (Figure 31).

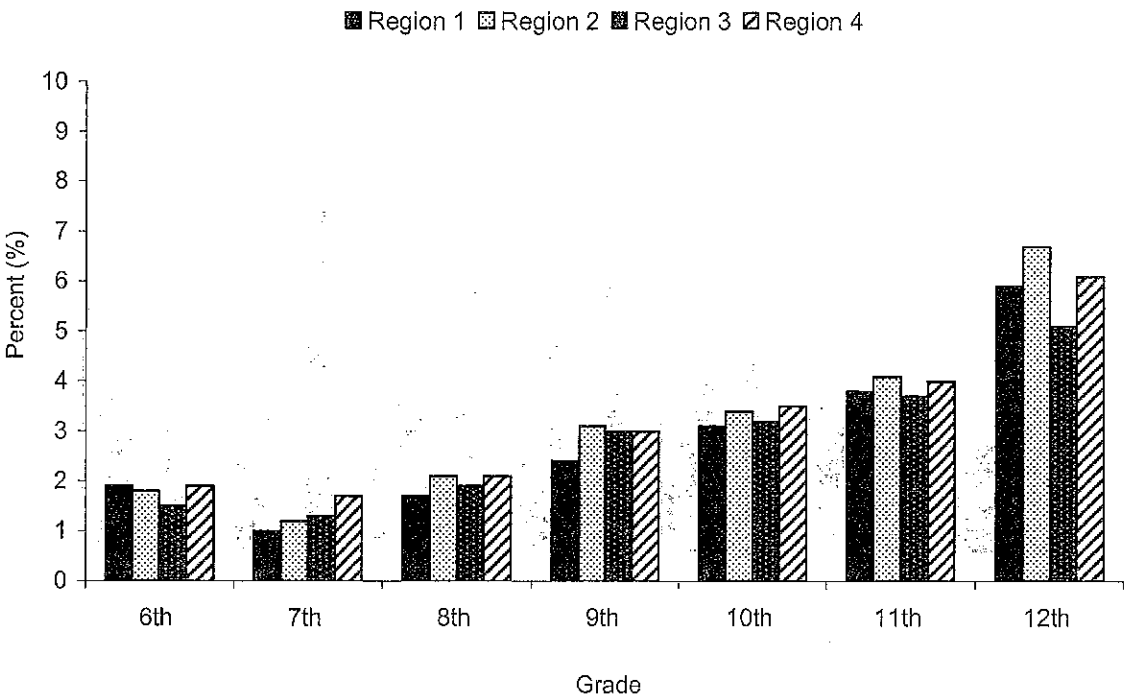
Figure 31—Percent of students reporting ecstasy use during the past month by grade and region, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported using methamphetamine during the past month increased as school grade increased for each region (Figure 32).
- Among 12th grade students, Region 2 had the highest percent of methamphetamine use during the past month (6.7%), followed by Region 4 (6.1%), Region 1 (5.9%), and Region 3 (5.1%) (Figure 32).

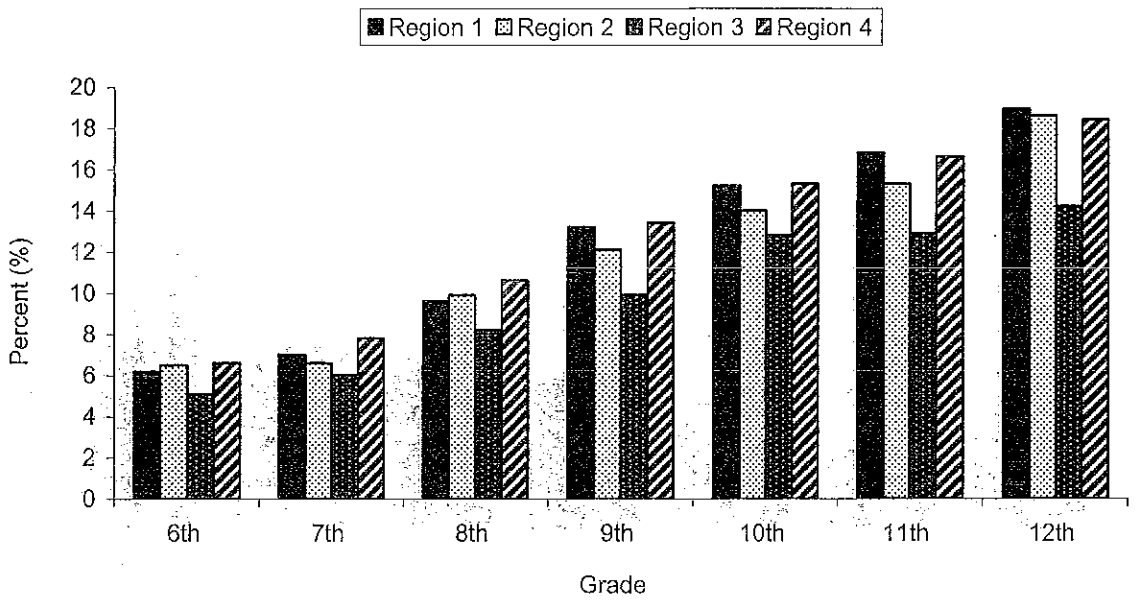
Figure 32—Percent of students reporting methamphetamine use during the past month by grade and region, 2008-2009



Source: Alabama Pride Survey

- The percent of students who reported non-medical use of prescription drugs increased as school grade increased for each region (Figure 33). Note: Non-medical use of prescription drugs reflects any use during the student's lifetime.
- Overall, Region 3 had the lowest percent of non-medcial use of prescription drugs. In 6th-10th grades, Region 4 had the highest percent (Figure 33).

Figure 33—Percent of students reporting non-medical use of prescription drugs by grade and region, 2008-2009

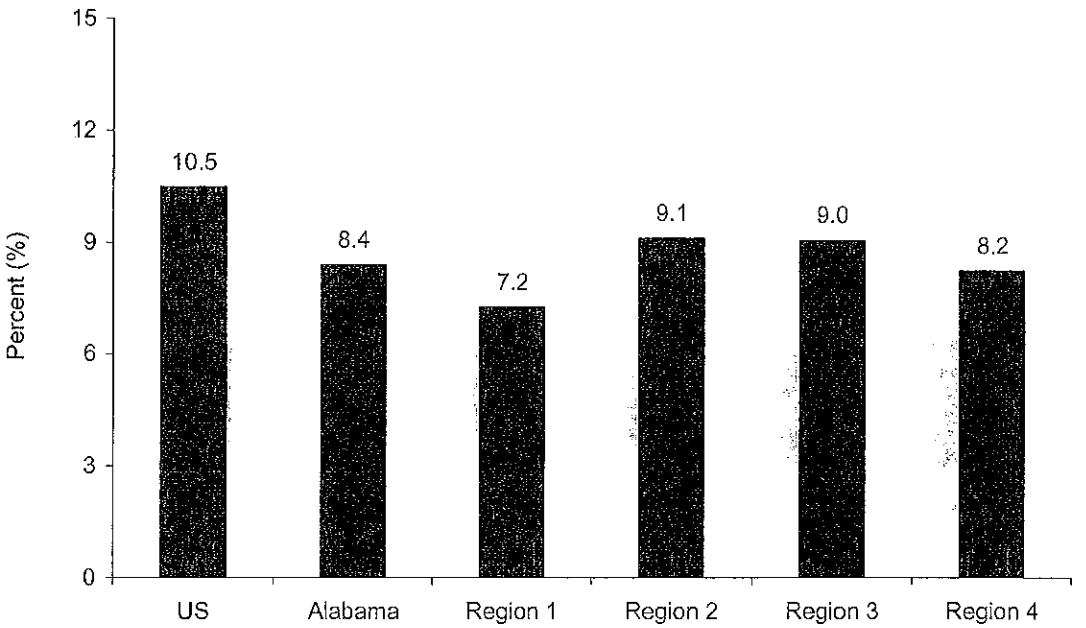


Source: Alabama Pride Survey

Adults and Youth Combined

- Marijuana use during the past year among persons 12 years and older in Alabama (8.4%) was lower than the U.S. national average (10.5%) (Figure 34).
- Marijuana use was comparable across regions. Region 2 had the highest percent of persons who reported marijuana use during the past year (9.1%) while Region 1 had the lowest percent (7.2%); however, these differences were not statistically significant (Figure 34).

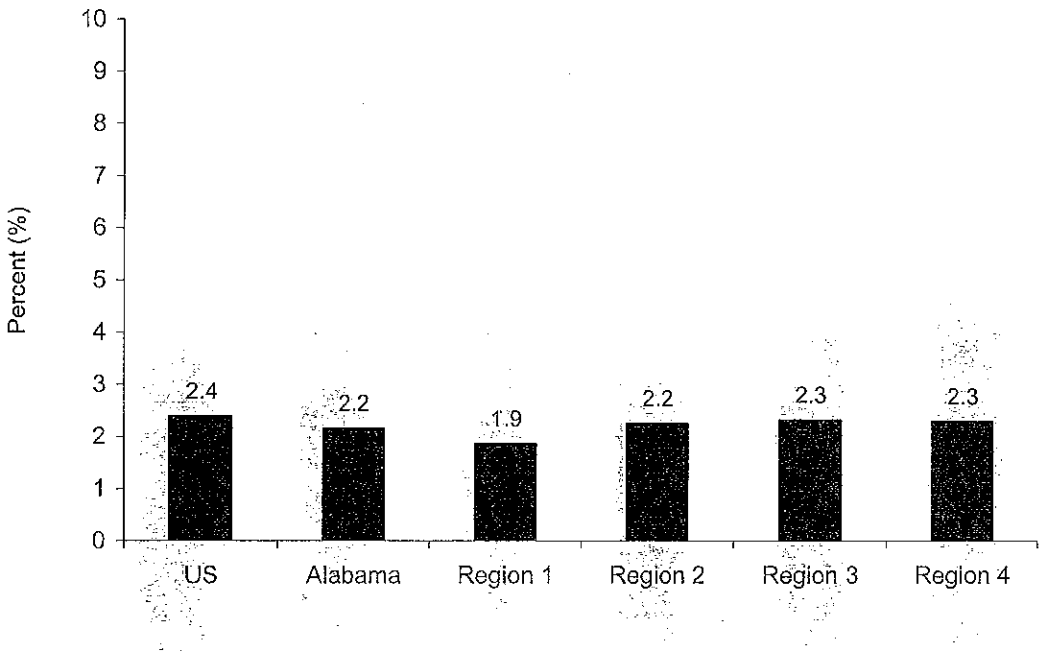
Figure 34—Percent of persons 12 years and older in Alabama who reported marijuana use during the past year, 2004-2006



Source: NSDUH

- Cocaine use during the past year among persons 12 years and older in Alabama (2.2%) was similar to the U.S. national average (2.4%) (Figure 35).
- Cocaine use was comparable across regions. Regions 3 and 4 had the highest percent of persons who reported cocaine use during the past year (2.3%) while Region 1 had the lowest percent (1.9%); however, these differences were not statistically significant (Figure 35).

Figure 35—Percent of persons 12 years and older who reported cocaine use during past year by region, 2004-2006



Source: NSDUH

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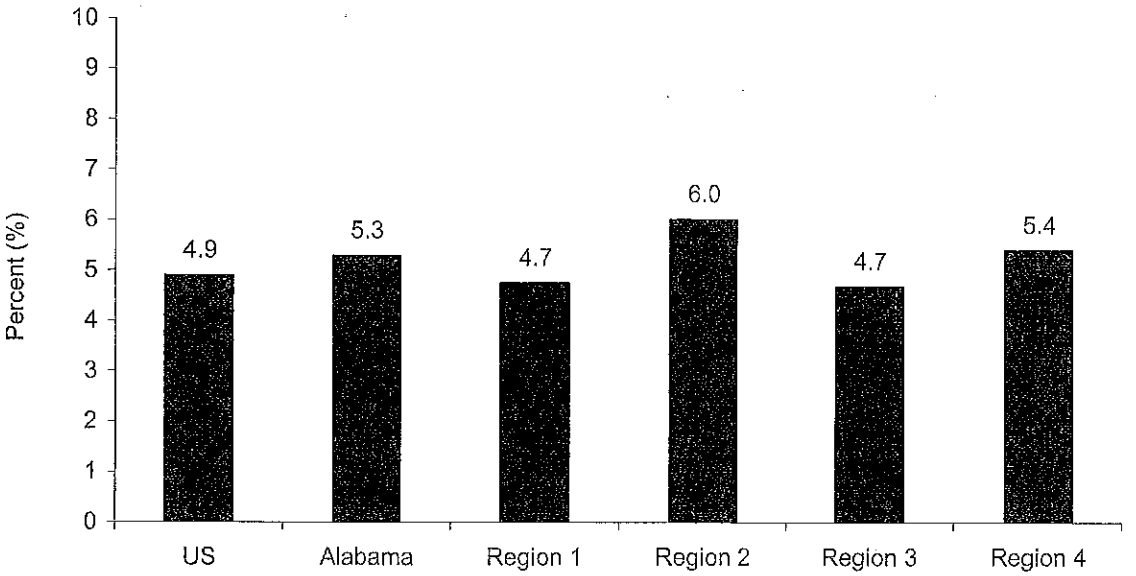
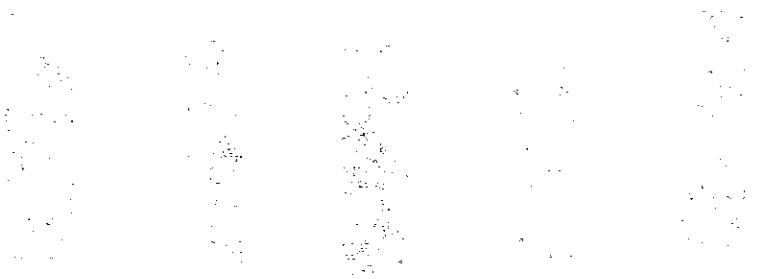
- Non-medical use of prescription pain relievers during the past year among persons 12 years and older in Alabama (5.3%) was higher than the U.S. national average (4.9%) (Figure 36).
- Non-medical use of prescription pain relievers was comparable across regions. Region 2 had the highest percent of persons who reported non-medical use of prescription pain relievers during the past year (6.0%) while Regions 1 and 3 had the lowest percent (4.7%); however, these differences were not statistically significant (Figure 36).

Figure 36---Percent of persons 12 years and older in Alabama who reported non-medical use of prescription pain relievers during the past year, 2004-2006



Source: NSDUH

OTHER DRUG CONSEQUENCES



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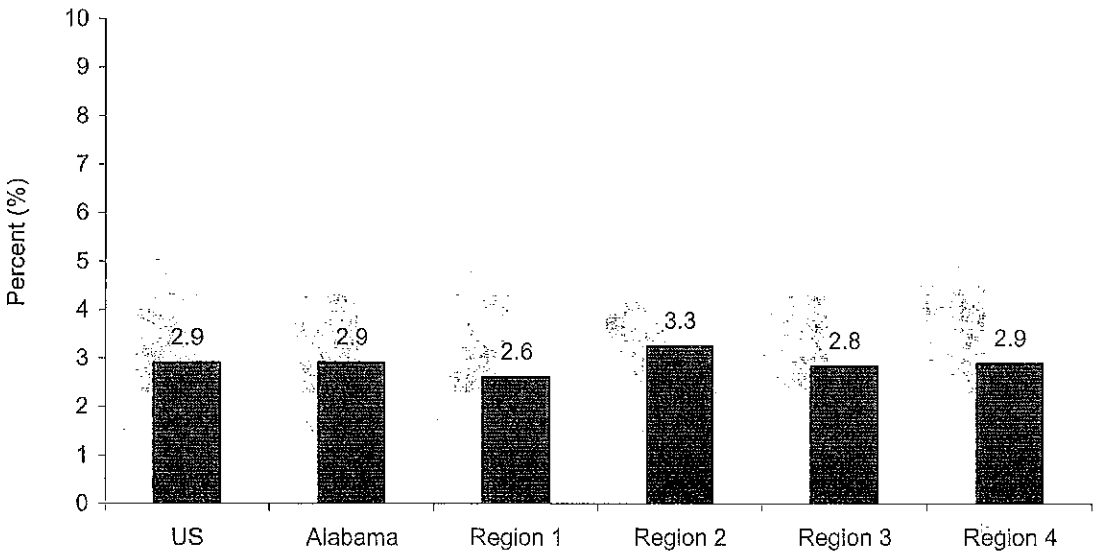
- Illicit drug use, including recreational and experimental use, can result in dependence or abuse and a need for treatment services.
- The percent of persons 12 years and older who abused or were dependent on illicit drugs during the past year was the same for Alabama (2.9%) and the U.S. national average (2.9%) (Figure 37).
- Illicit drug abuse or dependence was comparable across regions. Region 2 had the highest percent of persons with illicit drug abuse or dependence during the past year (3.3%) while Region 1 had the lowest percent (2.6%); however, these differences were not statistically significant (Figure 37).

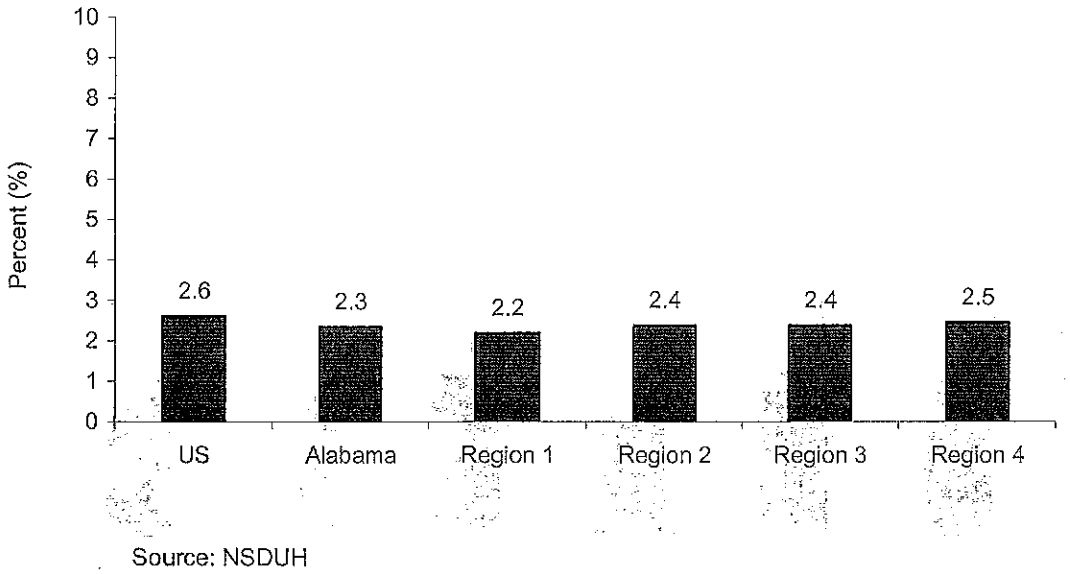
Figure 37—Percent of persons 12 years and older in Alabama who abused or were dependent on illicit drugs during the past year, 2004-2006



Source: NSDUH

- The percent of persons 12 years and older that needed but did not receive treatment for illicit drug abuse or dependence during the past year was slightly lower for Alabama (2.3%) than the U.S. national average (2.6%) (Figure 38).
- Needing but not receiving treatment for illicit drug abuse or dependence was comparable across regions. Region 4 had the highest percent of persons that needed but did not receive treatment for illicit drug abuse or dependence during the past year (2.5%) while Region 1 had the lowest percent (2.2%); however, these differences were not statistically significant (Figure 38).

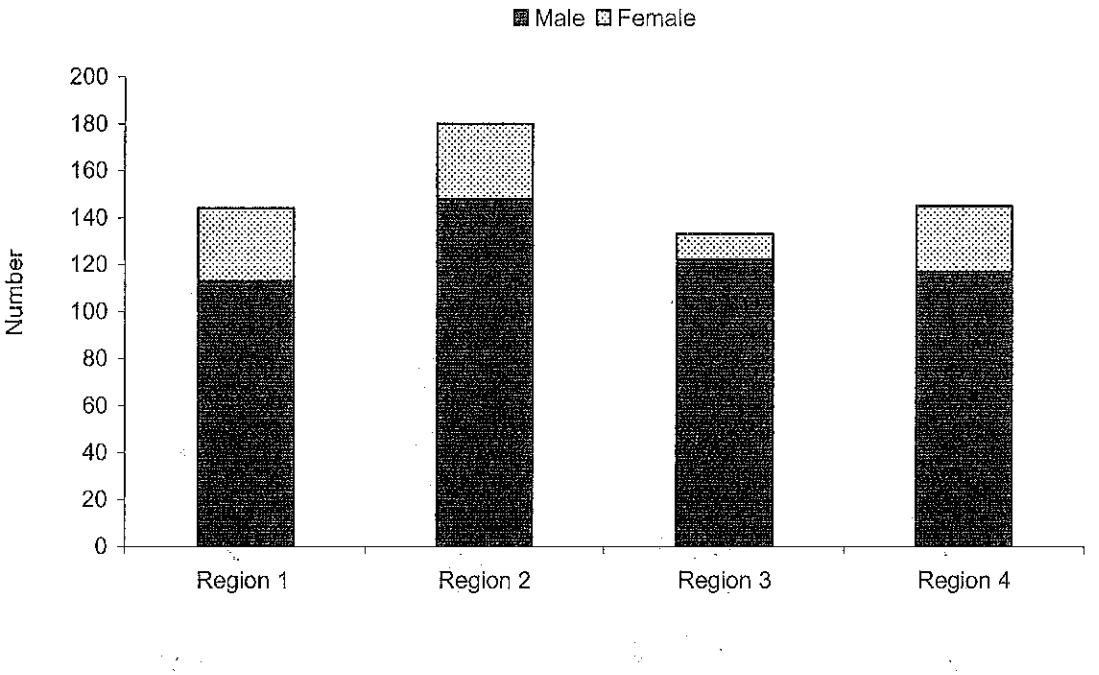
Figure 38—Percent of persons 12 years and older in Alabama who needed but did not receive treatment for illicit drug abuse or dependence during the past year, 2004-2006



Source: NSDUH

- The number of youth referrals for alcohol and drug treatment between January 1, 2008 and December 30, 2008 varied by region, with Region 2 having the most referrals and Region 3 having the least referrals (Figure 39).

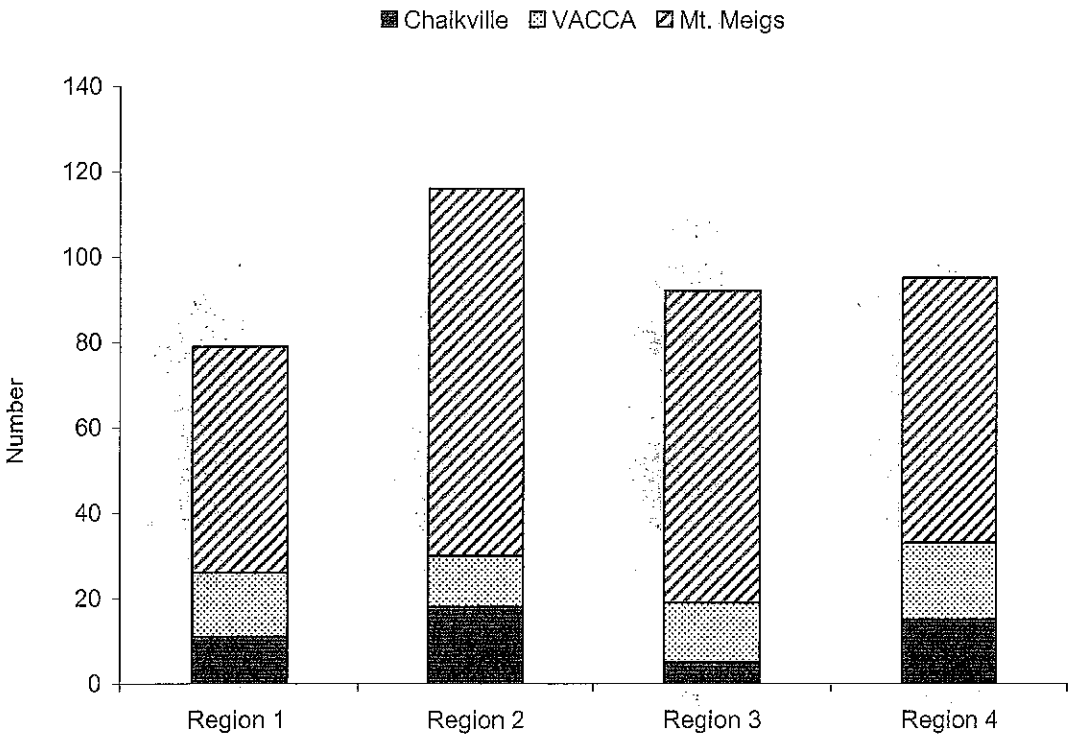
Figure 39—Number of youth referrals to treatment by region, 2008



Source: Alabama Department of Youth Services

- The number of youth referred to Department of Youth Services' facilities was comparable across regions, with Region 1 having the least number of referrals.
- Chalkville is the DYS facility for girls and VACCA and Mt. Meigs are the DYS facilities for boys.

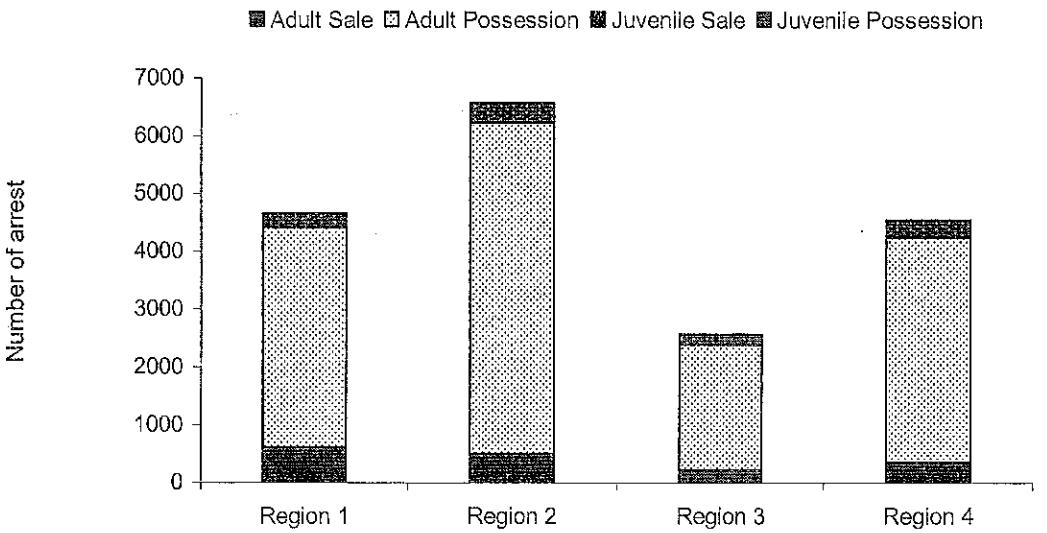
Figure 40—Number of youth referrals to DYS facilities, 2008



Source: Alabama Department of Youth Services

- Criminal arrests for the sale or possession of drugs are also possible consequences of substance abuse.
- In 2008, 18,346 adults and youth were arrested for the sale or possession of drugs in Alabama, with adult possession being the most common offense (Figure 40).

Figure 41—Number of arrests for the sale and possession of drugs by region, 2008



Source: ACJIC

References

1. Folsom, R. E., Shah, B., & Vaish, A. (1999). Substance abuse in states: A methodological report on model based estimates from the 1994-1996 National Household Surveys on Drug Abuse. In *Proceedings of the 1999 Joint Statistical Meetings, American Statistical Association, Survey Research Methods Section, Baltimore, MD* (pp. 371-375). Alexandria, VA: American Statistical Association. [Available as a PDF at http://www.amstat.org/sections/SRMS/proceedings/]
2. Department of Archives and History. State of Alabama. All about Alabama. http://www.alabamainteractive.org/alabamainteractive_shell/Welcome.do?url=http://www.archives.state.al.us/aaa.html.
3. U.S. Department of Agriculture. Economic Research Service. State fact sheets: Alabama. http://www.ers.usda.gov/StateFacts/AL.htm.
4. Institute for Rural Health Research. Black Belt Fact Book. http://irhr.ua.edu/blackbelt/intro.html.
5. United States Census Bureau. State and County QuickFacts. http://quickfacts.census.gov/qfd/states/01000.html.

Appendix A

Substance Abuse Services in Alabama

The Alabama Department of Mental Health is the state agency authorized to supervise, coordinate, and establish standards for all operations and activities related to mental health services in the State of Alabama. The department has three service divisions (Mental Illness, Intellectual Disabilities, and Substance Abuse Services) to address the mental health needs of Alabama residents.

The Substance Abuse Services Division is responsible for contracting with community providers, overseeing services provided, certifying programs, and promoting a continuum of prevention, intervention, treatment, and after-care services for substance abuse in Alabama.

Prevention Services

The Office of Prevention within the Substance Abuse Services Division coordinates and manages all prevention services and programs throughout the state, including the Strategic Prevention Framework, State Incentive Grant (2004-2009), Alabama Epidemiological Outcomes Workgroup, Synar (Tobacco Sales to Minors Program), and Regional Information Clearinghouses. *Currently, 22 prevention providers with locations in 20 counties receive funding from the State of Alabama to deliver substance abuse prevention services.*

Treatment Services

The Office of Treatment within the Substance Abuse Services Division coordinates and manages all treatment services throughout the state, including Adolescent Treatment, Adult Treatment, Co-occurring Disorders, Opiate Replacement Therapy, and Medicaid Services. *Currently, 42 certified community-based providers with locations in 45 counties receive funding from the State of Alabama to provide substance abuse treatment services. An additional 46 community-based providers are certified but are privately funded to deliver substance abuse treatment services.*

Note: All treatment providers in Alabama must be certified according to the standards developed by the Substance Abuse Services Division, with the exception of professionals in private practice.

Appendix B

Members of the Alabama Epidemiological Outcomes Workgroup

Vacant	Department of Children's Affairs
Ms. Kimberly Desmond	Department of Human Resources
Mr. Brandon Folks	Department of Mental Health
Ms. Sarah Harkless	Department of Mental Health
Ms. Joan Leary	Southern Coast Addiction Technology Transfer Center
Ms. Stephanie McCladdie	Department of Mental Health
Mr. Robert Oakes	Board of Pardons and Paroles
Capt. Vance Patton	Alcoholic Beverage Control Board
Mr. Pat Pendergast	Department of Youth Services
Ms. Sondra Reese	Department of Public Health
Mr. Bill Shanks	Department of Public Safety
Dr. Marcus Vandiver	Department of Education
Mr. Kristopher Vilamaa	Department of Mental Health
Dr. Ting Withers	Department of Mental Health
Mr. Bennet Wright	Alabama Sentencing Commission
Mr. Bob Wynn	Department of Mental Health

Appendix C
Methodology

The indicators that were included in this community-level epidemiological profile were selected based on the following criteria:

1. Availability of data at regional-level;
2. Relevance to ATOD consumption and consequences;
3. Data collection methods.

Many of the indicators included in this profile are reasonable measures of ATOD consumption and consequences at the regional-level in Alabama. This profile includes consumption data for youth and consumption data for persons 12 years and older; however, there is no data available at the regional-level to assess adult consumption only (18 years and older).

Measures for arrests and youth referrals were included as consequence indicators in this profile, but these measures are widely influenced by enforcement policies and available resources and may not be representative of the underlying issue of substance use and abuse. Also, these measures may include duplicate counts so that persons may be included more than once. This profile presents arrests and youth delinquency referrals as total counts, and not rates, so these counts may be affected by population size and should not be compared across counties.

The indicators included in this profile, data sources, and comments about the use of the indicators are provided in the table below.

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Indicator	Source	Comments
Alcohol Consequences		
Arrests for alcohol violations	ACJIC	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions.
% of students in grades 6-12 reporting driving when they had been drinking alcohol	Pride	Reasonable measure of youth drinking and driving.
% of students in grades 6-12 reporting riding with a driver who had been drinking alcohol	Pride	Reasonable measure of youth riding with a drinking driver.
% with alcohol dependence or abuse	NSDUH	Based on DSM-IV criteria; includes all persons 12 years and older.
Alcohol Consumption		
% of students in grades 6-12 reporting use of alcohol during past month	Pride	Reasonable measure of alcohol use.
% of students in grades 6-12 reporting that friends use alcohol	Pride	Reasonable measure of alcohol use by friends.
% of students in grades 6- 12 reporting having 5 or more drinks within a few hours	Pride	Reasonable measure of binge drinking.
Age of first use of alcohol by students in grades 6-12	Pride	Reasonable measure of age at first use.
Tobacco Consequences		
Incidence of lung and bronchus cancers per 100,000 population	SEER	Reasonable measure of tobacco-related morbidity.
Mortality rate for lung and bronchus cancers per 100,000 population	SEER	Reasonable measure of tobacco-related mortality.
Mortality rate for chronic lower respiratory diseases per 100,000 population	CDC Wonder	Reasonable measure of tobacco-related mortality.
Tobacco Consumption		
% of students in grades 6-12 reporting use of tobacco during past month	Pride	Reasonable measure of tobacco use. Includes various forms of tobacco.
% of students in grades 6-12 reporting that friends use tobacco	Pride	Reasonable measure of friends' tobacco use. Includes various forms of tobacco.
Age of first use of tobacco by students in grades 6-12	Pride	Reasonable measure of age at first use.
% of persons who smoked cigarettes during past month	NSDUH	Reasonable measure of cigarette smoking. Ages 12 years and older.
% of persons who used tobacco during past month	NSDUH	Reasonable measure of any tobacco use. Ages 12 years and older.
Other Drug Consequences		
% with illicit drug dependence or abuse	NSDUH	Based on DSM-IV criteria; includes all persons 12 years and older
Number of youth referrals for alcohol and drug treatment	DYS	May be affected by seriousness of youth delinquency and enforcement policies rather than actual magnitude of underlying problem.
Arrest rate for drug possession or sale per 100,000 population	ACJIC	May be affected by available personnel, resources, and enforcement policies and can vary substantially across jurisdictions.
Other Drug Consumption		
% of students in grades 6-12 reporting marijuana use during past month	Pride	Reasonable measure of marijuana use.
Age of first use of marijuana by students in grades 6-12	Pride	Reasonable measure of age at first use.
% of students in grades 6-12 reporting cocaine use during past month	Pride	Reasonable measure of cocaine use.
% of students in grades 6-12 reporting ecstasy use during past month	Pride	Reasonable measure of ecstasy use.
% of students in grades 6-12 reporting inhalant use during past month	Pride	Reasonable measure of inhalant use.
% of students in grades 6-12 reporting hallucinogen use during past month	Pride	Reasonable measure of hallucinogen use.
% of students in grades 6-12 reporting methamphetamine use during past month	Pride	Reasonable measure of methamphetamine use.
% of students in grades 6-12 reporting non-medical use of prescription drugs	Pride	Reasonable measure of non-medical use of prescription drugs.
% of persons who used marijuana during past year	NSDUH	Reasonable measure of marijuana use; ages 12 years and older.
% of persons who used cocaine during past year	NSDUH	Reasonable measure of cocaine use; ages 12 years and older.
% of persons who reported non-medical use of prescription pain relievers during past year	NSDUH	Reasonable measure of non-medical prescription pain reliever use; ages 12 years and older.

Appendix D

Glossary

Age-adjusted rate — A weighted average of age-specific rates where the weights are the proportions of persons in the corresponding age groups of a standard population. A standard population is used (2000 U.S. standard population) to allow for comparisons among counties, states, and national estimates by taking into account differences in the age composition of different areas.

Age-specific rate — A rate determined by the number of cases or events that occur within a specific age group divided by the population of that age group. Example: age-specific mortality rates can be calculated for youth 11-14 years and 15-17 years or any other age group of interest.

Crude rate — An unadjusted rate based on the total number of cases or events divided by the population.

Epidemiology —The study of the distribution and determinants of health-related states and events in populations and the application of this study to control health problems.

ICD-10 codes — The International Classification of Diseases, 10th Revision, is a classification system published by the World Health Organization that is used to classify causes of death.

Incidence — The number of new cases of a disease, illness, or injury that occurs in a population.

Morbidity — The effects of disease, illness, or injury in a population. Typical measures of morbidity are incidence rates and prevalence rates.

Mortality — The total number of deaths due to a particular disease, illness, or injury in a population.

Prevalence — The total number of cases (existing and new) of a disease, illness, or injury that occurs in a population.

Protective factor — A factor that is associated with a decreased risk of disease, illness, or injury.

Risk factor — A factor that is associated with an increased risk of a disease, illness, or injury.

Statistical significance — the probability that the observed difference (e.g., between percentages) occurred by chance. If a finding is not statistically significant, the difference observed could be attributed to chance and not a reflection of any true differences.

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Goal # 13
Attachment # 4

SAMHSA, Office of Applied Studies
National Survey on Drug Use and Health, 2002-2008

MH CATCHMENT AREAS	TOTAL RANKING	AVG. RANKING
CATCHMENT #15	38	4.22
CATCHMENT #8	97	4.41
CATCHMENT #5	113	4.91
CATCHMENT #16	135	5.87
CATCHMENT #2	149	6.48
CATCHMENT #12	144	7.58
CATCHMENT #22	79	7.90
CATCHMENT #14	179	8.14
CATCHMENT #1	160	8.42
CATCHMENT #7	181	8.62
CATCHMENT #19	150	8.82
CATCHMENT #21	144	9.00
CATCHMENT #6	131	9.36
CATCHMENT #11	192	10.11
CATCHMENT #17	214	11.26
CATCHMENT #4	249	11.32
CATCHMENT #3	220	11.58
CATCHMENT #18	250	11.90
CATCHMENT #9	289	13.76
CATCHMENT #20	215	14.33
CATCHMENT #10	ND	ND
CATCHMENT #13	ND	ND

Ranking from "Worst" to "Best"
"Worst" equals most need

ND = No Data

SAMHSA, Office of Applied Studies
National Survey on Drug Use and Health, 2002-2008

REGIONAL RANKIING

REGION #3	7.22 1
REGION #2	8.23 2
REGION #4	9.30 3
REGION #1	9.86 4

Ranking from "Worst" to "Best"
"Worst" equals most need

ND = No Data

Table SP41.1 Past Month Use of Illicit Drugs among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	19,725	(19,399-20,056)	8.1	(8.0-8.3)
Southern Region	6,463	(6,286-6,645)	7.4	(7.2-7.6)
Alabama	255	(225-290)	6.8	(6.0-7.7)
Catchment Areas				
Riverbend	5	(2-12)	5.1	(2.1-12.1)
North Central	15	(9-24)	6.5	(3.8-10.8)
Huntsville/Madison County	9	(5-17)	4.8	(2.6-8.7)
Northwest	14	(7-27)	7.0	(3.5-13.7)
Jefferson/Blount/St. Clair	64	(49-84)	9.6	(7.3-12.5)
CED	7	(3-20)	6.1	(2.1-16.6)
Calhoun Cleburne	12	(7-21)	7.8	(4.6-12.9)
Indian Rivers	11	(7-17)	6.7	(4.3-10.2)
Cheaha	3	(1-8)	2.4	(0.9-6.3)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	7	(3-13)	4.6	(2.2-9.3)
East Alabama	16	(11-21)	7.1	(5.2-9.7)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	13	(8-21)	5.7	(3.5-9.4)
East Central	*	(*-*)	*	(*-*)
Mobile	33	(21-50)	9.1	(5.9-13.9)
Southwest	3	(1-6)	3.7	(1.8-7.5)
South Central	4	(2-8)	2.8	(1.5-5.2)
Wiregrass	14	(6-30)	6.0	(2.7-12.9)
Marshall Jackson	1	(0-5)	1.3	(0.2-6.6)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.2 Past Year Use of Marijuana among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	25,435	(25,076-25,798)	10.5	(10.3-10.6)
Southern Region	8,137	(7,938-8,341)	9.3	(9.1-9.5)
Alabama	302	(268-341)	8.0	(7.1-9.1)
Catchment Areas				
Riverbend	5	(2-13)	5.2	(2.0-12.7)
North Central	19	(11-32)	8.4	(4.8-14.1)
Huntsville/Madison County	16	(10-27)	8.4	(5.0-13.7)
Northwest	10	(5-20)	5.1	(2.5-10.1)
Jefferson/Blount/St. Clair	68	(52-87)	10.1	(7.8-13.0)
CED	11	(5-22)	8.9	(4.1-18.1)
Calhoun Cleburne	16	(7-33)	10.1	(4.6-20.9)
Indian Rivers	13	(9-19)	8.1	(5.7-11.4)
Cheaha	3	(1-12)	2.6	(0.7-9.5)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	8	(4-16)	5.4	(2.5-11.4)
East Alabama	15	(9-24)	7.0	(4.3-11.2)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	18	(10-33)	8.3	(4.5-14.8)
East Central	*	(*-*)	*	(*-*)
Mobile	40	(28-56)	11.1	(7.8-15.7)
Southwest	4	(2-7)	5.4	(3.0-9.6)
South Central	5	(2-9)	3.2	(1.6-6.3)
Wiregrass	16	(8-31)	7.0	(3.5-13.4)
Marshall Jackson	2	(1-3)	2.6	(1.8-3.7)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	3	(1-7)	5.4	(2.2-12.5)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.3 Past Month Use of Marijuana among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	14,698	(14,428-14,973)	6.1	(5.9-6.2)
Southern Region	4,609	(4,463-4,758)	5.3	(5.1-5.4)
Alabama	164	(141-190)	4.3	(3.8-5.0)
Catchment Areas				
Riverbend	3	(1-11)	2.6	(0.6-11.0)
North Central	9	(5-15)	3.9	(2.3-6.6)
Huntsville/Madison County	6	(4-8)	2.8	(1.9-4.2)
Northwest	7	(3-17)	3.5	(1.4-8.4)
Jefferson/Blount/St. Clair	41	(31-54)	6.1	(4.6-8.1)
CED	7	(2-21)	5.3	(1.5-16.8)
Calhoun Cleburne	9	(5-16)	5.6	(3.1-10.1)
Indian Rivers	6	(4-7)	3.4	(2.6-4.3)
Cheaha	1	(0-3)	0.7	(0.2-2.3)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	3	(1-10)	1.8	(0.5-7.0)
East Alabama	10	(6-15)	4.4	(2.9-6.8)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	8	(5-13)	3.6	(2.1-6.0)
East Central	5	(2-10)	10.4	(4.3-23.0)
Mobile	23	(16-32)	6.3	(4.3-9.0)
Southwest	2	(1-5)	2.9	(1.2-6.9)
South Central	2	(1-3)	1.1	(0.6-2.0)
Wiregrass	11	(4-27)	4.6	(1.7-11.7)
Marshall Jackson	1	(0-6)	0.7	(0.1-7.8)
Baldwin County	10	(4-27)	7.8	(2.7-20.9)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.4 Perceived Great Risk of Smoking Marijuana Once a Month among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	92,401	(91,702-93,103)	38.7	(38.4-39.0)
Southern Region	36,864	(36,426-37,303)	42.9	(42.4-43.4)
Alabama	1,807	(1,716-1,899)	48.7	(46.2-51.1)
Catchment Areas				
Riverbend	48	(34-63)	50.4	(35.4-65.3)
North Central	108	(86-130)	47.9	(38.1-57.9)
Huntsville/Madison County	*	(*-*)	*	(*-*)
Northwest	*	(*-*)	*	(*-*)
Jefferson/Blount/St. Clair	306	(271-341)	46.2	(40.9-51.5)
CED	55	(39-71)	44.6	(32.2-57.6)
Calhoun Cleburne	79	(62-95)	50.4	(39.9-60.9)
Indian Rivers	84	(64-105)	51.3	(38.9-63.5)
Cheaha	66	(59-72)	55.3	(49.7-60.7)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	*	(*-*)	*	(*-*)
East Alabama	111	(86-135)	51.6	(40.2-62.9)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	98	(78-119)	45.0	(35.9-54.5)
East Central	*	(*-*)	*	(*-*)
Mobile	173	(145-201)	48.6	(40.8-56.4)
Southwest	*	(*-*)	*	(*-*)
South Central	*	(*-*)	*	(*-*)
Wiregrass	120	(106-134)	51.9	(45.9-57.9)
Marshall Jackson	37	(28-45)	52.9	(40.5-64.9)
Baldwin County	60	(48-73)	46.6	(37.0-56.6)
Cullman County	23	(17-31)	45.6	(32.5-59.4)

*Low precision; no estimate reported.

NOTE: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.5 Average Annual Rate of First Use of Marijuana among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	2,502	(2,020-2,107)	1.7	(1.7-1.7)
Southern Region	867	(660-712)	1.6	(1.5-1.6)
Alabama	34	(22-28)	1.3	(1.2-1.5)
Catchment Areas				
Riverbend	1	(0-2)	1.2	(0.3-4.4)
North Central	2	(1-3)	1.3	(0.8-2.3)
Huntsville/Madison County	2	(1-3)	1.8	(1.0-3.1)
Northwest	1	(0-2)	0.9	(0.3-2.3)
Jefferson/Blount/St. Clair	5	(3-6)	1.2	(0.8-1.8)
CED	1	(0-1)	0.7	(0.2-2.2)
Calhoun Cleburne	2	(1-2)	1.4	(0.7-2.6)
Indian Rivers	3	(1-3)	2.6	(1.6-4.1)
Cheaha	1	(0-2)	0.9	(0.3-2.5)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	1	(0-2)	1.1	(0.5-2.6)
East Alabama	2	(0-4)	1.2	(0.4-3.3)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	2	(1-3)	1.6	(0.9-2.6)
East Central	1	(0-2)	4.0	(1.8-8.8)
Mobile	3	(2-4)	1.5	(1.0-2.1)
Southwest	1	(0-2)	2.1	(1.1-4.0)
South Central	1	(0-2)	1.0	(0.4-2.2)
Wiregrass	2	(1-4)	1.3	(0.5-3.2)
Marshall Jackson	1	(0-1)	1.2	(0.6-2.2)
Baldwin County	1	(0-2)	1.0	(0.4-2.6)
Cullman County	0	(0-1)	0.7	(0.2-2.1)

*Low precision; no estimate reported.

NOTE: *Average annual rate* = $100*\{[X_1 \div (0.5 * X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in past 24 months and X_2 is the number of persons who never used marijuana. Both of the computation components, X_1 and X_2, are based on a survey-weighted hierarchical Bayes estimation approach. Note that the age group is based on a respondent's age at the time of the interview, not his or her age at first use.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.6 Past Month Use of Illicit Drugs Other Than Marijuana among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	8,898	(8,688-9,113)	3.7	(3.6-3.8)
Southern Region	3,248	(3,121-3,379)	3.7	(3.6-3.9)
Alabama	145	(124-169)	3.8	(3.3-4.5)
Catchment Areas				
Riverbend	3	(2-6)	3.5	(2.1-5.7)
North Central	8	(4-16)	3.7	(1.9-7.1)
Huntsville/Madison County	4	(2-11)	2.2	(0.9-5.4)
Northwest	8	(3-19)	3.9	(1.5-9.6)
Jefferson/Blount/St. Clair	39	(27-55)	5.8	(4.0-8.2)
CED	3	(1-6)	2.1	(0.9-4.7)
Calhoun Cleburne	7	(3-17)	4.4	(1.7-10.9)
Indian Rivers	8	(5-14)	4.9	(2.7-8.5)
Cheaha	3	(1-7)	2.1	(0.8-5.3)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	5	(3-11)	3.8	(1.8-7.8)
East Alabama	9	(7-13)	4.4	(3.1-6.1)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	7	(3-15)	3.3	(1.6-6.8)
East Central	4	(1-9)	8.1	(3.2-19.3)
Mobile	18	(10-33)	5.1	(2.8-9.3)
Southwest	2	(1-4)	2.2	(1.1-4.6)
South Central	4	(2-7)	2.5	(1.2-5.1)
Wiregrass	5	(2-13)	2.0	(0.8-5.4)
Marshall Jackson	1	(0-5)	1.3	(0.2-6.6)
Baldwin County	4	(1-14)	2.9	(0.7-10.6)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates are based on data from the original questions not including methamphetamine items added in 2005 and 2006.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.7 Past Year Use of Cocaine among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	5,722	(5,560-5,888)	2.4	(2.3-2.4)
Southern Region	2,013	(1,918-2,113)	2.3	(2.2-2.4)
Alabama	71	(59-87)	1.9	(1.6-2.3)
Catchment Areas				
Riverbend	1	(0-2)	0.7	(0.3-1.7)
North Central	7	(2-20)	3.0	(1.0-8.8)
Huntsville/Madison County	5	(2-16)	2.6	(0.8-8.2)
Northwest	2	(1-5)	1.0	(0.4-2.6)
Jefferson/Blount/St. Clair	21	(15-31)	3.2	(2.2-4.6)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	2	(0-12)	1.4	(0.2-7.7)
Indian Rivers	4	(2-10)	2.6	(1.1-6.1)
Cheaha	0	(0-1)	0.3	(0.1-1.1)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	2	(1-6)	1.5	(0.5-4.2)
East Alabama	4	(2-6)	1.8	(1.1-2.9)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	4	(2-10)	1.8	(0.7-4.6)
East Central	*	(*-*)	*	(*-*)
Mobile	9	(6-13)	2.5	(1.7-3.6)
Southwest	1	(0-2)	0.9	(0.3-3.2)
South Central	2	(1-4)	1.1	(0.5-2.7)
Wiregrass	1	(0-4)	0.6	(0.2-1.7)
Marshall Jackson	0	(0-4)	0.3	(0.0-5.2)
Baldwin County	3	(1-9)	2.0	(0.5-7.0)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.8 Past Year Nonmedical Use of Pain Relievers among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	11,819	(11,585-12,057)	4.9	(4.8-5.0)
Southern Region	4,286	(4,147-4,430)	4.9	(4.7-5.1)
Alabama	190	(165-219)	5.0	(4.4-5.8)
Catchment Areas				
Riverbend	4	(2-7)	3.8	(2.2-6.5)
North Central	12	(7-19)	5.1	(3.1-8.3)
Huntsville/Madison County	3	(1-7)	1.3	(0.5-3.3)
Northwest	7	(3-17)	3.5	(1.4-8.6)
Jefferson/Blount/St. Clair	49	(34-70)	7.3	(5.0-10.4)
CED	3	(1-6)	2.2	(1.0-5.0)
Calhoun Cleburne	8	(4-16)	4.9	(2.4-9.9)
Indian Rivers	12	(6-23)	7.4	(3.8-13.8)
Cheaha	3	(1-8)	2.6	(1.0-6.6)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	6	(4-9)	4.0	(2.6-6.1)
East Alabama	14	(9-21)	6.4	(4.2-9.7)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	9	(4-17)	3.9	(1.9-7.9)
East Central	3	(1-8)	7.0	(2.4-18.9)
Mobile	27	(18-40)	7.5	(5.1-11.0)
Southwest	3	(2-7)	4.5	(2.1-9.3)
South Central	7	(3-13)	4.6	(2.2-9.0)
Wiregrass	8	(3-18)	3.3	(1.3-7.9)
Marshall Jackson	3	(2-5)	4.8	(3.4-6.7)
Baldwin County	6	(2-17)	4.7	(1.7-12.6)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.9 Past Month Use of Alcohol among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	123,827	(123,067-124,587)	51.0	(50.7-51.3)
Southern Region	40,629	(40,149-41,111)	46.5	(45.9-47.0)
Alabama	1,469	(1,377-1,563)	39.0	(36.6-41.5)
Catchment Areas				
Riverbend	35	(25-47)	35.5	(25.0-47.6)
North Central	101	(81-122)	44.5	(35.8-53.6)
Huntsville/Madison County	76	(56-99)	38.9	(28.4-50.4)
Northwest	45	(27-70)	22.7	(13.6-35.2)
Jefferson/Blount/St. Clair	296	(250-343)	43.9	(37.1-51.0)
CED	32	(22-46)	26.1	(17.5-37.1)
Calhoun Cleburne	56	(47-67)	35.5	(29.4-42.2)
Indian Rivers	67	(48-88)	40.2	(28.6-53.0)
Cheaha	42	(32-52)	33.7	(26.2-42.1)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	51	(37-66)	35.3	(26.0-46.0)
East Alabama	*	(*-*)	*	(*-*)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	*	(*-*)	*	(*-*)
East Central	*	(*-*)	*	(*-*)
Mobile	163	(138-189)	45.4	(38.5-52.5)
Southwest	20	(13-30)	26.6	(17.1-39.0)
South Central	40	(28-54)	26.8	(18.9-36.6)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	22	(17-28)	31.4	(24.1-39.7)
Baldwin County	63	(44-82)	47.7	(33.6-62.2)
Cullman County	17	(13-21)	33.0	(25.9-40.9)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.10 Past Month Use of Alcohol among Persons Aged 12 to 20 in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	10,695	(10,569-10,823)	28.2	(27.9-28.5)
Southern Region	3,553	(3,479-3,628)	26.2	(25.6-26.7)
Alabama	147	(135-161)	24.8	(22.7-27.0)
Catchment Areas				
Riverbend	*	(*-*)	*	(*-*)
North Central	9	(8-11)	27.5	(22.9-32.6)
Huntsville/Madison County	6	(3-9)	20.2	(11.5-33.1)
Northwest	4	(3-6)	17.5	(11.4-25.9)
Jefferson/Blount/St. Clair	24	(20-29)	25.6	(21.1-30.6)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	*	(*-*)	*	(*-*)
Indian Rivers	10	(9-12)	38.3	(34.4-42.4)
Cheaha	*	(*-*)	*	(*-*)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	*	(*-*)	*	(*-*)
East Alabama	*	(*-*)	*	(*-*)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	8	(6-10)	21.4	(16.6-27.2)
East Central	*	(*-*)	*	(*-*)
Mobile	11	(9-14)	18.5	(15.0-22.7)
Southwest	*	(*-*)	*	(*-*)
South Central	7	(5-10)	37.4	(25.5-51.1)
Wiregrass	10	(7-13)	21.1	(14.8-29.2)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.11 Past Month Binge Alcohol Use among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	55,689	(55,143-56,239)	22.9	(22.7-23.2)
Southern Region	18,710	(18,382-19,041)	21.4	(21.0-21.8)
Alabama	668	(611-729)	17.7	(16.2-19.4)
Catchment Areas				
Riverbend	20	(17-23)	20.2	(17.3-23.4)
North Central	32	(25-42)	14.2	(10.8-18.4)
Huntsville/Madison County	26	(15-42)	13.0	(7.7-21.2)
Northwest	21	(13-32)	10.5	(6.6-16.2)
Jefferson/Blount/St. Clair	129	(105-157)	19.2	(15.6-23.3)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	29	(18-46)	18.6	(11.2-29.1)
Indian Rivers	40	(27-56)	23.8	(16.1-33.6)
Cheaha	24	(15-36)	19.3	(12.4-28.6)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	*	(*-*)	*	(*-*)
East Alabama	30	(20-43)	13.7	(9.4-19.6)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	48	(36-63)	21.7	(16.4-28.3)
East Central	*	(*-*)	*	(*-*)
Mobile	77	(64-92)	21.4	(17.9-25.5)
Southwest	13	(7-21)	16.7	(9.3-28.2)
South Central	22	(15-31)	14.9	(10.3-20.9)
Wiregrass	36	(24-53)	15.6	(10.3-22.9)
Marshall Jackson	6	(3-13)	8.3	(3.6-17.8)
Baldwin County	30	(18-48)	23.0	(13.4-36.7)
Cullman County	6	(2-12)	11.0	(4.6-23.8)

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.12 Past Month Binge Alcohol Use among Persons Aged 12 to 20 in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	7,144	(7,037-7,252)	18.8	(18.5-19.1)
Southern Region	2,310	(2,246-2,374)	17.0	(16.5-17.5)
Alabama	96	(86-107)	16.2	(14.5-18.0)
Catchment Areas				
Riverbend	*	(*-*)	*	(*-*)
North Central	6	(5-8)	18.1	(13.7-23.6)
Huntsville/Madison County	4	(2-7)	13.0	(6.6-24.0)
Northwest	4	(2-6)	14.6	(9.0-22.8)
Jefferson/Blount/St. Clair	14	(11-17)	14.7	(12.0-17.9)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	*	(*-*)	*	(*-*)
Indian Rivers	9	(8-10)	33.7	(29.3-38.3)
Cheaha	*	(*-*)	*	(*-*)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	*	(*-*)	*	(*-*)
East Alabama	*	(*-*)	*	(*-*)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	4	(2-6)	10.0	(5.6-17.5)
East Central	*	(*-*)	*	(*-*)
Mobile	7	(5-10)	11.3	(8.0-15.8)
Southwest	*	(*-*)	*	(*-*)
South Central	*	(*-*)	*	(*-*)
Wiregrass	6	(3-10)	12.6	(7.3-20.8)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.13 Perceived Great Risk of Having 5 or More Drinks of an Alcoholic Beverage Once or Twice a Week among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	100,551	(99,872-101,231)	41.7	(41.4-42.0)
Southern Region	38,755	(38,329-39,181)	44.6	(44.1-45.1)
Alabama	1,746	(1,669-1,823)	46.9	(44.8-48.9)
Catchment Areas				
Riverbend	42	(37-48)	44.2	(38.4-50.1)
North Central	100	(85-117)	45.4	(38.2-52.8)
Huntsville/Madison County	*	(*-*)	*	(*-*)
Northwest	90	(69-111)	44.8	(34.6-55.6)
Jefferson/Blount/St. Clair	312	(279-345)	46.7	(41.7-51.7)
CED	58	(49-67)	47.5	(40.5-54.6)
Calhoun Cleburne	83	(67-100)	53.5	(42.6-64.0)
Indian Rivers	*	(*-*)	*	(*-*)
Cheaha	61	(50-73)	51.1	(41.5-60.6)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	72	(57-87)	50.3	(40.1-60.5)
East Alabama	96	(70-123)	44.8	(32.8-57.5)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	103	(88-118)	47.2	(40.6-53.9)
East Central	*	(*-*)	*	(*-*)
Mobile	167	(137-198)	46.6	(38.2-55.2)
Southwest	*	(*-*)	*	(*-*)
South Central	66	(54-78)	45.6	(37.3-54.2)
Wiregrass	100	(79-123)	43.1	(33.9-52.9)
Marshall Jackson	35	(25-46)	49.7	(34.8-64.7)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.14 Past Month Use of Tobacco Products among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	71,245	(70,593-71,900)	29.3	(29.1-29.6)
Southern Region	27,396	(26,977-27,819)	31.3	(30.8-31.8)
Alabama	1,252	(1,164-1,342)	33.2	(30.9-35.6)
Catchment Areas				
Riverbend	*	(*-*)	*	(*-*)
North Central	73	(55-95)	32.3	(24.1-41.7)
Huntsville/Madison County	*	(*-*)	*	(*-*)
Northwest	82	(61-105)	41.1	(30.3-52.7)
Jefferson/Blount/St. Clair	207	(167-251)	30.7	(24.9-37.3)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	53	(33-78)	33.6	(21.1-48.9)
Indian Rivers	58	(44-73)	34.9	(26.7-44.1)
Cheaha	54	(39-71)	43.6	(31.2-57.0)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	37	(24-53)	25.3	(16.6-36.7)
East Alabama	*	(*-*)	*	(*-*)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	78	(62-97)	35.5	(27.8-43.9)
East Central	*	(*-*)	*	(*-*)
Mobile	109	(81-141)	30.2	(22.5-39.3)
Southwest	22	(16-29)	28.8	(20.8-38.4)
South Central	51	(38-65)	34.3	(25.9-43.7)
Wiregrass	91	(74-109)	39.1	(32.0-46.7)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	39	(26-54)	29.2	(19.8-40.9)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco. Tobacco Product use in the past year excludes past year pipe tobacco use, but includes past month pipe tobacco use.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.15 Past Month Use of Cigarettes among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	60,488	(59,871-61,108)	24.9	(24.6-25.2)
Southern Region	22,977	(22,585-23,374)	26.3	(25.8-26.7)
Alabama	1,021	(944-1,103)	27.1	(25.1-29.3)
Catchment Areas				
Riverbend	*	(*-*)	*	(*-*)
North Central	63	(42-88)	27.7	(18.6-38.9)
Huntsville/Madison County	41	(25-64)	21.0	(12.6-32.8)
Northwest	69	(47-96)	34.7	(23.4-48.0)
Jefferson/Blount/St. Clair	173	(139-213)	25.7	(20.6-31.7)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	44	(28-66)	28.0	(17.4-41.7)
Indian Rivers	43	(31-58)	26.0	(18.8-34.7)
Cheaha	45	(31-62)	36.3	(24.7-49.7)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	33	(20-50)	22.9	(14.1-34.8)
East Alabama	55	(35-80)	25.2	(16.2-36.9)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	60	(47-76)	27.3	(21.3-34.3)
East Central	*	(*-*)	*	(*-*)
Mobile	95	(72-122)	26.3	(20.0-33.8)
Southwest	18	(12-24)	23.0	(15.9-32.0)
South Central	38	(26-52)	25.5	(17.6-35.5)
Wiregrass	75	(65-86)	32.5	(28.2-37.1)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	34	(24-46)	25.6	(18.1-34.8)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.16 Perceived Great Risk of Smoking One or More Packs of Cigarettes Per Day among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	176,830	(176,239-177,418)	73.2	(73.0-73.5)
Southern Region	62,691	(62,318-63,060)	72.1	(71.7-72.5)
Alabama	2,592	(2,513-2,668)	69.3	(67.2-71.3)
Catchment Areas				
Riverbend	74	(61-83)	74.0	(61.0-83.9)
North Central	144	(114-170)	63.5	(50.3-75.0)
Huntsville/Madison County	*	(*-*)	*	(*-*)
Northwest	139	(113-160)	69.5	(56.6-79.9)
Jefferson/Blount/St. Clair	494	(469-516)	74.2	(70.4-77.6)
CED	74	(56-89)	60.2	(46.0-72.9)
Calhoun Cleburne	111	(100-120)	70.3	(63.4-76.3)
Indian Rivers	121	(106-133)	73.4	(64.1-81.0)
Cheaha	84	(72-94)	68.8	(59.0-77.1)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	96	(85-107)	67.1	(59.0-74.4)
East Alabama	150	(133-164)	68.7	(61.2-75.2)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	140	(123-155)	63.2	(55.8-70.0)
East Central	32	(28-35)	72.6	(64.2-79.6)
Mobile	270	(254-284)	75.2	(70.8-79.2)
Southwest	59	(50-65)	77.4	(66.1-85.7)
South Central	103	(86-117)	70.1	(58.4-79.6)
Wiregrass	156	(136-173)	67.1	(58.7-74.5)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	93	(84-100)	70.3	(63.9-76.0)
Cullman County	33	(26-40)	64.6	(49.5-77.3)

*Low precision; no estimate reported.

NOTE: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.17 Alcohol Dependence or Abuse in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	18,426	(18,133-18,724)	7.6	(7.5-7.7)
Southern Region	6,110	(5,933-6,291)	7.0	(6.8-7.2)
Alabama	215	(183-252)	5.7	(4.9-6.7)
Catchment Areas				
Riverbend	7	(3-16)	7.1	(2.9-16.5)
North Central	12	(6-25)	5.3	(2.5-10.9)
Huntsville/Madison County	8	(3-24)	4.2	(1.4-12.2)
Northwest	5	(1-18)	2.3	(0.6-9.1)
Jefferson/Blount/St. Clair	47	(31-69)	7.0	(4.7-10.2)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	6	(2-18)	4.0	(1.3-11.4)
Indian Rivers	15	(11-21)	9.0	(6.4-12.6)
Cheaha	3	(2-5)	2.3	(1.3-4.3)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	8	(3-18)	5.6	(2.4-12.5)
East Alabama	12	(7-20)	5.7	(3.4-9.3)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	12	(7-22)	5.6	(3.1-10.1)
East Central	4	(2-6)	8.7	(5.2-14.2)
Mobile	25	(15-39)	6.8	(4.2-10.9)
Southwest	5	(2-11)	6.8	(3.2-13.9)
South Central	7	(4-12)	4.6	(2.5-8.3)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	4	(2-7)	7.2	(4.0-12.6)

*Low precision; no estimate reported.

NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.18 Alcohol Dependence in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	8,247	(8,044-8,454)	3.4	(3.3-3.5)
Southern Region	2,766	(2,642-2,896)	3.2	(3.0-3.3)
Alabama	98	(76-126)	2.6	(2.0-3.3)
Catchment Areas				
Riverbend	2	(1-4)	1.9	(0.9-3.9)
North Central	7	(2-22)	3.2	(1.0-9.5)
Huntsville/Madison County	3	(1-8)	1.7	(0.7-4.2)
Northwest	1	(0-2)	0.4	(0.1-1.2)
Jefferson/Blount/St. Clair	30	(16-52)	4.4	(2.4-7.8)
CED	3	(1-13)	2.7	(0.6-10.7)
Calhoun Cleburne	1	(0-6)	0.7	(0.1-4.1)
Indian Rivers	6	(4-10)	3.9	(2.5-5.9)
Cheaha	1	(0-5)	1.2	(0.3-3.9)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	5	(2-16)	3.7	(1.2-11.0)
East Alabama	5	(2-12)	2.1	(0.8-5.3)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	8	(3-19)	3.7	(1.5-8.6)
East Central	1	(0-3)	1.8	(0.4-7.3)
Mobile	7	(3-16)	2.0	(0.9-4.5)
Southwest	2	(1-4)	2.7	(1.5-4.8)
South Central	1	(0-3)	0.7	(0.2-2.2)
Wiregrass	9	(3-31)	4.0	(1.1-13.2)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	2	(1-6)	1.5	(0.5-4.7)
Cullman County	2	(1-8)	4.4	(1.2-14.8)

*Low precision; no estimate reported.

NOTE: Dependence is based on the definition found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.19 Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	6,992	(6,832-7,155)	2.9	(2.8-2.9)
Southern Region	2,501	(2,405-2,601)	2.9	(2.7-3.0)
Alabama	107	(86-133)	2.8	(2.3-3.5)
Catchment Areas				
Riverbend	3	(2-6)	3.1	(1.7-5.7)
North Central	7	(3-13)	3.0	(1.5-5.9)
Huntsville/Madison County	2	(1-3)	1.0	(0.6-1.8)
Northwest	4	(1-10)	1.8	(0.6-4.8)
Jefferson/Blount/St. Clair	27	(17-44)	4.1	(2.5-6.5)
CED	3	(1-10)	2.8	(1.0-7.7)
Calhoun Cleburne	4	(1-13)	2.7	(0.9-8.0)
Indian Rivers	7	(4-12)	4.2	(2.4-7.1)
Cheaha	1	(0-3)	0.9	(0.3-2.5)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	5	(2-11)	3.2	(1.3-7.7)
East Alabama	7	(4-13)	3.4	(1.8-6.0)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	3	(1-11)	1.5	(0.5-4.8)
East Central	*	(*-*)	*	(*-*)
Mobile	12	(4-31)	3.2	(1.2-8.5)
Southwest	1	(1-2)	1.4	(0.7-2.8)
South Central	4	(2-8)	2.6	(1.3-5.3)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	1	(0-3)	1.6	(0.6-4.3)
Baldwin County	4	(2-10)	3.1	(1.1-7.9)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006.

NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.20 Illicit Drug Dependence in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	4,710	(4,582-4,841)	1.9	(1.9-2.0)
Southern Region	1,670	(1,592-1,753)	1.9	(1.8-2.0)
Alabama	65	(49-85)	1.7	(1.3-2.3)
Catchment Areas				
Riverbend	3	(2-6)	3.1	(1.7-5.7)
North Central	4	(1-11)	1.8	(0.6-5.0)
Huntsville/Madison County	1	(1-2)	0.7	(0.4-1.2)
Northwest	1	(0-3)	0.6	(0.2-1.7)
Jefferson/Blount/St. Clair	19	(11-33)	2.9	(1.7-5.0)
CED	2	(1-6)	1.4	(0.4-4.8)
Calhoun Cleburne	4	(1-13)	2.4	(0.7-8.1)
Indian Rivers	5	(2-9)	2.7	(1.4-5.2)
Cheaha	0	(0-1)	0.2	(0.1-1.0)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	2	(0-7)	1.3	(0.3-4.9)
East Alabama	3	(2-7)	1.6	(0.8-3.2)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	3	(1-11)	1.3	(0.3-4.9)
East Central	*	(*-*)	*	(*-*)
Mobile	8	(2-32)	2.2	(0.5-9.0)
Southwest	1	(1-2)	1.4	(0.7-2.8)
South Central	1	(1-3)	0.9	(0.5-1.8)
Wiregrass	2	(1-3)	0.6	(0.3-1.5)
Marshall Jackson	1	(0-2)	1.4	(0.6-3.0)
Baldwin County	2	(1-5)	1.3	(0.4-3.9)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006.

NOTE: Dependence is based on the definition found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.21 Illicit Drug or Alcohol Dependence or Abuse of in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	22,210	(21,889-22,536)	9.1	(9.0-9.3)
Southern Region	7,488	(7,294-7,687)	8.6	(8.3-8.8)
Alabama	265	(231-303)	7.0	(6.1-8.0)
Catchment Areas				
Riverbend	9	(5-16)	8.8	(4.7-16.1)
North Central	15	(8-27)	6.4	(3.4-11.8)
Huntsville/Madison County	10	(4-22)	4.9	(2.0-11.4)
Northwest	8	(3-21)	3.8	(1.3-10.3)
Jefferson/Blount/St. Clair	59	(41-83)	8.7	(6.0-12.4)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	9	(3-22)	5.6	(2.1-14.0)
Indian Rivers	20	(16-25)	12.0	(9.5-14.9)
Cheaha	3	(2-6)	2.5	(1.4-4.4)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	10	(5-22)	7.0	(3.1-15.0)
East Alabama	16	(11-23)	7.2	(4.9-10.4)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	14	(9-23)	6.5	(4.1-10.3)
East Central	*	(*-*)	*	(*-*)
Mobile	29	(21-40)	8.2	(6.0-11.2)
Southwest	5	(2-11)	6.8	(3.2-13.9)
South Central	8	(5-14)	5.6	(3.2-9.5)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	2	(1-8)	3.4	(0.9-11.5)
Baldwin County	*	(*-*)	*	(*-*)
Cullman County	4	(2-6)	7.5	(4.5-12.3)

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine items added in 2005 and 2006.

NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.22 Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	6,311	(6,163-6,462)	2.6	(2.5-2.7)
Southern Region	2,253	(2,164-2,346)	2.6	(2.5-2.7)
Alabama	85	(68-107)	2.3	(1.8-2.9)
Catchment Areas				
Riverbend	3	(2-4)	2.7	(1.6-4.4)
North Central	6	(3-12)	2.8	(1.5-5.1)
Huntsville/Madison County	2	(1-4)	1.0	(0.5-2.0)
Northwest	3	(1-9)	1.7	(0.6-4.7)
Jefferson/Blount/St. Clair	18	(10-31)	2.7	(1.6-4.6)
CED	3	(1-10)	2.6	(0.8-7.8)
Calhoun Cleburne	4	(1-12)	2.5	(0.8-7.6)
Indian Rivers	5	(2-10)	2.9	(1.5-5.7)
Cheaha	1	(0-3)	0.9	(0.3-2.5)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	3	(1-6)	2.0	(1.0-3.9)
East Alabama	7	(3-13)	3.0	(1.6-5.8)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	2	(1-9)	1.1	(0.3-4.1)
East Central	2	(0-6)	3.4	(0.8-14.1)
Mobile	10	(4-26)	2.7	(1.0-7.2)
Southwest	1	(1-2)	1.4	(0.7-2.8)
South Central	2	(1-5)	1.4	(0.6-3.2)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	1	(0-3)	1.6	(0.6-4.3)
Baldwin County	3	(1-9)	2.6	(1.0-6.5)
Cullman County	*	(*-*)	*	(*-*)

*Low precision; no estimate reported.

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but have not received treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine use items added in 2005 and 2006.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.23 Needing But Not Receiving Treatment for Alcohol Use in the Past Year among Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: Numbers in Thousands, Percentages, and 95% Confidence Intervals, Annual Averages Based on 2002-2008

	Numbers in Thousands	95% Confidence Intervals	Percentages	95% Confidence Intervals
United States	17,524	(17,243-17,810)	7.2	(7.1-7.3)
Southern Region	5,842	(5,670-6,020)	6.7	(6.5-6.9)
Alabama	201	(171-237)	5.4	(4.5-6.3)
Catchment Areas				
Riverbend	7	(3-16)	7.0	(2.9-16.1)
North Central	11	(6-23)	5.0	(2.4-10.1)
Huntsville/Madison County	8	(3-23)	4.1	(1.3-11.6)
Northwest	4	(1-18)	2.1	(0.5-9.2)
Jefferson/Blount/St. Clair	44	(29-66)	6.6	(4.3-9.8)
CED	*	(*-*)	*	(*-*)
Calhoun Cleburne	6	(2-17)	3.7	(1.3-10.6)
Indian Rivers	14	(10-19)	8.2	(5.8-11.5)
Cheaha	3	(2-5)	2.3	(1.3-4.3)
West Alabama	*	(*-*)	*	(*-*)
Chilton-Shelby	8	(3-18)	5.4	(2.3-12.3)
East Alabama	11	(6-18)	4.9	(2.8-8.4)
Cahaba	*	(*-*)	*	(*-*)
Montgomery	12	(7-20)	5.2	(3.1-8.8)
East Central	3	(2-5)	7.6	(5.1-11.2)
Mobile	24	(14-40)	6.6	(3.9-11.1)
Southwest	5	(2-11)	6.8	(3.2-13.9)
South Central	6	(3-12)	4.3	(2.2-8.0)
Wiregrass	*	(*-*)	*	(*-*)
Marshall Jackson	*	(*-*)	*	(*-*)
Baldwin County	4	(1-9)	2.8	(1.1-6.9)
Cullman County	4	(2-7)	7.2	(4.0-12.6)

*Low precision; no estimate reported.

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but have not received treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center).

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.24 Survey Sample Size and Numbers (in Thousands) of Persons Aged 12 or Older in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: 2002-2008

	Survey Sample Size	Numbers in Thousands
United States	476,386	242,892
Southern Region	145,538	87,454
Alabama	6,373	3,765
Catchment Areas		
Riverbend	175	99
North Central	378	227
Huntsville/Madison County	301	197
Northwest	286	200
Jefferson/Blount/St. Clair	1,085	673
CED	211	123
Calhoun Cleburne	265	159
Indian Rivers	334	167
Cheaha	191	124
West Alabama	72	51
Chilton-Shelby	204	144
East Alabama	418	218
Cahaba	94	48
Montgomery	405	221
East Central	113	44
Mobile	609	360
Southwest	145	76
South Central	238	148
Wiregrass	415	232
Marshall Jackson	136	71
Baldwin County	187	132
Cullman County	111	52

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Table SP41.25 Survey Sample Size and Numbers (in Thousands) of Persons Aged 12 to 20 in the United States, Southern Region of the United States, Alabama, and the Alabama Catchment Areas: 2002-2008

	Survey Sample Size	Numbers in Thousands
United States	220,955	37,935
Southern Region	67,310	13,578
Alabama	3,001	596
Catchment Areas		
Riverbend	77	13
North Central	178	34
Huntsville/Madison County	146	28
Northwest	125	25
Jefferson/Blount/St. Clair	463	95
CED	80	14
Calhoun Cleburne	114	23
Indian Rivers	138	27
Cheaha	80	14
West Alabama	27	5
Chilton-Shelby	98	21
East Alabama	221	52
Cahaba	57	13
Montgomery	200	35
East Central	58	12
Mobile	304	61
Southwest	83	16
South Central	108	20
Wiregrass	227	46
Marshall Jackson	69	11
Baldwin County	85	20
Cullman County	63	10

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002-2008.

Goal # 5 Program Compliance Monitoring Attachment # 1

Alabama Department of Mental Health

SUBSTANCE ABUSE SERVICES DIVISION

Contract and SAPT Block Grant

Program Compliance Monitoring Survey

INSERT PROVIDER NAME

Reviewer Name **Date of Review**

	Certain Allocations: 45 CFR 96.124 Required Services for Programs Receiving SAPTBG funds set aside for pregnant women and women with dependent children.	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program provides services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children.							1. Admissions Policies/ Procedures 2. Population sheets 3. Admission criteria 4. ASAIS
2.	The program treats the family as a unit and therefore admits both women and their children into treatment services, if appropriate.							
3.	The program provides or arranges for:							1. Individual/group/ case management notes 2. MOUs 3. Contracts 4. Program Description 5. Curriculum 6. Group Syllabus 7. Service Logs 8. Organizational Chart 9. HSNA 10. ASAIS billing activity
	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.							
4.	The program provides written documentation of its compliance with this section.							1. Policies/ Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

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	Capacity of treatment for intravenous substance abusers: 45 CFR 96.126	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program provides treatment and related therapeutic services to individuals who are IV substance abusers.							1.Admissions Policies/ Procedures 2.Program Description 3. Waiting List : Is WL coded & prioritized? 4. ASAIS tracking: Are clients referred from non-contracted programs being tracked)
2.	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.							1. Review log of phone calls, emails, or completed SASD Capacity Management Notice
3.	Each individual who requests and is in need of treatment for IV drug use is admitted not later than:							1.Admissions Policies/ Procedures 2. ASAIS billing activity / admissions data 3. Client charts
	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.							
4.	The program provides interim services that include:							1. Policies/ Procedures 2. Program Descriptions 3. Client charts 4. ASAIS billing activity 5. Individual / Group / Case Mgmt Notes 6. MOUs 7. Contracts
	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:							
	i. Counseling on the effects of alcohol and drug use on the fetus; and							
	ii. Referral for pre-natal care.							

Cont. Capacity of treatment for intravenous substance abusers:	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:

45 CFR 96.126									
5.	The program has established a formal waiting list process that includes:								1. Policy & Procedures: Admissions, Waiting List 2. ASAIS 3. Individual / Group / Case Mgmt Notes 4. Service Log
	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.							
6.	The program carries out formal activities to encourage individuals in need of IV drug use treatment to undergo such treatment, that consist of:								1. Participation in Street outreach programs, public service announcements, advertisements in local/regional print media, Posters placed in targeted areas, speaking engagements, distribution of fliers/brochures / pamphlets
	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.							
7.	The program provides written documentation of its compliance with this section.								1. Policies/ Procedures

Cont. Capacity of treatment for intravenous substance abusers: 45 CFR 96.126	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:

Findings/Corrective Action:
Corrective Action Required: ☐ Yes ☐ No Technical Assistance Recommended: ☐ Yes ☐ No

Requirements regarding tuberculosis: 45 CFR 96.127	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:

1.	**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.**								1. Policy & Procedures on TB 2. Program Description 3. Assessment
2.	**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:**								1. MOUs 2. Contracts 3. Individual / Group / Case Mgmt Notes 4. Clinical notes for referral 5. Program Description
	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.**							
3.	**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:**								1. Policies & Procedures on Health & Safety 2. Assessment 3. Individual / Group / Case Mgmt Notes
	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.**							
4.	**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.**								1. Policies & Procedures 2. Clinical notes for referral
5.	**The program provides written documentation of compliance with this section.**								1. Policy & Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

Requirements regarding human immunodeficiency virus: 45 CFR 96.128		**Yes**	**No**	**N/A**	**SAPTBG**	**Contract**	**Comments**	**As evidenced by:**
1.	**The program makes available early intervention services for HIV disease to individuals undergoing treatment for substance abuse at**							*Does this apply to all providers

	the sites where individuals are undergoing such treatment, including								1. Polices & Procedures: HIV services 2. Program Description 3. MOUs 4. Contracts 5. On-site testing scheduling 6. Curriculum 7. Group Syllabus 8. Individual / Group / Case Management Notes 9. Clinical notes for referral
	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.							
2.	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.								1. MOUs 2. Contracts 3. Referral Directories
3.	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.								1. Polices & Procedures: HIV services 2. Program Description 3. Site Visit reports
4.	The program implements written policies and procedures to ensure that :								1. Polices & Procedures: HIV services 2. Program Description
	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.							
5.	The program provides written documentation of compliance with this section.								1. Polices & Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

	Treatment services for pregnant women: 45 CFR 96.131		**Yes**	**No**	**N/A**	**SAPTBG**	**Contract**	**Comments**	**As evidenced by:**
1.	The program gives preference in admission to individuals with substance use disorders in the following priority:								1.Admissions Policies/ Procedures 2.Program Description 3. Waiting List :
	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.							Is WL coded & prioritized? 4. ASAIS tracking: Are clients referred from non-contracted programs being tracked)
	d.	Women with substance use disorders and dependent children.							
	e.	All other individuals with substance use disorders.							
2.	The program publicizes the availability of treatment services for women and the fact that pregnant women receive preference for admission.								1. Brochures 2. Pamphletts 3. Community Directories 4. Website 5. Speaking Engagements 6. Health Fairs
3.	The program utilizes the following mechanisms to publicize admission preference for pregnant women:								1. Documentation of participation in Street outreach programs, public service announcements, advertisements in local/regional print media, Posters placed in targeted areas, speaking engagements, distribution of fliers/brochures / pamphlets
	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.							
4.	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.								1. Review documentation such as cast notes, phone log, copied emails, or referrals
5.	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.								1. Individual / Group / Case Mgmt Notes 2. Service Log 3. Case review 4. ASAIS billing
6.	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.								1. ASAIS data review
7.	The program provides written documentation of compliance with this section.								1. Policies & Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

	Additional agreements: 45 CFR 96.132		Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program has developed and implements a formal admissions waiting list system.								1. Policy & Procedures 2. ASAIS data 3. Waiting List 4. Contact Log for waiting list
	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.								5. Case review 6. Service Log 7. Individual / Group / Case Management Notes
		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.								
2.	The program provides continuing education for employees as according to rules established by SASD.										1. Sign In sheets for agency In-Service 2. CEU & diploma's within employee records 3. Policy & Procedures for Staff
3.	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.										1. Program Description 2. MOUs 3. Contracts 4. Case review
4.	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.										1. Policies & Procedures 2. Visual examination of files room/staff offices 3. In-Service Logs 4. Personnel Files
	a.		The program provides employee education on confidentiality requirements.								
	b.		The program provides for employee disciplinary action upon inappropriate disclosure of client information.								
5.	The program provides written documentation of compliance with this section.										1. Policies & Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ Yes ☐ No **Technical Assistance Recommended:** ☐ Yes ☐ No

			Restrictions on expenditures of grant: 45 CFR 96.135	**Yes**	**No**	**N/A**	**SAPTBG**	**Contract**	**Comments**	**As evidenced by:**
1.	The program does not expend SAPT Block Grant funds on the following activities:									1. Internal & External Audit Reports 2. Account coding 3. Yearly check run's 4. Invoices 5. Accounting & Procurement Procedures
	a.		To make cash payments to intended recipients of health services.							
	b.		To purchase or improve land, 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.								6. Internal Compliance Plan 7. Renumeration Policies 8. Capital Acquisitions
	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.							
2.	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.									
3.	The program provides written documentation of compliance with this section.									
Findings/Corrective Action:										
Corrective Action Required: ☐ Yes ☐ No **Technical Assistance Recommended:** ☐ Yes ☐ No										

	Payment schedule: 45 CFR 96.137	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program has established the SAPT Block Grant as payment of last resort for the provision of treatment services.							1. Policy & Procedures 2. Financial Determination Forms 3. Sliding Scale & Fee Structure 4. Assessment
2.	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.									
3.	The program has established:									1. Policy & Procedures 2. Financial Determination Forms 3. Sliding Scale & Fee Structure
	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.								
4.	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.									1. Policies & Procedures 2. Anonymous Calls inquiring about services 3. Case review
5.	The program does not bill multiple payment sources for the same client service procedure.									1. Billing Records
6.	The program provides written documentation of compliance with this section.									1. Policy & Procedures
Findings/Corrective Action:										
Corrective Action Required: ☐ Yes ☐ No **Technical Assistance Recommended:** ☐ Yes ☐ No										

	Indigent Offenders: DMH Contract		Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program provides treatment and related therapeutic services to individuals who are categorized indigent by the courts.								*Applicable only to Dauphin Way Lodge, Mt. Lakes MHC, Oakmont, & Wiregrass MHC.* 1. Program Description 2. Policies & Procedures 3. Client Record 4. MOUs
	a.	A court order declaring indigent status is on file.							
	b.	Ability / inability to pay is substantiated throughout the provision of services.							
	c.	Waiver of fees is revoked when client income exceeds indigent status level							

									5. Court Order

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

	Other Requirements	Yes	No	N/A	SAPTBG	Contract	Comments	As evidenced by:
1.	The program provides unimpeded access to clients by Department of Mental Health advocates.							1. Client interviews 2. Public display of advocacy number
2.	The program verifies U. S. citizenship for all clients for whom services are billed to the Alabama Department of Mental Health.							1. Case review 2. Billing Records
3.	HIV risk education is provided to each client.							1. Program Description 2. Case review 3. Curriculum 4. Group Syllabus
4.	The program admits clients with co-occurring disorders who are appropriately stabilized on medication. (PROGRAM SPECIFIC)							1. Policies & Procedures 2. Program Description 3. Admissions criteria 4. Case review
5.	The program provides vocational assistance and housing support. (CORRECTIONAL PROGRAMS)							1. Program Description 2. Case Mgmt Notes
6.	The program provides written documentation of compliance with this section.							1. Policy & Procedures

Findings/Corrective Action:

Corrective Action Required: ☐ **Yes** ☐ **No** **Technical Assistance Recommended:** ☐ **Yes** ☐ **No**

On-Site Reviewer Signature _____ **Date** _____

Supervising Reviewer Signature _____ **Date** _____

Reviewer Signature _____ **Date** _____

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580-9-40 ORGANIZATIONAL GOVERNANCE AND MANAGEMENT

580-9-40.01 GOVERNING AUTHORITY

(1) **OPERATIONAL AUTHORITY.** The service provider shall be a legally constituted entity and shall maintain current written evidence of its source of authority to operate and to provide the services for which certification is requested. This evidence shall consist of:

(a) Articles of Incorporation;

(b) A corporate charter;

(c) A partnership agreement;

(d) Executive Order of the Governor;

(e) Act of the Legislature;

(f) A statement of sole proprietorship; or

(g) Other documentation that establishes the provider as a legal Alabama entity.

(2) **GOVERNING AUTHORITY DESIGNATION.** There shall be written documentation of the entity's designation of a Governing Authority that shall have ultimate managerial control and legal responsibility for all program operations, which includes at a minimum, the following specifications:

(a) The Governing authority shall be distinct in composition and function from its operating and administrative staff.

(b) When an entity is organized as a for-profit or not-for-profit corporation, partnership, or association, the governing authority shall be a formal board of directors.

(c) When an entity's organizational structure designates an individual as the governing authority, there shall be written documentation of the existence and operation of an organized advisory board which, at a minimum, shall:

1. Provide advice to the governing authority.

2. Establish and document implementation of written bylaws.

3. Reflect the diversity of the community and the clientele served by the agency.

4. Meet on a regular basis.

5. Maintain written records of meetings.

(3) DUTIES OF THE GOVERNING AUTHORITY. The entity shall provide written documentation of all responsibilities of the governing authority and shall maintain written evidence of implementation of these duties, which at a minimum shall include:

(a) Ensure compliance with all applicable federal, state, and local laws and regulatory requirements;

(b) Establish the entity's mission, goals, and objectives;

(c) Establish and monitor controls to ensure the appropriateness, adequacy, and quality of services provided by the entity.

(d) Secure adequate resources to operate on a fiscally sound basis and to accomplish the goals and objectives of the organization, including

1. Ensure that the agency is adequately funded to provide the certified services;

2. Provide physical facilities, staff, equipment, supplies, and other needs adequate and sufficient to provide the certified services;

3. Review and approve the entity's annual budget;

4. Insure that the agency maintains adequate insurance coverage to protect its resources.

(e) Maintain a qualified executive director to manage the day-to-day affairs of the agency, including

1. Establish the qualifications of the executive director in accordance with the mission of the agency.

2. Specify the duties and authority of the executive director.

3. Recruit, hire, and perform annual evaluations of the executive director's job performance.

(f) Establish processes to engage and obtain ongoing input from all stakeholders, including personnel, current and former program participants, and community representatives for the purpose of identifying needs, enhancing services, and improving outcomes.

(g) Maintain accessibility to personnel, program participants, and the community served.

(h) Review and approve all contracts.

(i) Routinely evaluate the efficiency and effectiveness of the organization and make recommendations for modifications as deemed necessary or beneficial based on the evaluation.

(j) Ensure governing authority participation in the entity's DMH certification review process.

(k) Provide immediate notification to DMH of changes of the agency's executive director.

(l) Meet as the board of directors or with the governing body's advisory committee, in accordance with the entity's organizational structure, no less than on a quarterly basis.

(m) Ensure the development, maintenance, and implementation of a Polices and Procedures Manual as specified in [redacted]

(n) Review and approve written administrative, personnel, and clinical policies and procedures as specified by these rules.

(4) BYLAWS. The governing authority shall develop and adopt written bylaws and/or policies that shall minimally:

(a) Delineate the powers and duties of:

1. The board of directors;

2. Governing authority committees and task groups;

3. Advisory groups to the governing authority; and

4. The entity's executive director.

(b) Describe membership requirements, terms of appointment, and attendance requirements;

(c) Define the process of election or appointment of officers, and terms of office;

(d) Establish meeting frequency;

(e) Establish the quorum necessary to transact business.

(f) Define conflict of interest and establish procedures to address such.

(5) MEMBERSHIP. The membership of the board of directors, advisory board to the governing body, and related committees shall be inclusive of persons who:

(a) Represent the geographic regions served by the organization;

(b) Reflect the diversity of the geographic region served by the organization;

(c) Are persons who are consumers of the types of services provided by the entity; and

(d) Are family members of consumers of the types of services provided by the entity.

(6) CONSUMER ADVISORY COMMITTEE. The governing authority shall establish the organizational structure for, support, and maintain an active consumer advisory committee that shall function to inform and assist the entity's efforts to appropriately address the needs of individuals and communities served. This committee shall minimally:

(a) Participate in an orientation and training process established by the governing authority;

(b) Make recommendations to the governing authority as a result of systematic monitoring and review of the entity's operational policies and procedures;

(c) Advocate for resources to address the needs of individuals and communities adversely impacted by substance use and addiction;

(d) Participate in the entity's performance improvement processes;

(e) Incorporate a process to obtain feedback from active clients and their families relative to, at a minimum, timeliness, appropriateness, and effectiveness of services provided by the agency.

(f) Maintain formal meeting minutes and other records of its activities, and provide access to this information as directed by the governing authority.

(g) Consist of no less than ten members, all being former recipients of services for prevention, treatment, or care of substance related disorders, and:

1. Are representative of the entity's target population; and

2. Who are not employed in an occupation relating to alcoholism or drug addiction.

(7) MINUTES. Minutes of all board of directors, advisory board, committee, and task group meeting shall be kept and shall:

(a) Minimally include:

1. Date of the meeting.

2. Meeting Location.

3. Names of persons in attendance.

4. Discussion summaries.

5. Decisions reached.

6. Actions taken.

7. Signature of the recorder and an authorized officer of the governing body.

(b) Be accessible for review by DMH upon request.

(c) Be made available upon request to personnel, program participants, families served, and the general public, subject to limitations imposed to protect confidentiality, privacy, and proprietary information.

(8) EXECUTIVE DIRECTOR. The governing body shall designate an individual to serve as the entity's executive director.

(a) The executive director's qualifications, authority, and responsibilities shall be:

1. Defined in writing;

2. Incorporated into the entity's policy and procedures manual;

3. Incorporated into the bylaws of the governing authority, as appropriate to the entity's organizational structure;

4. Incorporated into the executive director's personnel record; and

5. Reviewed, updated as necessary, and reauthorized by the governing body, annually.

(b) The executive director shall demonstrate responsibility and authority for the following functions, at a minimum:

1. Management of the day-to-day operations of the entity's facilities and programs as according to policies and procedures established by the governing body.

2. Compliance with laws, rules, regulations, standards, and policies relative to all aspects of the entity's operations.

3. Planning, organizing, and directing activities as may be delegated by the Board of Directors.

4. Designating, in writing, an individual to act in the absence of the executive director.

(c) The executive director shall have access to all programs and premises under governance of the entity.

(9) PROGRAM PLANNING AND EVALUATION. The governing body shall develop and document implementation of a written strategic plan.

(a) The entity's strategic plan shall, at a minimum:

1. Define the entity's mission, goals, and objectives.

2. Incorporate a process for ongoing analysis of the substance abuse service needs of the population within the geographic area served, and for identification of accessible community resources to address those needs.

3. Demonstrate an understanding of the service needs of the population within the geographic area served.

4. Incorporate findings from the entity's performance improvement system, as appropriate.

5. Incorporate results relative to previously established goals and strategies.

6. Include an evaluation process to assess progress toward goal attainment.

7. Be formally approved by the governing body.

8. Be reviewed and updated as necessary, but no less than annually.

(b) The entity shall prepare an annual year-end management report representative of strategic planning activities.

(c) The entity shall describe and document implementation of the process utilized for dissemination of the strategic plan and management report to key stakeholders, including but not limited to:

1. The governing authority.

2. The entity's staff.

3. DMH.

4. The public.

10. PERFORMANCE IMPROVEMENT: The provider shall provide written documentation of the entity's operation and maintenance of a Performance Improvement System.

(a) The Performance Improvement System shall be designed to:

1. Monitor and assess organizational processes and outcomes;

2. Correct and follow-up on identified organizational problems;

3. Improve the quality of services provided;

4. Improve client and family satisfaction with services provided.

(b) The Performance Improvement System shall provide meaningful opportunities for input, relative to the operation and improvement of services, from key stakeholders including clients, family members, consumer groups, advocates, and advocacy organizations.

(c) The Performance Improvement System shall be described in a written plan which, at a minimum shall:

1. Identify and encompass all program service areas and functions, including volunteer and subcontracted client services;

2. Outline the provider's mission related to Performance Improvement.

3. Include the entity's goals and objectives for Performance Improvement.

4. Define the organizational structure of Performance Improvement activities, which shall include establishment of a functional Performance Improvement Committee. This committee shall:

(i) Consist of representatives of various professional disciplines within the organization.

(ii) Determine the processes and outcomes to be monitored, in addition to those required by theses rules.

(iii) Determine the frequency in which information will be reviewed.

(iv) Select indicators.

(v) Evaluate gathered information.

(vi) Decide actions to be taken to correct identified problems.

(vii) Recommend corrective actions.

(viii) Evaluate implementation and effectiveness of corrective actions taken.

(ix) Meet at least quarterly.

(x) Generate written, dated minutes of each meeting prior to the next meeting that shall include, at a minimum:

(I) Member attendance.

(II) Indicators reviewed at the meeting.

(III) Conclusions reached.

(IV) Recommendations for corrective action, if any; and

(V) Indicators to be reviewed at the next meeting.

(xi) Document all performance improvement activities and maintain them on-site for review for a minimum of two (2) years.

(xii) Establish specific staff responsibility for coordination of the Performance Improvement System;

(xiii) Specify the manner in which Performance Improvement findings and recommendations are communicated to all levels of the organization and key stakeholders, including, but not limited to:

(I) The governing authority.

(II) Staff.

(III) Clients, families, and advocates.

(IV) DMH.

xiv. Provide for review and approval by the Governing Body on an annual basis and when revisions are made.

(d) PERFORMANCE IMPROVEMENT ACTIVITIES. The entity shall develop, maintain, and document implementation of written policies and procedures to:

1. Establish quality indicators that are:

   (i) Relevant to the level of care and services provided;

   (ii) Based upon professionally recognized standards of care;

   (iii) Inclusive of indicators required by DMH.

2. Systematically record, monitor, and evaluate in comparison with state-wide data provided by DMH, the entity's program utilization data, including, but not limited to:

   (i) Time from initial client contact with the program to initial appointment.

   (ii) Appointment no show rates.

   (iii) Assessment only (i.e. clients who have an assessment and do not follow through with treatment recommendation and those who are not deemed appropriate for any LOC).

   (iv) The number of active cases.

   (v) Retention rates.

   (vi) Length of stay.

   (vii) The number of re-admitted cases;

   (viii) The number of program discharges;

   (ix) The number of terminated due to chooses no further treatment;

   (x) The number of drop outs due to unable to contact.

   (xi) The number of referrals to another agency.

   (xii) The number of transfers to another level of care within the continuum of care

   (xiii) The number and types of services rendered to clients;

Comment [DML1]: The agencies won't actually record the comparative data but couldn't figure out how to word this

Comment [DML2]: Cross reference NIATx information

(xiv) Average number of individuals waiting for admission; and

(xv) Average number of days individuals remain on the waiting list for admission.

3. Monitor service access and retention processes;

4. Conduct periodic and timely review of any deficiencies, requirements, and performance improvement recommendations received from DMH 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;

5. Conduct an administrative and clinical review of a representative sample of active and closed client records. This review shall function to:

(i) Assess the appropriateness of the admission relative to published admission criteria.

(ii) Assess the presence, accuracy and completeness of clinical documentation in relation to these rules and the organization's policies and procedures;

(iii) Monitor the timeliness, adequacy, and appropriateness of service planning for each client, which shall address, at a minimum:

(I) Timeliness of individualized service plan development.

(II) Implementation of service plan reviews and updates as required by program policy and DMH.

(III) Appropriateness of the individualized service plan in relation to assessed client needs.

(IV) Involvement of the client and family in the service planning process.

(V) Evidence of cultural competency in service planning and delivery.

(VI) Documentation of service delivery in relation to the Individualized Service Plan.

(iv) Adequacy of case development and management.

6. Assess the satisfaction of clients and families, including,

(i) The client's perception of the outcome of services received.

(ii) The client's perception of the quality of the therapeutic alliance.

(iii) Other perceptions of clients and families regarding factors which impact care and treatment, including but not limited to:

(I) Access to care.

(II) Program information.

(III) Staff helpfulness.

7. Monitor Treatment outcomes, with proximal formal client feedback in real time (i.e. session rating scales, stage of change, etc.) and post-treatment outcomes (i.e. NOMs) including but not limited to those specified in [illegible] follow-up2.

8. Monitor appropriate utilization of clinical/treatment services and other resources for the clients served i.e. clinical peer reviews, clinical reviews, etc.

9. Determine if treatment or care procedures are deficient or flawed;

10. Monitor critical incidents involving clients to include at a minimum:

(i) Timeliness of identification and reporting of critical incidents;

(ii) Identification of trends and actions taken to reduce risk, and to improve the safety of the service environment for clients, families, employees, and visitors.

11. Monitor staff development activities.

(e) The entity shall document development and implementation of a process to develop:

1. Quarterly reports of performance improvement activities, findings, and recommendations; and

2. An annual aggregate review of performance improvement findings, assessment of trends and patterns, actions taken relative to findings, and recommendations for needed improvements.

(11) OPERATIONAL POLICIES AND PROCEDURES MANUAL: The entity shall develop a written, indexed, Policies and Procedures Manual which shall, minimally, contain each of the required written policies, procedures, practices, plans, and processes as specified by these rules.

(a) All policies and procedures contained within the Policies and Procedures manual shall be:

1. Approved by the organization's governing body.

2. Developed with the input by the programs' staff, clients, their families, and client advocates.

3. Consistent with DMH-SASD standards relative to client rights

(b) The Policies and Procedures Manual shall be:

1. Updated as needed, with changes approved by the governing authority before they are instituted, as documented in writing.

2. Reviewed, at least, on an annual basis by the Governing Authority with this review process documented in writing.

3. Easily accessible to all program personnel, with a copy available at each service location.

4. Accessible for review by DMH upon request.

(c) There shall be written policies and procedures to describe how the Policies and Procedures Manual is made accessible to the public.

(d) All entries in the policies and procedures manual shall be dated and signed by the entity's executive director and an authorized officer of the governing body.

(e) Revisions to any page or section of the Policies and Procedures Manual must show the date of governing body approval and the effective date of each respective revision.

580-9-40.02 FISCAL MANAGEMENT.

(1) The entity shall establish and document compliance with written fiscal management policies and procedures.

(a) The Governing Body shall consistently monitor compliance with formal fiscal management policies and procedures and to ensure the source and adequacy of financial assets necessary to operate the program:

1. The entity shall document and demonstrate the availability of adequate funding to provide the certified or certification eligible services described in its operational plan.

2. The entity shall document and demonstrate the availability of physical facilities, staff, equipment, supplies, and other essential resources that are adequate and appropriate for provision of the certified services or certification eligible services described in its operational plan.

3. The entity provide documentation of adequate insurance coverage for the protection of the physical and financial resources of the program, coverage of the building, automobiles, and equipment, and coverage of the governing body, clients, staff, and the general public relative to its interaction with the entity.

(i) The governing body shall determine and secure insurance coverage limits based upon assessment of the risks associated with the services provided.

(b) The entity shall document utilization of an accounting system and generally accepted procedures to support fiscal monitoring and management that, at a minimum:

1. Ensures financial transactions are handled in a uniform manner.

2. Enables financial transactions to be reconciled and summarized at least monthly.

3. Establishes processes for accounts receivable, accounts payable, purchasing and inventory.

4. Establishes policies and procedures for the handling of cash.

5. Establishes policies and procedures to account for employees' time and to allocate this time to appropriate cost centers.

4. Establishes non-conflicting staff responsibilities for management of the entities finances implementation of accounting procedures.

(c) The entity shall establish and implement written accounting procedures to determine cost per unit of service.

1. Costs per unit of service shall be reviewed annually.

2. Results of the annual review shall be incorporated into the development of the operating budget in the form of increased charges or expenses.

(d) The entity shall establish and implement written accounting procedures to recover third party payments.

1. A process to determine eligibility of all clients for third party coverage shall be established.

2. All third party payers obliged to pay all or part of a fee for service shall be billed by the entity.

3. A process to monitor and follow-up third party billings shall be established.

(e) The entity shall establish a written schedule of fees for each service provided.

1. The fee schedule shall be reviewed and adjusted annually to reflect current costs for each unit of service.

2. Clients and third party payers shall be charged and billed in a manner consistent with the fee schedule.

3. The entity shall not charge exorbitant or unreasonable fees that are unsubstantiated by reasonable costs for delivery of the specific service.

(f) The entity shall operate on the basis of an annual budget that is established and approved by the governing body.

1. The governing body, executive director, and senior management staff shall participate in development of the operating budget.

2. The operating budget shall specify revenues by source and expenditures by both line item and component.

3. Written procedures shall be established and implemented relative to the steps and authority required for budget revisions.

4. The operating budget shall be formally reviewed and approved by the governing body prior to the beginning of each entity's fiscal year.

(g) The entity shall have an annual audit which shall conform to the requirements of General Audit and Accounting Principle (GAAP) and shall be:

1. Performed in accordance with applicable state and Federal regulations.

2. Shall accurately reflect the entity's financial position at the time of the audit and shall assess its accounting policies, procedures, and operations in light of generally accepted accounting practices.

3. Shall be reviewed by and accepted by the governing authority.

4. Subject to review by DMH.

(h) The entity shall develop and document implementation of written policies and procedures that prohibit members of the governing body or personnel employed by the entity from payment or receipt of any commission, remuneration, gift, consideration, or benefit of any kind related to the referral of an individual to any of the entity's programs for services.

(2) The entity shall establish and document implementation of a written plan outlining strategies for sustainability, that shall be reviewed and updated annually.

(3) The entity shall adhere to all reporting requirements of the DMH in regard to fiscal management.

580-9-40.03 PERSONNEL

(1) PERSONNEL POLICIES AND PROCEDURES: The entity shall develop, maintain, and document implementation of written personnel policies and procedures that are in compliance with all federal, state, and local laws and regulations relative to personnel and employment. The entity shall, at a minimum:

(a) Establish a written and dated non-discrimination policy in the organization's hiring practices that shall address nondiscrimination on the basis of:

1. Race.
2. Religion.
3. Gender.
4. Ethnicity.
5. Age.
6. Disabilities.
7. Sexual orientation.

(b) Maintain a U. S. Department of Labor certification for all employees paid less than the current minimum wage, as required by the Social Security Act and the Fair Labor Standards Act.

(c) Adhere to immigration/citizenship standards as outlined by the U. S. Department of Labor.

1. Specifically ensure that all labor performed for the entity by current and former clients is consistent with applicable local, state, and federal law.
2. Address, at a minimum:

(i) Recruitment, selection, and utilization of employees, volunteers, interns, and students.

(ii). Wage and salary administration.

(iii) Employee benefits.

(iv) Promotions.

(v) Working hours.

(vi) Leave time.

(vii) Lines of authority.

(viii) Rules of conduct.

(ix) Alcohol and drug use and use disorders by employees.

(x) Disciplinary action and termination.

(xi) Standards of ethical conduct.

(xii) Accidents and safety issues.

(xiii) Infection control.

(xiv) Employee grievance procedures.

(xv) Performance appraisal.

(xvi) Drug-free workplace.

(xvii) Employee drug testing.

(xviii) Requirements for physical exams and testing for and reporting infectious diseases.

(xix) Employee assistance for alcohol and drug use disorders and other employee problems.

(xx) Nepotism.

(xxi) Conflict of Interest.

(xxii) Employee retention.

(d) Specifically identify the entity's rules regarding hiring of current and former clients.

(d) Be reviewed annually, modified as needed, and approved in writing by the governing authority.

(2) **QUALIFIED TREATMENT PERSONNEL:** The entity shall employ a sufficient number of qualified and trained personnel to ensure the health, safety, and well-being of its clientele, and to support efficient utilization of its resources.

(a) The entity shall develop, maintain, and document implementation of written policies and procedures to ensure that all personnel meet and remain current on credentials required for certification, licensure, and for job performance and service delivery as specified by these rules.

(b) **CLINICAL DIRECTOR:** The entity shall employ a Clinical Director, who shall be responsible, in conjunction with the Executive Director, for the quality and appropriateness of clinical services within the entity's treatment program(s). The Clinical Director:

1. Shall possess, at a minimum, a master's degree from an accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and have a minimum of three years post master's relevant clinical experience; OR

3. Shall be a physician who has completed an approved three year residency in psychiatry.

(c) **PROGRAM COORDINATOR:** The entity shall employ a Program Director or Coordinator for each, respective, level of care offered within an organization who shall meet the qualifications set forth in these rules for the specified level of care. The individual shall assume responsibility for:

1. Management of the day-to-day operations of the respective level of care; and

2. Ensuring the availability of adequate resources to meet the program's objectives.

3. Ensuring that the level of care is provided in accordance with the rules established, herein, and in accordance with the goals and objectives established for this service by the governing authority.

(d) **QUALIFIED SUBSTANCE ABUSE PROFESSIONALS (QSAP):** The entity shall utilize qualified substance abuse professionals, exclusively, to provide clinical assessment, individual service planning, treatment, and care for individuals with substance related disorders, in accordance with personnel requirements of each Respective service. A QSAP shall consist of:

1. An individual who

   (i) Has a Master's degree or above from an accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work; and

   (ii) Has successfully completed a relevant clinical practicum; or

   (iii) Has one (1) year of relevant clinical experience under the supervision of a qualified substance abuse professional; or

   (iv) Holds a substance abuse counselor certification credential from the:

      (I) National Association of Alcoholism and Drug Abuse Counselors; or the

      (II) The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc; or

      (III) Participates in concurrent clinical supervision as according to the criteria specified in rule ***** by a QSAP who meets the criteria in rule ***** up until attainment of two years substance abuse treatment experience; OR

2. An individual licensed in the State of Alabama as a:

   (i) Professional Counselor;

   (ii) Clinical Social Worker;

(iii) Psychiatric Clinical Nurse Specialist;

(iv) Psychiatric Nurse Practitioner;

(v) Marriage and Family Therapist;

(vi) Clinical Psychologist;

(vii) Physician's Assistant; or

(viii) Physician; and

(ix) Documents competency by training and/or experience in the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or

(I) Holds a substance abuse counselor certification credential from the:

I. National Association of Alcoholism and Drug Abuse Counselors; or

II. The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.; or

III. The American Society of Addiction Medicine; OR

3. An individual who:

(i) Has a Bachelor's Degree from an accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work; and

(ii) Has two (2) years of relevant clinical experience under the supervision of a qualified substance abuse professional; or

(iii) Holds a substance abuse counselor certification credential from the:

(I) National Association of Alcoholism and Drug Abuse Counselors; or the

(II) The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.; or

(III) Participates in concurrent clinical supervision as according to the criteria specified in rule ******* by a QSAP who meets the criteria in rule ***** up until attainment of two years substance abuse treatment experience; OR

4. An individual licensed in the State of Alabama as a:

(i) Bachelor Level Social Worker; or as a Registered Nurse; and

(ii) Has two (2) years of relevant clinical experience under the supervision of a qualified substance abuse professional; or

(iii) Holds a substance abuse counselor certification credential from the:

(I) National Association of Alcoholism and Drug Abuse Counselors; or the

(II) The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.; or

(III) Participates in ongoing supervision as according to the criteria specified in rule ******* by a QSAP who meets the criteria in rule ***** up until attainment of two years substance abuse treatment experience; OR

5. An individual who:

(i) Has a minimum of four years full-time paid employment experience providing direct treatment and care services for individuals who have substance-related disorders, under the supervision of a qualified substance abuse professional; and

(ii) Documented competency by training and/or experience in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; and

(iii) Holds a substance abuse counselor certification credential from the:

(I) National Association of Alcoholism and Drug Abuse Counselors; or the

(II) The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.; and

(iv) All Clinical Directors and QSAPs who do not hold a license to practice, as specified in [redacted], shall within two years of hire or within two years of the effective date of these rules, attain a substance abuse counselor certification credential from the:

(I) National Association of Alcoholism and Drug Abuse Counselors; or the

(II) The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.

(e) **QUALIFIED PARAPROFESSIONALS:** The entity shall utilize qualified paraprofessionals to assist in the delivery of substance abuse treatment services and to provide recovery support services. A qualified paraprofessional shall have the following minimum qualifications:

1. A high school diploma or equivalent; and

(i) One year or more of experience providing direct treatment or recovery support services to persons with a substance related disorder; and

(ii) Demonstration of competency in the provision of addictions treatment; and

(iii) Completion of a minimum of nine (9) college semester hours or one hundred forty-four (144) contact hours of continuing education in areas of addiction counselor competency; or

2. Completion of a DMH approved recovery or peer support specialist training program; and

(i) Concurrent participation in clinical supervision as according to the criteria specified in rule ***** by a QSAP who meets the criteria in rule *****

(3) QUALIFIED PREVENTION PERSONNEL.

(4) ORGANIZATIONAL CHART: The entity shall maintain a current organizational chart that shall:

(a) Clearly describe the functional lines of authority, oversight, management, and consultative relationships between each position, body, or board that is operational within the organization, including part-time, volunteer, and contract positions.

(b) Be updated and disseminated to the governing body and all agency personnel annually.

(5) JOB DESCRIPTIONS: Each position contained within the organizational chart shall have a written job description that:

(a) States the position's title.

(b) States the position's requirements for education, training, experience, skills, and/or credentials.

(c) Identifies the reporting supervisor.

(d) Identifies each position supervised.

(e) Delineates the actual duties and responsibilities of the position.

(f) Identifies the effective date.

(g) Is reviewed, signed, and dated by the employee and the employee's immediate supervisor:

1. During the period of initial job orientation.

2. Within thirty days of a revision to the position's qualifications and/or duties.

3. At the time of change to a different position.

4. No less than on an annual basis.

(h) Is maintained in the personnel record of each employee.

(6) PERSONNEL RECORDS: Personnel records shall be maintained for each employee, and all contractors, students, and volunteers who have direct contact with program participants that contain, at a minimum:

(a) A complete job application.

(b) A resume.

(c) Documentation of the entity's verification of all professional credentials, including transcripts of education, license, registration, and/or certification for all applicable personnel.

(d) Documentation of the employee's criminal background check.

(e) Reference information.

(f) Starting date of employment, and ending date as applicable.

(g) Documentation of the content and completion of an initial orientation and training process.

(h) Documentation of continuing education.

(i) Documentation of incident reports, disciplinary actions, and commendations.

(j) Annual performance evaluations.

(k) A copy of the employee's valid drivers' license if the employee's job function entails or could entail the transportation of clients.

(l) A copy of the job description and documentation that a copy was provided to the employee.

(m) Documentation of review and agreement to adhere to privacy and confidentiality regulations that protect client information.

(n) Other information as required by law.

(7) PRIVACY AND CONFIDENTIALITY. The entity shall develop, maintain, and document implementation of written policies and procedures to protect the confidentiality and privacy of:

(a) Personnel records.

(b) Employee health related information received, including, but not limited to:

(1) Requests for medical or family leave.

(2) Results of infectious disease testing.

(3) Results of alcohol and/or drug screens.

(4) Physician authorized return to work permits.

(5) Results of physical examinations.

(8) STAFF DEVELOPMENT. The entity shall develop, maintain, and document implementation of written policies and procedures that establish a staff development and training program for all employees, students, and volunteers. This program shall include, at a minimum, the following requirements:

(a) **PERSONNEL ORIENTATION**: An orientation process shall be conducted for each new employee, student, or volunteer that includes, but is not limited to,

(1) Oral review of written information on:

(i) The agency's mission, philosophy, organizational structure, and description of services.

(ii) Program participants' rights to privacy and confidentiality.

(iii) Program participants' applicable rights to service provision.

(iv) The agency's personnel policies and procedures and code of ethics.

(v) Infection control, safety and emergency procedures.

(vi) Crisis intervention procedures.

(vii) Incident reporting procedures.

(viii) Job specific duties and responsibilities.

(ix) Supervision.

(x) Electronic media access requirements.

(xi) DMH Certification Standards.

(2) The provision that each employee will be given an employee handbook that addresses, at a minimum, each item presented during the orientation process.

(3) A policy stipulating that that an employee will not be permitted to assume job responsibilities until completion of the orientation process.

(b) **ANNUAL TRAINING**: On an annual basis, the entity shall provide training for each employee that addresses the following topics:

(1) Crisis intervention.

(2) Management of disruptive behavior.

(3) Suicide prevention/intervention.

(4) Confidentiality and privacy of client information.

(5) Cultural competency relative to the program's target population.

(6) Infectious disease prevention and management, to include at a minimum: TB, HIV/AIDS, Sexually Transmitted Diseases and Hepatitis.

(7) Program policies and procedures.

(8) DMH Certification Standards.

(c) **FIRST AID/CARDIOPULMONARY RESUSCITATION (CPR) TRAINING:** All staff shall obtain, within one month of hire, and continuously maintain current certification in First Aid and CPR.

(d) **PROFESSIONAL DEVELOPMENT:** The entity shall establish and support professional development activities for all paid personnel and permanent volunteers that shall include, at a minimum:

(1) An annual agency-wide training needs assessment, which shall incorporate, at a minimum:

(i) A survey of the entity's personnel to determine professional development needs.

(ii) Findings from performance appraisals and clinical supervision activities.

(iii) Findings from the entity's performance improvement activities.

(iv) Findings from DMH certification and other program monitoring site visits.

(2) The provision of in-service and offsite training opportunities to meet needs identified in the training assessment, including known credentialing requirements.

(3) Written agency and individual employee staff development plans that are, based, at a minimum, upon performance appraisals and training needs assessments as required in [redacted], implemented, reviewed, and updated, at least, annually.

(4) A process to inform the agency's personnel of:

(i) New developments in the treatment and prevention of substance use disorders;

(ii) Changes in regulatory requirements; and

(iii) Changes in the operational policies and procedures of the entity.

(e) **COMPETENCY AND TRAINING: TREATMENT PERSONNEL.** All individuals providing treatment and recovery support services shall have appropriate training to support knowledge and skill development in the transdisciplinary foundations of addictions practice.

1. Training provided shall be consistent with the clinician's job qualifications, work experience, and job responsibilities.

2. Training shall support development of appropriate competencies, in accordance with latest edition of TAP 21 published by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, incorporated, herein, by reference, within two (2) years of hire in the following transdisciplinary foundations:

(i) Understanding Addiction.

(ii) Treatment Knowledge.

(iii) Application to Practice.

(iv) Professional Readiness.

3. **QUALIFIED SUBSTANCE ABUSE PROFESSIONALS:** All qualified substance abuse professionals shall have appropriate training to support development of knowledge, skill, and attitude competencies underlying the eight practice dimensions of addiction counseling.

(i) Training shall be consistent with the clinician's job qualifications, work experience, and professional responsibilities.

(ii) Training shall support development of appropriate competencies, in accordance with latest edition of TAP 21 published by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, incorporated, herein, by reference, within two (2) years of hire in the following practice dimensions:

(I) Clinical Evaluation, including:

I. Screening.

II. Assessment.

(II) Treatment Planning.

(III) Referral.

(IV) Service Coordination, including:

I. Implementing the Treatment Plan.

II. Consulting.

III. Continuing Assessment and Treatment Planning.

(V) Counseling, including

I. Individual Counseling.

II. Group counseling.

III. Counseling Families, Couples, and Significant Others.

(VI) Client, Family, and Community Education.

(VII) Documentation.

(VIII) Professional and Ethical Responsibilities.

4. **ADOLESCENT PROGRAM SPECIFIC CRITERIA.**

(i) All clinical staff in adolescent programs shall have adequate knowledge, skills, attitudes, and attributes to provide effective service delivery for the program's specified target population.

(ii) The entity shall provide continuous training to ensure development of the following competencies for clinicians working in adolescent programs:

(I) Knowledge of developmental, cultural, gender, psychological, family, and legal issues unique to adolescents who have substance related disorders.

(II) Knowledge of the needs of special populations, including, homeless, juvenile justice involved, homosexual, bisexual, transgendered youth, and youth with co-existing disorders

(III) Knowledge and skills to implement treatment approaches specific to adolescents and their families that address:

I. Adolescent growth and development.

II. Trauma, including sexual and physical abuse.

III. Mental health problems.

IV. Sexual orientation issues.

VI. Psychopharmacology.

VII. Referral and community resources.

VIII. Cognitive impairments.

IX. Gender specific concerns.

(IV) Knowledge and skills to:

I. Perform age-appropriate assessments of individuals.

II. Formulate an individualized service plan and develop a community support plan for individuals.

III. Tailor interventions which support the process of recovery for individuals.

IV. Tailor interventions appropriate to the individual's assessed stage of readiness to change.

V. Make available required support for individuals who choose to participate in 12-Step Recovery programs.

(V) Attitudes and attributes to establish a supportive, therapeutic alliance with adolescents and their families.

5. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA.** All clinical staff working in co-occurring enhanced programs shall have adequate knowledge, skills, and attitudes to provide effective service delivery for the program's specified target population.

(i) Training shall be provided to support development of the following competencies within twelve (12) months of hire:

(I) Screen for mental health and substance use problems using DMH approved screening instruments.

(II) Develop a preliminary impression of the presenting problem.

(III) Use basic engagement skills, including:

I. Stabilization, outreach, assistance with practical needs, and building the therapeutic alliance.

II. Basic motivational interviewing.

III. Use techniques designed for de-escalation of client behavior when needed.

(ii) Knowledge of crisis management procedures, including:

(I) Know the behavior/physiological signs for intoxication and withdrawal from various stances, and the signs of risk to self or others.

(II) Follow the crisis management procedures if someone is intoxicated or in withdrawal from substances, and/or reporting suicidal ideation and/or homicidal ideation.

(III) Knowledge of referral processes and uses them assertively when needed.

(IV) Coordinate care assertively when multiple providers are concurrently involved in care.

(V) Display patience, persistence and optimism.

(iii) The entity shall provide continuous training to ensure development of the following competencies for clinicians working in co-occurring enhanced programs:

(I) Conduct integrated assessments.

(II) Knowledge of the drug classes and mental health diagnostic categories used in the DSM IV.

(III) Determine severity of disorders.

(IV) Knowledge of the current street names of the various drugs.

(V) Assess stage of change for both disorders.

(VI) Complete a functional assessment.

(VII) Document mental health and substance use disorder diagnoses.

(VIII) Perform integrated and collaborative service planning with a focus on shared decision making.

(IX) Conduct engagement, education, and treatment for both mental health and substance use disorders.

(X) Use advanced motivational interviewing strategies.

(XI) Know the basic social learning theory concepts that underlie a Cognitive Behavioral Therapy (CBT) Approach. Complete a functional analysis (behavior chain) and teach coping skills (e.g. rationale and guidelines, modeling, role plays,

providing constructive feedback, and assisting consumers/ individuals in recovery to practice exercises in their community).

(XII) Be able to modify counseling strategies for clients in recovery with a severe mental illness.

(XIII) Use stage-wise treatment methods, employing treatment strategies compatible with each stage of change for each disorder.

(XIV) Understand the 12-Steps used in AA/NA self-help groups, and assertively link people with COD to ones that are welcoming or specific to COD (i.e. Dual Recovery Anonymous).

5. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA.**

(i) All clinical staff working in women and dependent children's programs shall have adequate knowledge, skills, attitudes and attributes to provide effective service delivery for the program's specified target population.

(ii) The entity shall provide continuous training to ensure development of the following competencies for clinicians working in women and dependent children's programs:

(I) Knowledge of sex and gender differences in the experience of substance use.

(II) Knowledge of the relationship between substance use, violence, and mental health problems common to women and girls.

(III) Knowledge of barriers to care for women with substance use disorders, and skills to tailor strategies to minimize the impact of these barriers.

(IV) Skills to implement gender specific clinical interventions that address:

I. Substance use by pregnant women and mothers.

II. Fetal alcohol spectrum disorders.

III. The impact of substance use and parenting.

IV. The relationship between women, trauma, and substance use.

V. The role of relationships in women's lives.

VI. Race, ethnicity, culture, spirituality, sexual orientation and functioning.

VII. Child care issues relative to addiction, treatment, and recovery.

VIII. Economic and self-sufficiency.

IX. Competency building and empowerment.

V. Skills to provide gender specific assessments.

VI. Knowledge and skills to develop gender specific service plans that address the needs of the woman and her family.

iii. Knowledge and skills to:

(I) Tailor interventions appropriate to the individual's assessed stage of readiness to change.

(II) Tailor interventions which support the process of recovery for individuals.

(III) Provide family and social support.

(IV) Work across systems of care, facilitate and participate in teamwork and partnerships.

(V) Make available required support for individuals who choose to participate in 12-Step Recovery programs.

iv. Knowledge of:

(I) Medical, psychiatric, and behavioral syndromes and symptoms with which children and adolescents in families with substance abuse present.

(II) Medical and behavioral treatment of children in families affected by substance abuse.

(III) Potential benefit to both the child and the family of timely and early intervention services for children, and strategies for implementation of these services.

(IV) Community resources available for children and adolescents in families with substance abuse, and the ability to access these services.

(V) The impact of parental tobacco use on children.

v. Attitudes and attributes to establish a supportive, therapeutic alliance with women and their families.

QUALIFIED PARAPROFESSIONALS.

PREVENTION PERSONNEL:

(i) All individuals providing prevention services shall have adequate knowledge, skills, attitudes and attributes to provide effective service delivery for the program's specified target population.

(ii) The entity shall provide continuous training to ensure development of the following competencies for individuals providing prevention services:

(I)

(9) DOCUMENTATION: The entity shall maintain written records of completion of orientation, training, and professional development activities that document, at a minimum:

(a) Dates of the orientation, professional development, and training activity.

(b) Curriculum summary.

(c) Identification of the specific counseling competency addressed, as appropriate.

(d) Competency assessment or rating.

(e) Names and credentials of trainer.

(f) Length of session.

(g) Credits earned as applicable.

10. CLINICAL SUPERVISION. The entity shall document effective oversight of clinical services, as according to the following requirements:

(a) The entity shall identify a clinical supervisor for each level of care.

(b) Clinical supervision may be provided in-house or through a contractual arrangement established between the entity and a qualified clinical supervisor.

(c) Clinical supervision shall be provided by an individual who meets the requirements specified in [redacted].

(d) The entity shall develop, maintain, and document implementation of written policies and procedures that govern the process of clinical supervision, which shall, at a minimum, include the following requirements:

1. All staff providing direct services, who are not licensed independent practitioners, shall receive clinical supervision on a continuous basis.

(i) A minimum of one hour of clinical supervision shall be provided each week for each Qualified Substance Abuse Professional who provides at least twenty (20) hours of direct services weekly.

(ii) A minimum of one hour of clinical supervision shall be provided every two weeks for each Qualified Substance Abuse Professional who provides less than 20 hours of direct services weekly.

(iii) Master Degree level Qualified Substance Abuse Professionals participating in concurrent supervision as specified in [redacted], shall receive a minimum of two (2) hours of clinical supervision

monthly, in addition to that specified in [redacted] until such time that one year of substance abuse treatment experience is attained.

(iv) Bachelor Degree level Qualified Substance Abuse Professionals participating in concurrent supervision as specified in [redacted] and [redacted], shall receive a minimum of two (2) hours of clinical supervision monthly, in addition to that specified in [redacted] until such time that two years of substance abuse treatment experience is attained.

(v) Qualified Paraprofessionals working at least twenty hours per week shall receive a minimum of two hours clinical supervision weekly.

(vi) Qualified Paraprofessionals working less than twenty hours per week shall receive a minimum of one hour of clinical supervision every two weeks.

2. Supervision shall include, but shall not be limited to:

(i) Direct observation of service delivery.

(ii) Case study review and discussion.

(iii) Audit of clinical records.

(iv) Assessment and discussion of core competencies.

(v) Assessment and discussion of therapeutic alliances.

(vi) Assessment of treatment effectiveness and review of client outcomes.

(vii) Employee skill development.

(viii) Employee education relative to clinical policies and procedures, treatment modalities, and specific job functions.

3. Clinical supervision may be conducted on an individual and group basis.

(i) All employees shall have a minimum of one hour individual supervision monthly.

(ii) Group supervision shall include no more than twelve (12) supervisees.

(iii) Clinical supervision shall be documented.

(I) Documentation shall include, at a minimum:

I. Names of the supervisor and supervisee(s);

II. Specification of individual or group supervision;

III. Date of supervision;

IV. A description of supervisory activities;

V. Identification of opportunities for staff development and improvements in the quality of care.

(II) Supervisory audit of clinical records shall be documented within the records reviewed, in addition to documentation as specified in [redacted]

(11) VOLUNTEERS: Entities utilizing volunteers shall develop, maintain, and document implementation of written policies and procedures governing their selection and utilization within the organization.

(a) At a minimum, the entity's policies and procedures relative to volunteers shall include the following elements:

1. Procedures and criteria used to select volunteers, including sobriety requirements for individuals in recovery from substance use disorders.

2. Specific responsibilities and tasks of volunteers.:

3. Specific accountability and reporting requirements of volunteers.

4. Responsibility for reviewing the performance of volunteers and for providing appropriate feedback in regard to such.

5. Procedures for discontinuing or moving a volunteer from an assigned task or from the agency.

(b) Volunteers shall provide direct services to clients only if they meet all requirements applicable to paid staff for delivery of the same service, and are under the direct supervision of a qualified substance abuse professional.

(c) An appropriately qualified staff member shall be designated to coordinate and supervise volunteer services.

(d) An individual personnel record shall be maintained for each volunteer as specified in rule [redacted].

(e) All volunteers shall participate in an orientation process as specified in rule [redacted].

(12) STUDENTS/INTERNS: Entities providing on-the-job educational/training opportunities for students through practicums, internships, or other supervised learning experiences shall develop, maintain, and document implementation of written policies and procedures governing this process.

(a) At a minimum, policies and procedures relative to students and interns shall include the following requirements:

1. Procedures and criteria used to select students/interns.

2. Identification of minimum qualifications for each position available for learning experiences.

3. Delineation of specific roles and responsibilities of students and interns, including scope of practice restrictions.

4. Procedures for discontinuing a student/intern learning experience.

5. Identification of specific personnel who shall, at a minimum:

(i) Coordinate and supervise the entity's student/intern placement process.

(ii) Serve as the entity's liaison between the agency and the school making student/intern placements.

(iii) Provide direct supervision of the student/intern.

(iv) Assume responsibility for reviewing the performance of volunteers and for providing appropriate feedback in regard to such.

(b) An individual personnel record shall be maintained for each student/intern as specified in rule [redacted].

© All students/interns shall participate in an orientation process as specified in rule [redacted].

(13) PERFORMANCE APPRAISALS. Performance appraisals for each employee shall be conducted using pre-established criteria based upon the specific job responsibilities and required competencies of the position as stated in the job description.

(a) Performance appraisals shall be conducted at least annually.

(b) Each employee's personnel record shall contain a written, dated copy of the performance appraisal that includes:

1. Evidence of the employee's discussion of the appraisal with the supervisor.

2. Strategies for addressing identified deficiencies.

(14) BACKGROUND CHECKS. The entity shall develop, maintain, and document implementation of written policies and procedures for conducting personnel background checks which shall, at a minimum, include the following requirements:

1. Background checks shall be obtained for all prospective employees, volunteers, students/interns, and persons contracted to provide direct client care.

2. The specific type of background checks to be conducted and the source of these checks shall be identified.

3. Employment of any individual shall be contingent upon results of the background checks.

4. At a minimum, the entity shall not hire any individual who has a prior criminal conviction or disciplinary action by a professional licensing, registration, certification, or accrediting body that pertains to child, elder, or client neglect, abuse, or exploitation.

5. The process for addressing positive reports shall be described

6. Requirements for subsequent background checks to the initial check shall be specified.

580-9-40.04 AMERICANS WITH DISABILITIES ACT (ADA).

(1) The entity shall develop, maintain, and document implementation of written policies and procedures relative to compliance with the Americans with Disabilities Act that shall include, at a minimum, the following requirements:

(a) An individual shall be designated who shall have responsibility for monitoring the entity's compliance with the ADA and for informing all staff of issues in this regard.

(b) The entity shall post the ADA Public Notification in a manner that is accessible to staff, clients, and visitors.

(c) The entity shall adopt and document compliance with a written ADA non-discrimination policy.

580-9-40.05 CULTURAL COMPETENCY.

(1) The entity shall develop, maintain, and document implementation and promotion of a written strategic plan to provide culturally and linguistically appropriate services that shall, at a minimum:

(a) Outline clear goals, policies, operational plans, and management accountability mechanisms.

(b) Be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy.

(c) Provide for development and implementation procedures to ensure that clients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

(d) Include strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

(e) Provide for ongoing education and training for staff at all levels and across all disciplines in culturally and linguistically appropriate service delivery.

(f) Include a process to offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

(g) Provide verbal offers and written notices to clients in their preferred language that inform them of their right to receive language assistance services.

(h) Describe the process for assuring the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff.

(i) Describe how the entity makes available easily understood client-related materials and posts signage in the language of the commonly encountered groups and/or groups represented in the service area.

(j) Establish a process to evaluate the entity's strategies to provide culturally and linguistically appropriate services and incorporate findings and recommendations into the entity's performance improvement process.

(k) Provide for review and update as needed, but no less than annually by the Executive Director and Governing Body.

680-9-40.06 COMMUNITY RELATIONS AND EDUCATION

(1) The entity shall develop, maintain, and document implementation of a community relations and education plan which shall, at a minimum:

(a) Identify program personnel who will assume responsibility for coordination of the entity's community relations plan.

(b) Identify the goals and objectives of the community relations plan, which shall at a minimum, include:

1. Establish participatory, collaborative partnerships with the community it serves and utilize a variety of formal and informal mechanisms to facilitate community involvement with the agency's activities.

2. Serve as a community resource on substance abuse and related health and social issues.

3. Demonstrate and promote the benefits of substance abuse prevention and treatment in relation to public health and safety.

4. Address and/or strive to resolve community problems relative to the agency and/or substance abuse.

(c) Include a process for documentation of community relations efforts and community contacts.

(d) Establish communication mechanisms that enable interested parties and potential clients to obtain general information about the program outside of regular operating hours.

(e) Evaluate community relations efforts and incorporate findings and recommendations into the entity's performance improvement process.

(f) Provide for review and update as needed, but no less than annually by the Executive Director and Governing Body.

580-9-40.07 DISASTER PLANNING AND EMERGENCY RESPONSE.

(1) The entity shall develop, maintain, and document implementation of a written emergency/disaster response plan that shall, at a minimum:

(a) Identify an individual to whom the entity has assigned responsibility for administration and management of the agency's emergency/disaster response services.

(b) Reflect analysis and understanding of the potential impact of disasters and emergencies on:

1. The health and safety of clients.

2. The health and safety of personnel.

3. Continuity of operations and service delivery.

4. Property, facilities, and infrastructure.

5. Economic and financial conditions.

6. Regulatory and contractual obligations.

7. Reputation of or confidence in the entity.

8. Confidentiality and privacy of client information.

(c) Describe the process for managing specific emergencies and disasters, including, at a minimum,

1. Natural geological, meteorological, and biological hazards including, but not limited to, floods, tornados, hurricanes, or other severe weather, and medical emergencies;

2. Human-caused events, both accidental and intentional, including but not limited to, fires, acts of violence, injuries, terrorist threats, bomb threats, chemical spills, toxic waste exposure.

3. Technological-caused events, including but not limited to, power failures, prolonged loss of heat, air-conditioning, lights, water, or telephone service, gas leaks, computer drive crashes, data losses, ...

(d) Specify procedures, as appropriate , for evacuation, transportation, short-term and long term relocation, client record security, and continuation of medical and medication protocols.

(e) Specify functional roles and responsibilities of the entity's staff, as well as, external agencies and organizations.

(f) Specify logistics support, resource requirements, and the process to be utilized to access identified resources and support.

(g) Identify the process for managing the communication and flow of information, both internally and externally, including, but not limited to:

1. Emergency communication and warning protocols, systems, and processes.

2. Alerts to officials and emergency response personnel.

3. Stakeholder notifications, including DMH

4. Media and public information strategies.

(h) Include provisions for a personnel training and opportunities to simulate emergency/disaster response.

(i) Provide for evaluation of disaster planning and emergency response efforts, and incorporate findings and recommendations into the entity's performance improvement processes.

(j) Provide for review and update of the plan as needed, but no less than annually by the Executive Director and Governing Body.

580-9-41
CLIENT PROTECTION

580-9-41.01 CLIENT RIGHTS. The entity shall develop, maintain, and document implementation of written policies and procedures that demonstrate how the organization protects and promotes the client's welfare, the manner in which the client is informed of these protections, and the means by which these protections are enforced, which shall include, at a minimum, the following specifications:

(1) The entity's policies and procedures governing the rights of clients shall adhere to all applicable federal, state, and local laws and regulations.

(2) The entity shall be able to document and demonstrate through implementation of its policies and procedures that, at a minimum, each client has the following rights:

(a) To considerate, respectful, humane, adequate, and appropriate care from all employees of the agency, at all times, under all circumstances.

(b) To receive accurate, easily understood information at all times during every aspect of service delivery.

(c) The option to give or withhold informed consent:

1. Prior to the provision service delivery by the entity.

2. Prior to participation in research projects.

(d) To receive a copy of any informed consents authorized.

(e) To be informed of the person who has primary responsibility for the client's care.

(f) To participate fully in all decisions related to treatment and care provided by the entity.

(g) To be provided with information to facilitate decision making regarding treatment.

(h) To the provision of services in a manner that is responsive to and respectful of the client's unique characteristics, needs and abilities.

(i) To the development of a unique service plan formulated in partnership with the program's staff, and to receive services based upon that plan.

(j) To the availability of an adequate number of competent, qualified, and experienced professional clinical staff to insure appropriate implementation of the client's service plan.

(k) To the provision of care as according accepted clinical practice standards within the least restrictive and most accommodating environment possible.

(l) To be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services, and/or providers.

(m) To express preferences regarding choice of service provider(s).

(n) Service delivery that is absent of:

1. Physical abuse;

2. Sexual abuse;

3. Harassment;

4. Physical punishment;

5. Psychological abuse, including humiliation;

6. Threats;

7. Exploitation;

8. Coercion; and

9. Fiduciary abuse.

(o) To report without fear or retribution, any instances of perceived abuse, neglect, or exploitation.

(p) To choose and designate a personal advocate who can speak for or on behalf of the client, and who is protected from fear of retaliation, retribution, or coercion in the exercise of advocacy.

(q) To use a grievance and appeal process for dispute resolution.

(r) To provide input into the entity's service delivery processes through client satisfaction surveys and other avenues provided by the governing body.

(s) To be informed of all fees associated with treatment for which payment will be due from the client, and the consequences of nonpayment of required fees.

(t) To receive services in a safe and humane environment.

(u) To privacy, both inside and outside the program setting.

(v) To be informed of any potential restriction of right that may be imposed.

(w) To be informed of the parameters of confidentiality.

(x) To be informed of all program rules and client responsibilities prior to initiation of care, and the consequences of non-compliance.

(y) To be informed of client rights at the time of admission, both verbally and in writing.

(3) The entity shall develop, maintain, and document implementation of written policies and procedures that:

(a) Describe the mechanisms utilized for implementation and protection of client rights, which shall include at a minimum:

1. Informing the client of his/her rights at the time of admission in a manner understood by the client and as needed throughout the service delivery process.

2. Providing the client with a copy of the rights, in a medium that the client understands, at admission and documenting this process in the client's service record.

3. Prominently posting copies of the rights throughout the facility in which services are provided.

(b) Identify and govern implementation of program rules, which shall:

(1) Be appropriate relative to the population served, and the level of care provided.

(2) Be confined to those rules that are needed to insure order, safety, and promote client and staff wellness.

(3) Not be overly restrictive in their scope or consequence.

(4) Not be applied arbitrarily or capriciously.

(5) Not use involuntary withdrawal of medication or discharge from the program, unless all other means of insuring order, safety, or wellness have been attempted, documented in the service record, and exhausted.

(6) Provide clear guidelines relative to client visitation, telephone use privileges, and receipt of mail.

(7) Govern the use of seclusion and restraint.

(8) Govern any situation resulting in planned or unplanned restriction of client rights that shall include, at a minimum:

(i) Identify personnel authorized to initiate rights restrictions.

(ii) A process for regularly evaluating:

(I) Any restrictions placed on the rights or privileges of persons served.

(II) The purpose or benefit of any type of restriction.

(III) Methods to reinstate restricted or lost privileges and rights.

(iii) Documentation of the restriction entered in the service record and signed by the program director.

(c) Describe the methods by which the client may review his/her clinical record.

(d) Describe use of special equipment, such as two-way mirrors and/or audio - visual equipment, that as a minimum includes a requirement for the client's written informed consent for participation, and specification of:

(i) The mechanism by which audio - visual content will be destroyed; and

(ii) The time parameters in which destruction will take place.

(iii) Govern client participation in any research or study using human subjects, to include at a minimum, the following specifications:

(I) A description of the process utilized by the entity to adhere to all governmental regulations, including, Title 45 CFR (Code of Federal Regulations) Part 46. {1} Institutional Review Boards.

(II) The process utilized to insure adherence to professional ethics.

(III) The process by which the governing body:

I. Is informed of the research or study proposing utilization of the entity's clientele;

II. Grants and provides documentation of authorization of the research or study.

(e) Describe the process utilized to obtain client authorizations for release of confidential, private, or other protected information.

580-9-41.02 ABUSE AND NEGLECT.

(1) The entity shall develop, maintain, and document compliance with policies and procedures to protect each client's right to be free from physical and mental abuse, exploitation, or neglect. At a minimum, these policies and procedures shall:

(a) Affirm and safeguard the rights of each client pursuant to [redacted]

(b) Ensure that prompt action is taken to prevent the potential of further abuse while an investigation is in process.

(c) Provide for an immediate and thorough investigation of all allegations of abuse, exploitation, or neglect by trained, experienced personnel delegated with all necessary authority. The status of all investigations shall be reported to the executive director of the program or his or her designated representative on a continuous basis.

(d) Establish reasonable and appropriate corrective action, including education, training, and disciplinary action for any program-affiliated individual who has been found responsible for abuse, exploitation, or neglect of consumers. All criminal violations shall be reported to the Office of the Attorney General, State of Alabama, or the local district attorney for consideration of further legal action.

(e) Provide training and informational materials on client rights and on the prevention of abuse, exploitation, and neglect for administrators, professionals, direct-care staff, and volunteers. Each new staff member shall demonstrate working knowledge of this information, and training shall be provided on an ongoing basis for all the previously mentioned workers. When possible, clients and family members shall participate in ongoing training.

(2) The entity shall report all cases of suspected client abuse, neglect, and/or exploitation when the alleged perpetrator is an employee, contractor, subcontractor, volunteer, or another client to the SASD Associate Commissioner's office as according to SASD published incident reporting procedures, and to the Alabama Department of Human Resources in accordance with DMH incident reporting procedures, incorporated herein by reference.

(3) All notifications shall be made in accordance with applicable Federal and Alabama State Law.

580-9-41.03 GRIEVANCES, COMPLAINTS, AND APPEALS.

(1) The entity shall document implementation of written policies and procedures by which a person served may make a formal complaint, file a grievance, or appeal a decision made by the organization's staff members or team that, at a minimum:

(a) Specify that actions taken to file a complaint, grievance, or appeal will not result in retaliation or barriers to service.

(b) Identify program personnel with whom the grievance, complaint, or appeal may be initiated.

(c) Insure easy client accessibility to the grievance/complaint, and appeal process, including allowing the process to be initiated verbally or in writing.

(d) Describe each step of the grievance/complaint/appeal process, including:

1. Staff and client responsibilities.

2. The role of third parties, including advocates, in dispute resolution.

3. Procedures for review and investigation, including participation by external parties.

4. Time frames that are adequate for prompt consideration and that result in timely decisions for the person served.

5. Procedures to provide both verbal and written notification to the client regarding actions taken to address the grievance/complaint/appeal.

(2) Clients shall be provided a copy of the entity's grievance/complaint/appeal procedures at admission and the procedures shall be posted throughout the facility in which services are provided.

(3) The entity shall document implementation of procedures to explain the grievance/complaint/appeal process in a manner that is understandable to the client.

(4) The entity shall maintain a written log of all grievances, complaints, and appeals filed, including the date initiated and the date resolved.

(5) The governing authority shall annually review, update as appropriate, and approve the entity's grievance, complaint, and appeal process.

580-9-41.04 MANAGEMENT OF CLIENT FUNDS

(1) If the entity assumes control of funds belonging to the persons served, there shall be documentation of implementation of written policies and procedures that address:

(a) Delineation of responsibility for receipt and management of client funds.

(b) Accountability of client funds, including:

1. Procedures documenting receipt of client funds from the client or the client's authorized representative.

2. Specific identity of each client's funds in the entity's accounting system, including all receipts and disbursements.

3. Client accessibility to his/her funds and to records of receipt and expenditure.

4. Investment strategies utilized for client funds.

(i) Client funds shall be invested only with the written consent of the person served or his/her authorized representative.

(ii) If funds are invested, the interest earned shall accrue to the person served.

(2) Clients shall not be forced, as a condition of participation in treatment or care, to relinquish custody and control of their funds to the entity.

(3) The entity shall provide written documentation that client funds are used only for the purposes for which those funds were received.

580-9-41.05 CONFIDENTIALITY AND PRIVACY: The entity shall develop, maintain, and document implementation of written policies and procedures that govern confidentiality and privacy of client information that include, at a minimum, the following specifications:

(1) Policies and procedures shall comply with all state and federal laws and regulations relative to confidentiality and privacy of client information, including but not limited to, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164, and shall address:

(a) Protected Information, including, but not limited to:

1. Onsite and offsite correspondence.

2. Telephone correspondence.

3. Face-to-face correspondence other than by telephone.

4. Written correspondence.

5. The provision of any other information that would disclose the identity of an individual as an alcohol or drug abuse client.

6. The provision of identifiable health information, including medical record numbers.

(b) Disclosure of client information with the client's consent.

(c) Revocation of authorized information releases.

(d) Authorized information releases.

1. Disclosures with the client's consent shall be authorized in writing, in a manner understood by the client, and shall include, at a minimum:

(i) The name of the client for whom the information will be disclosed.

(ii) The name of the program making the disclosure.

(iii) The purpose of the disclosure.

(iv) The identity of the person or organization that will be the recipient of the disclosed information.

(v) A description of exactly what is information will be disclosed.

(vi) A statement that the client may revoke the consent to release information at any time, except to the extent the program has already acted in reliance upon the consent.

(vii) A statement that the revocation may be oral as well as written.

(viii) The date, event, or condition upon which the consent for release of information will expire, not to exceed one year from the date of its execution.

(ix) Notification to the information recipient prohibiting re-disclosure.

(x) The signature of the client or the signature of the person who is legally authorized to sign the release.

(xi) The name and signature of the staff member witnessing the client's signature.

(xii) The date the consent form is signed.

(e) Disclosure of protected information without the client's consent.

(f) Re-disclosure of protected information.

(g) The entity's response to:

1. Subpoenas.

2 Court Orders.

3 Search Warrants.

4. Arrest Warrants

4. Deceased client disclosures.

(h) Electronic health information and records.

(2) The entity shall:

(a) Document implementation of the process in which clients are notified of their rights to confidentiality and privacy. At a minimum, notice must:

1. Be given at first delivery of service.

2. Inform the client of the Federal law and regulations that protect alcohol and drug abuse patient records.

3. Describe limited circumstances of disclosure.

4. State that violation of the law and regulations is a crime.
5. State that the client's commission of a crime on the premises or against program personnel is not protected.

6. State that suspected child abuse or neglect may be reported.

7. Provide citations to the applicable Federal law and regulations.

8. Be provided in writing and orally in a manner understood by the client.

(b) Identify program personnel authorized to disclose protected client information.

(c) Specify procedures for documenting all disclosures of protected information in the client record.

(d) Specify procedures utilized to give clients access to their records and to insure protection of the information disclosed.

(3) The entity shall not release confidential information in a client's record that pertains to other clients.

(4) **ADOLESCENT SPECIFIC CRITERIA.** When a minor, age 14 through age 18, is treated for a substance related disorder, with or without parental consent, the entity shall document implementation of the following rules relative to disclosure of protected client information:

(a) The minor's signature alone on the release of information shall authorize a disclosure of that information; and

(b) Any disclosure of information to the minor's parents or guardian shall require a signed authorization to release the information by the minor.

580-9-41.06 SECLUSION AND RESTRAINT.

(1) The governing body shall establish and communicate, throughout its organizational structure and practice, a philosophy on the use of seclusion and restraint for behavior management that demonstrates a commitment to:

(a) Prevent, reduce, and strive to eliminate restraint and seclusion.

(b) Prevention of the occurrence of events that have the potential to lead to use of restraint or seclusion.

(c) Restrict the use seclusion or restraint to emergency circumstances in which there is an imminent risk of harm or danger to a client, a staff member, or others.

(d) Discontinue an episode of restraint or seclusion at the earliest possible time.

(e) Raise awareness among the entity's staff about the potential physiological and psychological impact of restraint or seclusion on clients' wellbeing.

(f) Preserve the client's rights to safety and dignity when restraint or seclusion is used.

(2) An entity may prohibit by policy and practice the use of behavior management interventions that include physical restraint, chemical restraint, mechanical restraint, seclusion, time out, or the use of behavior management plans.

(a) Entities prohibiting the use of restraint interventions shall specify such through its policies, procedures, and demonstrated practices, including but not limited to:

1. During the client intake process in which the client and significant others are informed of the program's rules.

2. In the entity's published statement of client rights.

3. In client rule handbooks.

4. In personnel policies and procedures.

(b) If seclusion and restraint for behavior management are used during the process of service delivery, the entity shall:

1. Obtain a separate written authorization from the DMH-SASD, as according to published guidelines, in addition to other requirements of this rule. The department may issue such authorization on a time limited basis subject to renewal.

2. Prohibit by policy and practice:

(i) Aversive conditioning of any kind.

(ii) Withholding of food, water, or bathroom privileges.

(iii) Painful stimuli.

(iv) Corporal punishment.

3. Establish written policies and procedures governing the use of such techniques.

(c) An entity utilizing seclusion or restraint interventions, within any level of care, shall develop, maintain, and document compliance with written policies and procedures that define, describe, and limit the conditions and circumstances of its use, which shall include, at a minimum, the following specifications:

1. **GENERAL PROCEDURES:** Seclusion and restraint shall be performed in a manner that is:

(i) Safe.

(ii) Appropriate and responsive to the client's:

(I) Age.

(II) Gender.

(III) Ethnicity.

(IV) Known disorders, including physical, medical, and psychiatric disorders.

(V) Speech, language, and hearing needs.

(VI) Personal history, including any history of physical or sexual abuse.

(iii) Time limited.

(iv) Employed only by personnel who have been properly trained and who have demonstrated competence in the proper use of and alternatives to these procedures.

2. **PROTECTION OF CLIENT RIGHTS**. Any behavior management methods used by an organization shall promote the rights, dignity and safety of individuals served.

(i) Clients shall be informed of the right to be free from physical or mental abuse, corporal punishment, and any restraints or

involuntary seclusions imposed for purposes of discipline or convenience, as according to rule . . .

(ii) The client and/or the client's significant others shall be informed orally and provided written information during the intake process that describes:

(I) The entity's philosophy on restraint and seclusion, to the extent that such information is not clinically contraindicated.

(II) The role of significant others relative to seclusion and restraint, including notification of an emergency situation requiring the use of seclusion or restraint, consistent with the client's right to confidentiality and privacy.

(III) Notifications to be made to family or others upon initiation of an episode of seclusion or restraint.

(iii) Individuals in seclusion or restraint shall be offered regular food, fluid and an opportunity to meet their personal hygiene needs no less than every hour.

(iv) Rooms in which seclusion are used shall be clean, neat, free of hazardous conditions, adequately ventilated (with heat or cooling as appropriate), adequately and appropriately lighted, reasonably spacious, and appropriately painted. All areas of the seclusion room must be visible by staff for monitoring.

3. **LIMITATIONS OF USE.** Seclusion and restraint shall only be used when an individual's behavior presents an immediate risk of danger to themselves or others, and no other safe or effective treatment intervention is possible or when alternative, less restrictive interventions have failed or cannot be safely implemented. It shall not be used:

(i) For the convenience of staff.

(ii) As a treatment intervention.

(iii) As a form of discipline or punishment.

(iv) As a substitute for less restrictive alternatives.

(v) As a substitute for adequate staffing.

(vi) As a substitute for staff training in positive behavior supports and crisis prevention and intervention.

4. **RISK ASSESSMENT**. The entity shall obtain information during each client's intake assessment process, and throughout the service delivery process, to assist in development of strategies aimed at minimizing the use of restraint or seclusion, including:

(i) Identification of individuals who are who are at risk of harm to themselves or to others.

(ii) Method, techniques, or other tools that could help the client control with behavior management.

(iii) Identification of pre-existing medical conditions or any physical disabilities and limitation that would place the client at greater risk during restraint or seclusion.

(iv) Identification of any history of sexual or physical abuse that would place the client at greater psychological risk during restraint or seclusion.

(v) The family's help in identifying such techniques.

5. **ORDERS FOR SECLUSION OR RESTRAINT:** The entity shall describe the timeframe and process utilized to obtain orders for initiation, management, and continuation of seclusion or restraint.

(i) Seclusion or restraint shall only be initiated and continued pursuant to an order initiated by an Alabama Licensed Independent Practitioner authorized by the governing authority to serve its clientele.

(ii) Procedures employed by the entity to address an emergency need seclusion or restraint when an authorized Alabama Licensed Independent Practitioner is not available to provide a valid order for such shall be described.

(iii) Orders for restraint or seclusion shall not be written as standing orders or on an as needed basis (PRN).

(iv) Orders for seclusion or restraint must define specific time limits. Seclusion and restraint shall be ended at the earliest possible time and not exceed a maximum duration of six (6) hours.

6. **MONITORING CLIENTS IN RESTRAINT OR SECLUSION:** The entity shall describe the time frames and process utilized to monitor and revaluate an individual for which an initial order for seclusion or restrain has been obtained.

(i) Individuals in restraint shall be monitored continuously. Monitoring may be face-to-face by assigned staff or by audiovisual equipment.

(ii) Individuals in seclusion shall be visually monitored at least every fifteen (15) minutes.

(iii) Individuals shall be reevaluated to determine their state of physical and psychological well-being, and the need for continuation of seclusion or restraint. This reevaluation shall take place within thirty (30) minutes of the initial order and, thereafter, in no less than thirty (30) minute increments.

(iv) The entity's monitoring activities shall include, but shall not be limited to:

(I) Taking and recording vital signs and interpreting their relevance to the physical safety of the client in restraint or seclusion.

(II) Recognizing nutritional and hydration needs.

(III) Checking circulation and range of motion in the extremities.

(IV) Addressing hygiene and elimination.

(V) Addressing the physical and psychological status and comfort.

(VI) Helping clients meet behavior criteria for discontinuing restraint or seclusion.

(VII) Recognizing readiness for discontinuing restraint and seclusion.

(VIII) Recognizing signs of any incorrect application of restraints.

(IX) Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the youth's physical status.

7. **DEBRIEFING:** Within a maximum of twenty four (24) hours after the use of seclusion or restraint, the entity shall engage the client and, as appropriate the client's significant others, along with involved staff in a review session about the restraint or seclusion episode.

(i) Debriefing after an episode of seclusion or restraint shall:

(I) Identify what precipitated the behavior that required the emergency intervention.

(II) Identify what could have been handled differently.

(III) Ascertain that the client's physical well-being, psychological comfort, and right to privacy were addressed.

(IV) Provide for counseling to address any trauma that may have resulted from the incident.

(V) Ascertain the need for follow-up action.

(VI) Identify and need for modification of the client's service plan.

(ii) The entity shall establish a process to document findings from the debriefing process for utilization in performance improvement activities.

8. **INDIVIDUALIZED BEHAVIORAL MANAGEMENT PLAN**: The entity shall establish a process for determining the need for implementation of a client behavioral management plan.

(i) The need for a behavioral management plan shall be evaluated, based upon:

(I) Any incident of seclusion or restraint.

(II) The use of time-out two (2) or more times per day.

(III) The use of time-out three (3) or more times per week.

(IV) At the request of the client.

(V) The results of debriefing session.

(ii) The behavioral management plan shall include the input of the client and the client's significant others, if appropriate.

(iii) The plan shall:

(I) Identify objectives the individual is attempting to communicate or achieve through maladaptive behavior, before identifying interventions to change it.

(II) Identify relevant strategies for addressing the maladaptive behavior.

(iii) Be reevaluated within the first seven (7) calendar days of its development, and every seven (7) calendar days thereafter to determine whether maladaptive and unacceptable behaviors are being reduced and more functional alternatives acquired.

9. **STAFF:** The entity shall describe the process for staff selection, training, and utilization in implementation of seclusion and restraint interventions for behavioral management.

(i) Staff qualifications, the physical design of the facility, the age, gender, diagnoses, and developmental and acuity levels of the clients shall be the basis for the entity's staffing plan.

(ii) Staffing levels and assignments shall be adequate to minimize circumstances leading to the use of restraint or seclusion, and to maximize safety when these interventions are used.

(iii) All staff shall be provided education and information that describes the entity's philosophy and related practices relative to the use of seclusion and restraint.

(iv) Prior to using seclusion or restraint interventions with clients, all personnel whose job responsibilities include participation in the implementation of seclusion or restraint interventions shall receive training in and demonstrate an understanding of the following subject matter:

(I) Types of seclusion.

(II) Types of restraint.

(III) Instruction in the use of seclusion and restraint.

(IV) Identification of events, environmental factors, and client behaviors that may trigger emergency safety situations.

(V) Description and identification of dangerous behaviors.

(VI) Methods for evaluating the risk of harm to determine whether the use of seclusion or restraint is warranted.

(VII) Proactive practices and strategies that ensure the dignity of the entities clientele.

(VIII) Conflict resolution.

(IX) De-escalation techniques.

(X) Positive behavior support strategies.

(XI) Related safety considerations, including:

I. Increased risk of injury to clients and staff when seclusion or restraint is used.

II. The risks of using seclusion and restraint in consideration of a client's known or unknown medical or psychological limitations.

III. Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a client reacts to physical contact.

IV. How to monitor the physical signs of distress.

V. How to obtain medical assistance.

(XII) The effects of seclusion and restraint on all clients.

(XIII) Using behavior criteria for discontinuing restraint or seclusion and how to help clients meet these criteria.

(XIV) The entity's policies and procedures relative to the use of seclusion and restraint.

(v) Staff authorized to physically apply restraint or seclusion shall receive annual training in and demonstrate competence in the safe use of restraint, including physical holding techniques and take-down procedures.

(vi) Prior to attaining authorization to monitor and evaluate clients placed in seclusion or restraint, staff with this designated responsibility shall demonstrate competence in the following areas:

(I) Taking and recording vital signs and interpreting their relevance to the physical safety of the youth in restraint or seclusion.

(II) Recognizing nutritional and hydration needs.

(III) Checking circulation and range of motion in the extremities.

(IV) Addressing hygiene and elimination.

(V) Addressing the physical and psychological status and comfort.

(VI) Helping clients meet behavior criteria for discontinuing restraint or seclusion.

(VII) Recognizing readiness for discontinuing restraint and seclusion.

(VIII) Recognizing signs of any incorrect application of restraints.

(IX) Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the youth's physical status.

10. **DOCUMENTATION:** Documentation supporting the use of restraint or seclusion should be consistent with these Rules and the entity's established policies and procedures.

(i) Each element of each episode of seclusion or restraint shall be recorded in the client record by the appropriate personnel.

(ii) Written documentation of use of seclusion or restraint shall include, at a minimum, the following information:

(I) Circumstances that led to implementation.

(II) Consideration or failure of less-restrictive interventions.

(III) The rationale for the type of intervention selected.

(IV) Notifications made consistent with organizational policy and agreed by the client and the client's significant others.

(V) Behavior criteria for discontinuation of restraint or seclusion.

(VI) The process of informing the client of behavior criteria for discontinuation of restraint or seclusion.

(VII) Each written and/or verbal order received from a licensed independent practitioner.

(VIII) Each evaluation and reevaluation of the individual.

(IX) Fifteen (15) minute assessments of the individual's status.

(X) Assistance provided to help the client meet the behavior criteria for discontinuation of restraint or seclusion.

(XI) Findings from continuous monitoring.

(XII) Staffing of the individual with staff.

(XIII) The debriefing process.

(XIV) Service plan modifications.

(XV) Any injuries that are sustained and treatment received for these injuries or death.

(XVI) Incident reporting as according to [redacted]

(iii) Documentation of each seclusion and restraint episode shall be completed in a manner that allows for data collection and analysis to support performance improvement activities.

11. **DATA COLLECTION**: The entity shall establish a process for the collection of data on the implementation of restraint or seclusion interventions. Data shall be used to:

(i) Monitor and improve the entity's performance of processes that involve risks or may result in special incidents.

(ii) Ascertain that restraint and seclusion are used only as emergency interventions>

(iii) Identify opportunities for incrementally reducing the rate and increasing the safety of restraint and seclusion use.

(iv) Identify any need to redesign care processes.

580-9-41.07 INCIDENT REPORTING: The entity shall develop, maintain, and document compliance with written policies and procedures to promptly address the occurrence of any serious event that has the potential to adversely impact the health, safety, and wellbeing of any client, employee, volunteer, or visitors at any location in which the entity provides services.

(a) A formal process shall be established to govern the entity's response to the following events, at a minimum, in the course of service delivery:

1. Actual or perceived abuse, including but not limited to:

(i) Physical abuse.

(ii) Mental or emotional abuse.

(iii) Sexual abuse.

(iv) Neglect.

(v) Exploitation.

(vi) Mistreatment.

(vii) Verbal abuse.

2. Assault

3. Confidentiality or Privacy Breach

4. Death

5. Client Elopement

6. Evacuation/Relocation

7. Injury

8. Legal/Criminal Activity

9. Serious Illness

10. Media Events

11. Medication Errors.

12. Non-Consensual Sexual Contact.

13. Property Destruction.

14. Quarantine

15. Suicide Attempt.

16. Any other events that adversely affect, or has the potential to be harmful or hazardous to the health, safety, or well being of a client, employee, volunteer, or others who are onsite at a provider location for any reason, and does not fall into one of the categories listed above.

(b) Policies and procedures governing the entity's response to the occurrence of a critical incident shall include, at a minimum:

1. Staff responsibilities relative to reporting critical incidents.

2. The process used to document the occurrence of a critical incident.

3. Timeframes for initial and subsequent response by the entity's executive and clinical leadership staff to the occurrence of a critical incident and to the need, as appropriate, to ensure the safety of the parties involved.

4. The process used to investigate the circumstances surrounding a critical incident and to take appropriate action bring resolution to the event.

5. Timely and appropriate review of critical incident reports by the organization's governing body, along with, its executive and clinical leadership staffs.

6. Incorporation of critical incident report data into the entity's performance improvement processes.

(c) The entity shall comply with the incident reporting requirements of DMH.

580-9-41.06 INFECTION CONTROL: The entity shall develop, maintain, and document compliance with a written plan for exposure control relative to infectious diseases that shall, at a minimum, include the following requirements:

(1) The plan shall be inclusive of the entity's staff, clients, and volunteers.

(2) The plan shall be consistent with protocols and guidelines established for infection control in healthcare settings by the Federal Center for Disease Control, and shall at a minimum include:

(i) Policies and procedures to mitigate the potential for transmission and spread of infectious diseases within the agency.

(ii) Risk assessment and screening of clients reporting high risk behavior and symptoms of communicable disease.

(iii) Procedures to be followed for clients known to have an infectious disease.

(iv) Provisions to offer and provide to all clients who voluntarily accept the offer for HIV/AIDS early intervention services to include, HIV pre-test and post-test counseling and case management and referral services, as needed, for medical care.

(v) The provision of HIV/AIDS, Hepatitis, STD, and TB education for all program admissions.

(vi) TB testing for all program admissions.

(vii) Annual TB testing for all employees and volunteers.

(viii) Annual employee education in regard to universal precautions and communicable diseases.

(ix) The entity shall document compliance with all laws and regulations regarding reporting of communicable diseases to the Alabama Department of Public Health.

580-9-41.08 THERAPEUTIC ENVIRONMENT: Each facility, designated by an entity as the site of service delivery for an identified level of care, shall provide a physical environment that is accessible, clean, safe, and augments the therapeutic process of recovery.

(1) Each facility shall maintain onsite documentation of compliance with:

(a) Alabama Administrative Code Regulations 580-3-22.

(b) All federal, state, and local building, fire, and safety regulations, codes, and statutory requirements.

(c) Each facility shall:

1. Be selected, constructed, modified and/or maintained so that the services offered, therein, are accessible to persons with disabilities in compliance with the Federal Americans with Disabilities Act and all applicable state and local laws and regulations.

2. Obtain an annual fire and safety inspection conducted by the state fire marshal or local fire authority.

(i) A copy of the fire and safety inspection report shall be maintained on the premises, along with any subsequent correspondence regarding deficiencies.

(ii) Documentation of actions taken to comply with identified fire and safety deficiencies shall be maintained on the premises.

3. Include a sufficient number of properly cleaned, maintained, and supplied restrooms to accommodate clients, staff, and other users of the building.

(d) Each program's physical environment shall be appropriate for and reflective of the age and culture of the target population.

(e) Each facility shall have sufficient and separate space for administrative functions that shall include, at a minimum:

1. An appropriately furnished waiting area near the program's entrance.

2. Sufficient office space for the entity's administrative staff.

3. Secure space for financial and client record storage.

(f) All program service areas shall be adequate in size and design, appropriately furnished and equipped, and sufficiently maintained so as to safeguard client dignity, self esteem, confidentiality, and privacy, and shall include, at a minimum:

1. An appropriately furnished sitting area for clients who are awaiting services that provides confidentiality and privacy protection.

2. Small group counseling rooms in sufficient number to accommodate the number of counseling groups needed simultaneously, as evident by the entity's program description and service capacity. Each small group counseling room shall:

   (i) Provide at least fifteen (15) square feet per person expected to participate, but not less than a total of one-hundred (100) square feet.

   (ii) Be constructed or provide an alternate mechanism to prevent sound transmission outside of the room.

   (iii) Be properly heated and ventilated.

3. Individual counseling rooms, if staff offices are not suitable or sufficient for this use.

4. At least one large group meeting for purposes such as, but not limited to, education groups, staff meetings, community meetings, and self-help group meetings.

5. Sufficient space for recreation, reading, and quiet time, as appropriate to the level of care.

(g) When provided, bedrooms or other sleeping areas shall:

1. Be separated by gender.

2. Provide enough space to reasonably provide clean and comfortable accommodations.

3. Provide an individual bed for each client that is:

(i) In good repair.

(ii) Free of odors.

(iii) Free of stains.

(iv) Free of infestation.

(v) Has a supportive mattress.

(vi) Equipped with clean bedding, pillows, sheets, bedspreads, and blankets, in good repair.

(vii) Include adequate drawer and closet space for storage of each client's belongings.

580-9-42
OPERATIONAL PROCEDURES

580-9-42.01 PROGRAM DESCRIPTION. All entities will develop, maintain current, and document implementation of a written program description that describes the people, processes, policies, and procedures utilized in the delivery of early intervention, treatment, and recovery support services for individuals with substance use disorders. The Program Description shall be so designated in the entity's Policies and Procedures Manual, and shall specifically address, but not be limited to the following specifications:

(1) A program description shall be maintained for each level of care provided by the entity and shall specify the name, address, FAX number, and email address of the program wherein the level of care is provided.

(2) PROGRAM PHILOSOPHY. The entity shall develop and maintain written documentation of a science, theological, or other evidence based philosophy that provides the framework around which the agency's programs and services have been developed.

(a) The framework shall reflect knowledge of and incorporate elements that address, at a minimum:

1. The NIDA Principles of Effective Treatment.

2. Principles of a recovery oriented system of care.

3. Principles of integrated services for individuals who have co-occurring mental illness and substance related disorders.

4. The American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders.

5. Gender, age, and cultural specificity.

(b) The entity shall develop and document implementation of written procedures to maintain and disseminate its philosophy, which shall minimally describe:

1. The process utilized to revise and update the program philosophy.

2. The manner in which the philosophy is accessible to those seeking admission, their families, the agency's personnel, and the general public.

(c) The entity's program philosophy shall be reviewed and approved, annually, by the governing body.

(3) GOALS AND OBJECTIVES:

The entity shall establish annual goals and objectives for each level of care that are:

(a) Reflective of the entity's service philosophy.

(b) Representative of the needs of the target population.

(c) Formally reviewed and evaluated annually.

(4) ACCESSIBILITY:

(a) Each entity shall provide documentation of the processes utilized to make the following information known to the public:

1. The address and directions to the program.

2. The hours of operation.

3. Telephone numbers for information, access to care, and emergencies.

4. The levels of care and services provided directly by the entity and those by affiliated subcontractors.

5. The criteria for admission to the program.

6. Referral services provided.

7. Fees required for services.

(b) Each entity shall provide written documentation and evidence of implementation of policies and procedures that seek to establish a welcoming, accessible, culturally competent system of care for all, including individuals who are at high risk for poorer outcomes if not successfully welcomed and engaged in care. At a minimum, the entity shall:

1. Incorporate a "welcoming policy" into the entity's philosophy and mission statement, and demonstrate implementation of this policy through staff training, business and clinical practice, and performance improvement efforts.

2. Establish policies governing, and the processes utilized to ensure access to care for individuals with co-occurring mental illness and substance use disorders; and

3. Describe the procedures utilized to publicize the organization's co-occurring capabilities.

4. Establish policies governing, and the processes utilized to ensure access to care for individuals with disabilities, speech, language, and/or hearing impairments; and

5. The procedures utilized to publicize the organization's capabilities for addressing these impairments.

6. Entities serving women shall develop, maintain, and document implementation of written policies and procedures to:

   (i) Ensure priority access to services for pregnant women; and to

   (ii) Make this information known to the public.

(c) Marketing and promotional material distributed by or on behalf of each entity shall accurately portray the scope of services provided.

(5) PRE-SCREENING. All entities seeking to have an individual admitted to a DMH certified program for early intervention, treatment, or recovery support services shall develop, maintain, and document implementation of written policies and procedures for a pre-screening process that at a minimum:

(a) Identify the staff positions authorized to conduct the pre-screenings.

(b) Specify when and where the pre-screening process may take place.

(c) Specify the instruments utilized to conduct the pre-screening process.

(d) Describe the procedures followed when the pre-screening process:

1. Identifies risk factors for a substance related disorder.

2. Does not identify risk factors for a substance related disorder.

3. Identifies the need for crisis intervention.

(e) Specify the procedures for documenting the pre-screening process.

(f) The entity shall document that the results of the pre-screening are clearly explained to the client and to the client's family when appropriate.

(g) The entity shall submit pre-screening data to the DMH management information system, ASAIS, as according to reporting standards established and published by DMH.

(6) PLACEMENT ASSESSMENT.

(a) All entities seeking to have a client admitted to a DMH certified facility for early intervention, treatment, or recovery support services shall develop, maintain, and document implementation of written policies and procedures to:

1. Conduct, or receive from another entity, a written assessment of each client's functioning in the six (6) ASAM dimensions which shall:

(i) Describe the process for scheduling placement assessments and how this information is publicized.

(ii) Identify the tools utilized to formulate the placement assessment, which shall include at a minimum the DMH authorized uniform assessment instrument.

(iii) Identify the staff positions authorized to conduct placement assessments.

(iv) Describe the procedures for addressing requests by other organizations to conduct placement assessments.

(v) Describe the process for receipt and utilization of placement assessments from external organizations;

2. Develop a level of care recommendation based upon the placement assessment, which shall describe:

(a) The process for determining the appropriate level of care.

(b) The role of the client and significant others in this process.

3. Initiate service delivery, including referral, as appropriate, based upon the client's level of care recommendation, which shall identify the procedures followed when the placement assessment:

(a) Identifies the need for an available level of care.

(b) Identifies the need for an unavailable level of care.

(c) Identifies the need for crisis intervention.

(d) Does not identify a need for an ASAM level of care.

4. The entity shall document that the results of the placement assessment are clearly explained to the client and to the client's family when appropriate.

5. The entity shall develop, maintain, and document implementation of policies and procedures to ensure completion of referrals resulting from the placement assessment, regardless of the outcome of the assessment.

6. The entity shall submit placement assessment data to the DMH management information system, ASAIS, as according to reporting standards established and published by DMH.

(7) **LEVELS OF CARE DESIGNATION**. Each entity shall specifically name and describe in policy each level of care provided. A charter, articles of incorporation, bylaws, or other legal source of authority shall document the authorization of each entity seeking certification by DMH to operate one or more of the following levels of care:

(a) Level 0.5: Early Intervention Services, consisting of:

1. Early Intervention Services for Adults.

2. Early Intervention Services for Adolescents.

3. Early Intervention Services for Pregnant Women and Women with Dependent Children.

4. Early Intervention Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

(b) Level 1: Outpatient Treatment, consisting of:

1. Outpatient Services for Adults.

2. Outpatient Services for Adolescents.

3. Outpatient Services for Pregnant Women and Women with Dependent Children.

4. Outpatient Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

5. Ambulatory Detoxification Without Extended on-site Monitoring.

6. Opioid Maintenance Therapy Program.

(c) Level 2: Intensive Outpatient Services/Partial Hospital Treatment, consisting of:

1. Intensive Outpatient Services for Adults.

2. Intensive Outpatient Services for Adolescents.

3. Intensive Outpatient Services for Pregnant Women and Women with Dependent Children.

4. Intensive Outpatient Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

5. Partial Hospital Program for Adults.

6. Partial Hospital Program for Adolescents.

7. Partial Hospital Program for Pregnant Women and Women with Dependent Children.

8. Partial Hospital Program for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

9. Ambulatory Detoxification With Extended on-site Monitoring.

(d) Level 3: Residential Treatment Services, consisting of:

1. Transitional Residential Services for Adults.

2. Transitional Residential Services for Adolescents.

3. Clinically Managed Low Intensity Residential Programs for Adults.

4. Clinically Managed Low Intensity Residential Programs for Adolescents.

5. Clinically Managed Low Intensity Residential Programs for Pregnant Women and Women with Dependent Children.

6. Clinically Managed Low Intensity Residential Programs for Person with Co-occurring Substance Use and Mental Illness Disorders.

7. Clinically Managed Medium Intensity Residential Programs for Adults.

8. Clinically Managed Medium Intensity Residential Programs for Adolescents.

9. Clinically Managed Medium Intensity Residential Programs for Pregnant Women and Women with Dependent Children.

10. Clinically Managed Medium Intensity Residential Programs for Person with Co-occurring Substance Use and Mental Illness Disorders.

11. Clinically Managed High Intensity Residential Programs for Adults.

12. Clinically Managed High Intensity Residential Programs for Pregnant Women and Women with Dependent Children.

13. Clinically Managed High Intensity Residential Programs for Person with Co-occurring Substance Use and Mental Illness Disorders.

14. Medically Monitored Intensive Residential Programs for Adults.

15. Medically Monitored Intensive Residential Programs for Pregnant Women and Women with Dependent Children.

16. Medically Monitored Intensive Residential Programs for Person with Co-occurring Substance Use and Mental Illness Disorders.

17. Medically Monitored High Intensity Residential Programs for Adolescents.

18. Medically Monitored Residential Detoxification Program.

(8) ADMISSION CRITERIA. Each entity shall develop, maintain, and document compliance with written criteria that shall govern admission to each, respective, level of care provided by the organization. The criteria shall, at a minimum:

1. Specify that no person, will be denied admission to the program, beyond the scope of unique service level eligibility criteria, on the basis of sex, race, color, creed, sexual orientation, handicap, or age, in accordance with Title VI of the Civil rights Act of 1964, as amended, 42 USC 2000d, Title XI of the Education Amendments of 1972, 20 USC 1681-1686 and s.504 of the Rehabilitation Act of 1973, as amended 29 USC 794, and the American with Disabilities Act of 1990, as amended, 42 USC 12101-12213.

2. Specify the unique characteristics of the program's target population.

3. Specify the program's maximum capacity.

4. Incorporate the admissions criteria for the respective level of care provided as specified in these rules.

5. Specify that priority access to admission for treatment will be given to the following groups in order of priority:

   (i) Pregnant intravenous substance abusers.

   (ii) Pregnant substance abusers.

   (iii) Intravenous substance abusers.

   (iv) Women with dependent children.

   v. Individuals who are HIV positive;

   vi. All others with substance use disorders.

6. Describe the process utilized for prioritizing admission requests.

7. Specify the criteria for readmission.

8. Describe the process implemented when an individual is found to be ineligible for admission. This process shall include the following procedures, at a minimum:

   (i) A written rationale that objectively states or describes the reasons for service denial shall be provided to clients who have been determined ineligible for admission;

   (ii) A dated record shall be maintained by the agency of those clients who are denied access to care and the reasons for such;

   (iii) The entity shall provide referrals appropriate to the prospective client's needs; and

   (iv) Reassessment shall be allowed when an individual presents for services after a previous denial of admission.

9. Describe the process for clients to appeal an adverse admission decision, which shall include the process in which clients are informed of this right.

(9) EXCLUSIONARY CRITERIA. Each entity shall provide written documentation of criteria used to deny admission or readmission of clients into the program. The entity's criteria and documented practice shall be based upon individual needs identified during a placement assessment in relation to the services offered by the entity

(a) Exclusionary criteria shall not indicate by policy or practice that it has been conceptualized on the basis of social background, client experiences, opportunities, or social consequences.

(b) The entities policies, procedures and practices shall not support admission denials based, exclusively, on:

(i) Age;
(ii) Gender;
(iii) Pregnancy status;
(iv) Educational achievement and literacy;
(v) Household composition;
(vi) Ethnic background;
(vii) Income level and ability to pay (unless private for profit);
(viii) Need for or use of medication assisted therapy;
(ix) Disability;
(x) Existence of a co-occurring mental illness and substance use disorder;
(xi) HIV status.
(xii) Current maintenance on methadone
(xiii) Previous admissions to the program;
(xix) Prior withdrawal from treatment against clinical advice;
(xx) Referral source;
(xxi) Involvement with the criminal justice system; OR
(xxii) Relapse.

(10) INTAKE PROCESS.

(a) Each entity shall develop, maintain, and document implementation of written policies and procedures defining a uniform intake process that:

1. Establishes an intake schedule and procedures for the provision of after hours, emergency, or other special needs intake.

2. Identifies the types of information to be gathered on all individuals upon admission.

3. Specifies the procedures to be followed when accepting referrals from outside agencies or organizations.

4. Specifies the types of records to be kept on all persons applying for admission.

5. Includes a process to obtain medical records from prior service providers when applicable.

6. Provides documentation, at admission, that each client is informed of:

   (i) General scope and goals of the program.

   (ii) Service schedule.

   (iii) Client rights and responsibilities.

   (iv) Confidentiality and privacy, and any limitations thereof.

   (v) Communicable diseases, including sexually transmitted diseases (STDs), Hepatitis, Tuberculosis (TB), and Human immunodeficiency virus (HIV).

   (vi) The program's smoking policies.

   (vii) Rules governing client conduct.

   (viii) Safety and emergency procedures.

7. Documents implementation of an initial assessment process as specified in [redacted].

(b) Each entity shall be able to document that the intake process is sensitive to each client's life circumstances and is accessible during and beyond traditional work hours.

(11) ASSESSMENT.

(a) Each entity shall develop, maintain, and document implementation of written policies and procedures defining a continuous clinical assessment process.

1. The assessment process shall begin during intake with the initial assessment.

(i) The initial assessment shall be conducted by a qualified substance abuse professional with appropriate credentials for conducting assessments.

(ii) The initial assessment shall be conducted as part of the client intake process and shall include, at a minimum:

(I) Establishment of the client's current substance use and withdrawal potential.

(II) Review of the client's ASAM placement assessment.

(iii) Additional ASAM dimensional assessment as needed.

(iv) Assessment of available information regarding other factors that seem to relate to the client's presenting problems.

(v) Development of an initial assessment summary.

(vi) Establishment of a diagnosis or diagnostic impression substantiated by most recent edition of the DSM********

(vii) Development of an initial service plan within twenty-four (24) hours of intake.

(viii) Documents collaboration with the client, and the client's significant others when appropriate, in development of the initial service plan.

2. The assessment process shall continue throughout the course of service delivery and for the purpose of:

(i) Evaluating current client data and historical information, along with presenting issues, relative to the ASAM diagnostic and dimensional criteria;

(ii) Establishing the scope of services needed to address the individual's needs in the least restrictive environment;

(iii) Determining if the care required by the client can be adequately provided in the level of care offered by the program; and

(iv) Assessing and identifying client risk for harm to self or others and arranging the appropriate interventions to establish safety.

(iv) Providing the foundation for treatment planning.

3. The continuing clinical assessment process shall be reflective of each client's presenting needs and may include:

(i) A review of the findings of the client screening and placement assessment;

(ii) A review of the initial assessment;

(iii) Current and historical data relative to the client's alcohol and drug use, including:

(I) Age of onset.

(II) Duration.

(III) Patterns.

(IV) Consequences.

(V) Family usage.

(VI) Types and duration of previous treatment.

(VII) Response to previous treatment.

(iv) Current and historical data relative to client strengths, and needs in the following functional areas:

(I) Physical health.
(II) Medication.
(III) Allergies.
(IV) Nutritional.
(V) Emotional.
(VI) Psychological.

(VII) Psychiatric.
(VIII) Cognitive.
(IX) Crisis intervention.
(X) Family history.
(XI) Current living environment.
(XII) Physical, emotional, sexual, and domestic abuse.
(XIII) Social supports.
(XIV) Legal.
(XV) Financial.
(XVI) Housing.
(XVII) Vocational.
(XVIII) Educational.
(XIX) Leisure and recreational interests.
(XX) Spirituality and religion.
(XXI) Cultural.
(XXII) Transportation.
(XXIII) Military.

3. **ADOLESCENT SPECIFIC CRITERIA.** The assessment process for adolescents shall address criteria , as relevant in [redacted] and shall also include an assessment of:

(i) The family's effect on the child's needs and the effect of those needs on the family;

(ii) Legal custody status, including clear identification of the legal guardian;

(iii) The use of a developmental perspective in evaluating all aspects of functioning, including the child's physical, emotional, cognitive, educational, nutritional and social development;

(iv) Assessment in relation to normative development for chronological age;

(v) The youth's play, recreation and daily activity needs;

(vi) The family history and current living situation;

(vii) The family dynamics and their impact on the youth's current needs;

(viii) Family dynamics that should be considered in discharge planning;

(vix) Environmental issues.

(x) Other client specific that should be addressed in the care, treatment and services process;

(I) When a physical health assessment is done for a youth it shall address:

I. Motor development and functioning;
II. Sensorimotor functioning;

III. Speech, hearing and language functioning;

IV. Visual functioning;

V. Immunization status; and

VI. Oral health and oral hygiene.

4. **CO-OCCURRING DISORDERS SPECIFIC CRITERIA.** The assessment process for individuals who have co-occurring disorders shall address criteria , as relevant in [redacted] and shall also:

(i) Include a chronological history of past mental symptoms, diagnosis, treatment, and impairment, particularly listing that period of time before the onset of substance abuse and during extended periods of abstinence.

(ii) Include a description of current strengths, supports, limitations, skills deficits, and cultural barriers as they affect the individual's (impede or enhance) ability to follow treatment recommendations due to their illness, disorder, or problem.

(iii) Identify and determine disability, and/or functional impairment. level of care.

5. **WOMEN AND DEPENDENT CHILDREN SPECIFIC CRITERIA**

(b) Each entity shall:

1. Identify the clinical tools used to obtain assessment information, and the specific dimensions addressed by each.

2. Specify the extent of client and significant other involvement in the assessment process;

3. Delineate the time frame and/or events which trigger clinical assessment;

(c) Each entity shall document that the assessment process results in:

1. A meeting with each client to discuss the findings of the assessment;

2. An assessment summary that consists of an evaluation of the information and/or data gathered that shall include but not be limited to:

(i) A summary of client problems and corresponding needs in each ASAM dimension;
(ii) A summary of client strengths and weaknesses in each ASAM dimension;
(iii) Client centered and informed recommendations for care to be incorporated into a service plan;
(iv) A primary substance related disorder DSM diagnosis or diagnostic impression, or a dual primary psychiatric and substance related DSM diagnoses.
(v) The signature, date signed, and credentials of the assessor and the client.

(12) INDIVIDUAL SERVICE PLANNING PROCESS. Each entity shall develop, maintain, and document implementation of written policies and procedures defining the client service planning process that shall include, at a minimum, the following components:

(a) An individualized service plan shall be developed for each person admitted to a level of care.

1. The plan shall be developed in partnership with the client and, initially, based upon the client's goals at the time of admission.

2. The client shall be in agreement with the service plan, and able to understand and articulate the plan's goals and strategies.

3. There shall be documentation in the clinical record describing the client's participation in development of the service plan, and the process utilized

to assure the client's understanding and ability to articulate the plan's goals and strategies.

(b) Development of the service plan shall be initiated during the intake process to a level of care.

(c) Primary responsibility for development of the service plan and implementation of the service planning process shall be specified in written policy, and shall identify agency personnel classifications authorized to develop service plans.

(d) The entity shall specify the processes used to ensure that the client:

(i) Will be an active participant in the service planning process;

(ii) Is able to state what he/she wishes to gain from participation in group and individual sessions and other strategies to advance their work on their service plan;

(iii) Is provided the opportunity to involve family members or significant others of his/her choice in formulation, review, and update of the service plan.

(e) The service plan shall:

1. Be formalized as a written document that the client receives, understands, and is in agreement.

2. Include measurable goals and strategies that make sense relative to the client's expressed reason for seeking treatment.

3. Be representative of the client's strengths, needs, abilities, and preferences as identified in the entity's assessment processes.

4. Specify goals and strategies for goal attainment in words understandable to the client.

5. Be developed in collaboration with other professional staff, the client, family and others designated by the client.

6. Be initially developed at time of intake.

7. Utilizes interventions and strategies that the client indicates are acceptable to the client's culture, age, ethnicity, development, and disabilities/disorders.

8. Include specific goals and strategies that address co-occurring mental illness and substance use disorders as indicated by assessed needs and in collaboration with client.

9. Include specific goals and strategies to address medication assisted treatment as indicated by assessed needs and in collaboration with client.

10. Clarify how client and stakeholders are aware of and in agreement with the strategies used to meet the goals.

11. Include a variety of strategies, that are relevant to the clients needs and desired outcomes for treatment that may include but are not limited to:

(i) Intervention, treatment, rehabilitation, recovery support, case management and other therapeutic supports and services;

(ii) Methods, frequency, responsibility for, and duration of, the designated therapeutic interventions and services;

12. Document what services are not provided by the organization and how the client is linked to needed services.

13. Describe the criteria for discharge from the current level of care.

Comment [DML3]: Consider moving into another section

14. Be dated and signed by the client and the entity's employee who has primary responsibility for development of the plan;
15. Be maintained as a working document throughout the client's treatment and/or care process with modifications to the service plan based on client's progress or lack thereof;

16. Be approved in writing by the program director, clinical director, or medical director, as appropriate to the level of care provided.

17. Be provided to the client when initially developed, and at each update and revision.

(f) **Service Plan Revisions.** The entity shall establish and implement written policies and procedures for service plan revisions

1. Service plan revisions for each client shall be:

   (i) Initiated at regular intervals in accordance with the client's severity and level of function, progress or lack of progress, and the intensity of services in the level of care. This may be achieved through the following processes:

      (I) The program's continued stay review process;

      (II) The program's staffing process;

      (III) At the request of the client.

      (IV) In response to the continuous assessment of the changing needs of the client.

   (ii) Developed in collaboration with other professional staff, the client, family and others designated by the client.

   (iii) Approved in writing by the program director, clinical director, or medical director.

2. A copy of the revised service plan shall be provided to the client.

??? ??Specify how the supervisory review will focus on how clients with declining progress will have service plans modified to reflect a more desired outcome.

(13) STAFFING. The entity shall document implementation of a process to conduct client case staffings at periodic intervals, dependent upon the client's current level of care.

(a) Staffing shall include the following elements, at a minimum:

1. Facilitation by the client's primary counselor and/or clinical director.

2. Participation by the client's treatment team, including, to the extent possible, consultants and the source of the client's referral, when the referral source is an agency.

3. Participation by the client and collaterals designated by the client.

4. Assessment, review and discussion of the client's progress or lack of progress relative to service plan goals, strategies, modifications, or level of care.

5. Discussion and recommendations for service plan modifications.

6. Discussion and recommendations for the client's continued stay, transfer, or discharge.

(b) A written report of the case staffing shall be developed by the client's primary counselor, discussed with the client and filed in the client's record as required in [redacted].

(14) SERVICE DELIVERY. The entity shall develop and describe in writing an organized process for service delivery within each respective level of care provided, which shall include:

(a) A description of the how the entity will meet the minimum service requirements for the specific level of care provided as specified in these rules, including:

1. A description of the capacity and availability of a variety of scheduled and unscheduled diagnostic, educational, intervention, treatment, and/or recovery support services as appropriate for each respective level of care provided.

2. Identification and description of each core and optional service provided within the respective level of care.

3. Service schedule, including days of the week and hours of operation.

4. Client attendance and participation requirements.

5. A description of staff coverage, including delineation of administrative and clinical supervisory responsibility, for each day of the week during which services are provided and/or clients are housed, including weekends and holidays.

(b) The entity shall document the availability of an adequate number of qualified personnel, as according to specifications published by DMH, to insure consistent, quality service delivery within each level of care provided.

(c) Client records shall document that participation in any service is based upon a documented need identified in the clinical assessment process.

(d) Family and Collateral Care

(e) Subcontracted Services

(15) CONTINUING STAY CRITERIA. The entity shall develop, maintain, and document implementation of written policies and procedures governing continuing stay for each level of care provided. At a minimum, these policies and procedures shall:

(a) Provide for a continuous process of clinical assessment of each ASAM dimension to determine each client's need for continued services at the current level of care.

(b) Delineate the roles of all persons participating in the continuing care assessment and decision making process.

(c) Include the client and others designated by the client as active participants in the continuing care assessment and decision making process.

(d) Establish criteria for continued stay that shall address the following areas, at a minimum:

1. The client is making progress, but has not yet achieved the goal(s) articulated in the individualized service plan. Continued treatment at the current level of care has been assessed as necessary to permit the client to continue to work toward the established goals.

2. The client is not yet making progress, but has the capacity to resolve identified problem(s). The client is actively working toward goal(s) articulated in individualized service plan. Continued treatment at this level of care has been assessed as necessary to permit the client to continue to work toward goals.

3. New problems have been identified that are appropriate for service delivery at this level of care. This level is the least intensive at which the client's new problem(s) may be addressed effectively.

(16) TRANSFER. The entity shall develop, maintain, and document implementation of written policies and procedures governing a process for client transfer from one level of care to another that shall, at a minimum:

(a) Provide for continuous clinical assessment of each ASAM dimension to determine each client's need for transfer from the current level of care.

1. Delineate the roles of all persons participating in the transfer consideration assessment and decision making process.

2. Include the client and others designated by the client as active participants in the transfer consideration assessment and decision making process.

3. Establish procedures to notify the client's referral source of a change of the client's status in accordance with privacy and confidentiality regulations.

(b) Establish criteria for transfer that shall minimally include:

1. The client has achieved the goals articulated in the individualized service plan, thus resolving the problem(s) that justified admission to the current level of care; or

2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite modifications of the service plan. Service at another level of care is therefore indicated; or

3. The client has demonstrated a lack of capacity to resolve identified problem(s). Service at another level of care is therefore indicated; or

4. The client has experienced an intensification of problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

(c) Delineate the roles of all persons participating in the transfer implementation process and the procedures to be followed to assure continuity of care.

(d) Establish a process for transferring clients to another service provider for a different level of care, or for changing a client's level of care within the current provider's service organization.

(e) Provide for development and utilization of a transfer summary.

1. A transfer summary shall be completed for each client transferred to another service provider for a different level of care, or for changing a client's level of care within the current provider's service organization, and shall at a minimum, include:

   (i) Identification of the client's current level of care.

   (ii) An evaluation of the client's progress toward goals established in the service plan and participation in the current level of care.

   (iii) The placement criteria utilized to establish the need for the client's transfer to a different level of care.

   (iv) The client's current status and condition.

   (v) A summary of goals for continuing care.

   (vi) Circumstances under which the client may return for additional treatment at the current level of care.

   (iii) Other relevant client information.

   (iv) The date the transfer is recommended and initiated.

2. The transfer summary shall be forwarded to the service to which the client is being transferred no later than two (2) days prior to the actual transfer.

3. A copy of the transfer summary shall be provided to the client.

(17) DISCHARGE.

(a) The entity shall develop, maintain, and document implementation of written policies and procedures governing discharge from the program when the client:

1. Is discharged to peer-led aftercare and/or mutual and self-help support after participation in professional care has ended.

2. Choose no further treatment.

3. Dropped out of residential care.

4. Dropped out of ambulatory care with unsuccessful efforts to contact.

5. Has irresolvable financial barriers.

6. Is arrested or incarcerated.

7. Is deceased.

(b) The entity's policies and procedures shall:

1. Delineate the roles of all persons participating in the discharge assessment and decision making process.

2. Include the client, and others designated by the client, as active participants in the discharge assessment and decision making process.

3. Describe the protocol used when a client desires to leave a program prematurely.

4. Establish procedures to notify the client's referral source of the client's change in status, in accordance with privacy and confidentiality regulations.

5. Describe the process utilized to assure continuity of care throughout the discharge planning process, dependent upon the nature of the discharge.

6. Provide for development of a discharge summary.

(i) A written discharge summary shall be entered into each client's case record within five days after discharge and shall include:

(I) A summary of goals for continuing care after discharge.
(II) A description of the reasons for discharge.
(III) The client's status and condition at discharge.
(IV) An evaluation of the client's progress toward goals established in the service plan and participation in the program.
(V) Circumstances under which a return for additional treatment or care may be needed.

7. Discharge summaries shall be completed for all clients regardless of discharge status.

8. The discharge summary shall be signed by the client when possible, the primary counselor, and the clinical supervisor or program director.

9. A copy of the discharge summary shall be provided to the client upon discharge, when possible.

(18) CONTINUING CARE. The entity shall develop, maintain, and document implementation of and compliance with written policies and procedures established to support continued service delivery after transfer or discharge from each level of care provided. At a minimum, these policies and procedures shall include:

(a) Establishment of a continuing care plan for each client as a part of the service planning process that shall:

1. Be formalized as a written document no later than two days before a client's planned transfer or discharge.

2. Be based upon the client's unique strengths, assessed needs, preferences, experiences, age, and culture.

3. Be developed in collaboration with other professional staff, the client, family and others designated by the client.

4. Include measurable goals and strategies, in words understandable to the client.

5. Specify the:

(i) Intervention, treatment, rehabilitation, recovery support, case management, and other therapeutic supports and services to be utilized in meeting the goals and strategies articulated in the continuing care plan.

(ii) Methods, frequency, responsibility for, and duration of the designated therapeutic interventions and services.

6. Include a range of client specific formal, family, natural, and community supports and services:

7. Include a plan for stable housing.

8. Address specific strategies that address the client's goals for the next level.

9. Address specific crisis intervention strategies.

10. Address transportation.

11. Incorporate a plan for ongoing clinical and self assessment.

12. Be approved in writing by the program director, clinical director, or medical director.

13. Be provided to the client upon discharge.

14. A process for assignment of a staff person who will have primary responsibility for insuring development of the continuing care plan and for coordination of continuing care resources.

15. A description of the referral process that:

    (i) Addresses communication between the client, the referring agency and the agency to which the client has been referred.

    (ii) Addresses requirements and expectations of programs and agencies that will provide continuing care services for the client and how this information is made known to the client.

16. The referring agencies requirements for follow-up and the process for informing clients of these requirements.

(b) A copy of the continuing care plan shall be filed in the client's case record.

(19) WAITING LIST MAINTENANCE: The entity shall establish a formal process to address requests for services when space is unavailable in the program. This process shall include, at a minimum:

(a) Written procedures for management of the waiting list that shall include, at a minimum, provisions for:

1. Priority admission of pregnant women and IV drug users.

2. Referral for emergency services.

3. Client access to interim services while awaiting program admission.

4. Maintaining contact with a client while awaiting space availability.

5. Adding and removing a client from the waiting list.

6. Data gathering and reporting of the following information:

(i) Demographic description of clients on the waiting list, including age, race, sex, pregnancy status, and IV drug use status.

(ii) Length of stay on the waiting list from initial request for care to admission.

(iii) Service need.

(iv) Number/percentage of clients on waiting list who are never admitted to a level of care.

(v) Number of clients receiving interim services.

(b) The entity shall designate a staff person with responsibility for management of the waiting list.

(c) The entity shall comply with requests from DMH for data reports relative to waiting list maintenance and management.

(20) REFERRAL POLICIES/COMMUNITY LINKAGE: The entity shall develop, maintain, and document compliance with written policies and procedures for referring clients and receiving client referrals from other service providers that shall include the following requirements, at a minimum:

(a) The entity shall establish written referral agreements with other organizations that offer services relevant to the holistic care of the entity's target population that shall specify, at a minimum:

1. Specific services that shall be provided by the outside organization.

2. Procedures to be followed in regard to making a referral to the outside organization.

3. Responsibilities for continuity of client care.

4. Reports needed by and provided by the outside organization.

5. A process for communication between the two agencies.

6. Agreement between the two agencies to protect client confidentiality and privacy relative to 42 C.F.R. Part 2 and HIPAA.

7. Service costs, if applicable.

8. Duration of the referral agreement.

(b) The entity's executive director shall authorize and approve in writing all referral relationships with outside organizations.

(21) CLIENT RECORDS: The entity shall develop, maintain, and document implementation of written policies and procedures governing the care, custody, and control & maintenance of records of persons served, that shall, at a minimum, include the following specifications:

(a) A client record shall be established for each client accepted for service delivery by a provider organization.

1. The client record shall communicate information in a manner that is:

(i) Organized into related sections with entries in chronological order.

(ii) Clear and complete.

(iii) Current.

(iv) Legible.

(b) The content and format of the client record shall be uniform, and shall not be modified by individual clinicians to include additions or deletions of forms, form formats, assessment instruments, etc. unless such modifications are approved by the program director and clinical director, and formally adopted for use by all clinicians.

(c) Client records shall contain the following information, at a minimum:

1. Client identifying data including:

(i) Name.

(ii) Address.

(iii) Phone number.

(iv) Social security number.

(v) Sex.

(vi) Race/ethnic background.

(vii) Date of birth.

(viii) Marital status.

(ix) Case number.

(x) Unique client identifier.

2. Date of service initiation.

3. Source of referral.

4. Screening information.

5. Presenting problem(s).

6. Informed consents for treatment, drug screens, release of protected information, etc.

7. Documentation of client orientation.

8. Assessments, at a minimum:

(i) ASAM placement assessment.

(ii) Intake assessment.

(iii) Physical health assessment.

(iv) Other assessments as pertaining to client needs.

9. Diagnosis.

10. Service plans.

11. Progress notes.

12. Staffing reports.

13. Medication records.

14. Records of praiseworthy and less than praiseworthy activities.

15. Copies of service relate correspondence.

16. Transfer summaries.

17. Discharge summaries.

18. Continued care plans.

(d) All entries included in the client record:

1. Shall be dated and signed.

2. Shall be made in ink and be legible.

3. Shall have a typed, printed, or stamped name below any non-legible signature.

4. Shall be appropriately authenticated in the electronic system for organizations that maintain electronic records.

(e) When client records are corrected or amendments are completed using the mark-through method, amendments or marked-through changes must be executed as follows:

1. The information to be amended is struck out with a single line that allows the struck information to be read; and

2. The amended entry is signed and dated.

(f) The provider organization shall establish a formal system to control and manage access to client records that shall include, at a minimum:

1. A designated staff member responsible for the storage and protection of client records at each location where records are stored.

2. A process in which the location of a record can be tracked and documented at all times.

3. Identification of program personnel with access to client records.

4. A process for providing clients access to their records.

5. A process for storing closed client records and for disposing of outdated records.

(g) Client records shall be retained after termination, discharge or transfer of the client for a minimum of seven (7) years.

(h) **ADOLESCENT SPECIFIC CRITERIA:** Client records shall be retained after termination, discharge or transfer of the client for a minimum of seven (7) years after age of majority for children/adolescents.

(22) CLINICAL DOCUMENTATION. The entity shall develop, maintain, and document compliance with written policies and procedures governing clinical documentation for each level of care provided, that shall include, at minimum, the following specifications:

(a) Written documentation shall be maintained in the client record to support each service, activity, and session provided, within the scope of the program, for a client or for a collateral source in regard to the client.

(b) Written documentation of service delivery shall be recorded on the date of service provision, shall be filed in the client record immediately, and shall consist of the following elements, at a minimum:

1. Identification of the service rendered.

2. Identification of the service recipient.

3. Identification of the setting in which the service was rendered.

4. Date the services were rendered.

5. The start and ending time of the service.

6. Relationship of the service to the client's individual service plan.

7. Client's or collateral's participation in and response to the service provided.

8. Service provider's evaluation of the client's progress, lack of progress, or other response relative to the service's objective.

9. Service provider's evaluation of the collateral's response to the service provided.

10. Client's or collateral's evaluation of the efficacy of the service in relation to identified needs and/or service objective.

11. Signature and credentials of the staff person providing the services.

(c) A staffing report shall be developed and entered into the clinical record at periodic intervals that includes, at a minimum, the following elements:

1. A summary to date of the client's progress or lack of progress relative to service plan goals, strategies, modifications, or level of care.

2. Recommendations for modifications of service plan goals, strategies, or level of care.

3. Documentation of active participation and input from the client in regard to his/her progress or lack of progress relative to service plan goals, strategies, modifications, or level of care.

4. Summary of collateral involvement and the impact of that involvement relative to the client's care.

5. Summary of client's involvement with other systems of care and the impact of that involvement relative to the current episode of care.

6. Identification of participants in the staffing.

7. Signature of the client and of the client's primary counselor.

(d) SERVICE RECORD: For each level of care, the entity shall maintain, within the client record, a log of all services received by the client. At a minimum:

(i) Information entered in the log shall include the service provided, date provided, length of service, and staff providing the service.

(ii) Services shall be entered in the log by the performing provider unless the document is created automatically in an electronic record system.

(iii) Services shall be entered in the log in chronological order.

(23) EMERGENCY/CRISIS CARE. The entity shall develop, maintain, and document implementation of policies and procedures governing the provision of routine and emergency health care for clients. At a minimum, the policies and procedures shall:

(a) Be specific to the population served and the level of care provided.

(b) Provide for emergency service availability twenty four (24) hours a day, seven (7) days each week.

(c) Describe the extent of services provided, including but not limited to:

1. Emergency medical services.

2. Suicide Intervention services.

3. Emergency psychiatric services.

4. First Aid and CPR.

5. Emergency transportation.

(d) Specify the process for implementation of emergency services provided on site as well as those provided off site through contract, MOU, or other arrangement

(d) Specify staff responsibilities for implementation of emergency services.

(24) MEDICAL SERVICES. The entity shall have medical protocols established for each level of care by a licensed physician on staff or under contract with the entity as the medical

director. The medical protocols shall be in compliance with standards, ethics, and licensure requirements of the medical profession and these rules and shall:

(a) Establish the protocol for collection of a medical history, establish the time frame in which this shall occur, and when prior collected information will suffice.

(b) Designate those medical symptoms that when assessed require further investigation, examination, or medical care beyond the scope of the program.

(c) Describe the process for determining the need for a client to have physical examination.

(d) Establish the entity's procedures for medical emergencies.

(25) PHARMACOTHERAPY & MEDICATION ADMINISTRATION. The entity shall develop, maintain, and document implementation of written policies and procedures regarding the use, purchase, control, administration, and disposal of medication that include, at a minimum, the following elements:

(a) **COMPLIANCE WITH REGULATORY REQUIREMENTS:** The organization shall document compliance with all applicable federal and state laws and regulations regarding the use, purchase, control, administration, disposal, and use of medication 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; and Nurse Delegation Act, where applicable.(clarify and make sure others aren't needed here)

(b) **MEDICATION USE:** The entity shall develop, maintain, and document implementation of written policies and procedures governing the use of pharmacotherapy that shall include the following requirements, at a minimum:

1. A description of how pharmacotherapy is utilized in the program, including identification of specific drugs and/or drug classifications utilized in the program and the purpose of each.

2. Identification of medical personnel responsible for implementation of the agency's pharmacotherapy services.

3. Specify that applicants for admission, who otherwise meet the entity's criteria for care, will not be denied access to services because they are

taking psychotropic medication, methadone, or other physician authorized medication.

4. The process utilized to involve a client and the client's family/significant others in decisions relative to pharmacotherapy.

5. The process utilized to insure integration of pharmacotherapy into the client's service plan, when utilized.

6. The process utilized to support continuity of pharmacotherapy when a client is transferred to another level of care, discharged, during emergencies, etc.

7. Identification of an adequate number of qualified personnel to insure proper management and implementation of the entity's pharmacotherapy services, including procedures to insure continuity of care during emergencies, employee vacations, sick leave, and unexpected absences.

(c) **MEDICATION ACQUISITION:** The entity shall describe the process utilized to acquire medication for use in the program, including:

1. Identification of all mechanisms utilized to obtain medicine for use of the entity's clientele.

2. Identification of all personnel authorized to acquire medication, including making medication purchases.

3. Describe procedures for safe handling, transportation and delivery of medication purchases and other methods of medication acquisition to the facility.

4. Adding acquired drugs to the facility's inventory and establishing a process to track medication usage.

(d) **MEDICATION CONTROL:** The organization must demonstrate implementation of accurate accounting, tracking, and inventory procedures for all medication acquired for use by the entity's clientele, as well as, for any client owned medication that is present in the facility. These procedures shall include the following elements, at a minimum:

1. The entity shall identify all personnel with responsibilities relative to medication control, and shall specify the required responsibilities of each and the timeframes in which these duties shall be performed.

2. The following records must be kept on all drugs administered by the agency's staff, or self-administered by clients:

   (i) A medication log/running inventory in which the following information is recorded:

      (I) Date on which drug(s) were placed in inventory.

      (II) Brand name/generic name.

      (III) Quantity/dosage of drug(s).

      (IV) Date drug(s) were administered.

      (V) Initials/signature of individual administering drug(s).

   (ii) A medication sheet for each individual client on which the following information is recorded each time drugs are administered:

      (I) Client's name

      (II) Brand name/generic name.

      (III) Date/time drugs were administered.

      (IV) Quantity/dosage dispensed.

      (V) Running totals of each medication dispensed;

      (VI) The signature of the individual administering the medication, or the signature of the individual monitoring self-administration of medication and the signature of the client self-administering.

3. Any organization 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:

(i) The supervising or consulting physician for the program has registered the facility as one of his offices with the DEA Registration Branch; or

(ii) The program itself has been registered with the DEA Registration ranch when there is more than one physician involved with the program.

4. Medications shall be kept in the original containers unless properly labeled and stored in medication planners or medication packs by a pharmacist utilizing a valid prescription.

5. All medications must be stored in a locked cabinet or other substantially constructed storage that precludes surreptitious entry.

6. Narcotic medications shall be stored under double lock and key.

7. Medications shall be stored separately from non-medical items.

8. Medications shall be stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.

9. All medication storage units must be locked when not in use.

10. 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.

11. A listing of employees permitted access to the medication storage units will be on file at the organization. This listing should be displayed in the drug storage area.

12. In the event of loss or the theft of controlled substances, the entity shall document implementation of the following procedures:

(i) Notify local law enforcement personnel immediately upon detection of the loss.

(ii) 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.

(iii) Notify the DEA Registration Branch directly if the program itself has been registered with the DEA.

(iv) Notify the DMH Associate Commissioner for Substance Abuse Services Division within 24 hours of detection of the loss.

(v) Provide subsequent written reports of the events and extent of the loss to the DMH Associate Commissioner for Substance Abuse, as according to DMH published incident reporting procedures.

13. Entities providing this service shall establish procedures for calibrating medication dispensing instruments that:

(i) Are consistent with the manufacturer's recommendations.

(ii) Ensure accurate dosing and tracking.

14. The entity shall document implementation of written procedures to account for all medication acquired by agency by whatever means, and for reconciliation of the drug inventory, which shall include the following processes, at a minimum:

(i) Identification of an individual who does not participate in the drug control process to reconcile the drug inventory.

(ii) Supervision of the inventory reconciliation process by the entity's program director or medical director.

(iii) Performance of the reconciliation at least semiannually, and each time there is a change in the responsibilities among those individuals with designated access to the drug supplies.

(iv) Development of a written report of the inventory reconciliation, and dissemination of the report to the program director, medical director, and executive director, at a minimum.

(e) **MEDICATION ADMINISTRATION:** The entity shall develop, maintain, and document implementation of written policies and procedures governing

medication administration that shall, at a minimum, incorporate the following requirements:

1. Medication shall only be administered by an authorized licensed medical professional, self-administered by the client, or provided by a Medication Assistant Certified (MAC) worker with delegated authority to administer client medications.

2. A list of licensed medical personnel and Medication Assistant Certified (MAC) Workers authorized to administer medication shall be posted at each facility in which medications are administered.

3. No prescription or nonprescription medication, including over-the-counter medication, shall be administered to a client without a current written order from a physician, certified registered nurse practitioner, physician's assistant or dentist.

4. A copy of each client's prescription(s) shall be kept in the clinical record at the facility/agency that administers the client's medication.

5. All medications, prescription, nonprescription, routine, and PRN, shall be administered and recorded as according to valid orders and in compliance with the Nurse Practice Act and the Alabama Administrative Code, [redacted] others.

6. All clients shall be provided information on the risks and benefits of the medication prescribed for administration during treatment.

7. Medications shall only be used by the person for whom they are prescribed.

8. Each medication shall be identifiable, i.e. clearly labeled with the name of the person, name of the medication, specific dosage, and the expiration date, up to the point of administration.

9. Each person who receives medication shall receive medical supervision by the prescribing or the entity's physician, to include regular evaluation of the person's response to the medication.

   (i) Factors/criteria to be taken into account for consideration of changes in medication dose levels shall be identified, assessed, and documented in the clinical record.

10. The entity's incident prevention and management plan shall include procedures to follow in the event of a medication related emergency, including, adverse reactions, accidental overdose, administration of the wrong medication, dosage, or frequency, etc.

11. All medication errors and adverse reactions to medications shall be recorded in the client's clinical record, and reported in accordance with the entity's incident prevention and management plan, and as according to the SASD published incident reporting procedures.

12. Documentation of corrective action taken in regards to medication errors shall be maintained by the agency, and reported to DMH as required by the SASD incident reporting procedures.

(f) **NURSE DELEGATION:** Entities utilizing unlicensed personnel to administer medication to clients shall develop, maintain, and document implementation of written policies and procedures to assure compliance with the Alabama Board of Nursing regulation 610-X-6-.15. The entity's policies and procedures shall incorporate, at a minimum, the following specifications:

1. The entity shall employ a registered nurse or licensed practical nurse as a full-time, part-time, or consultant employee who shall be responsible for delegation of specific limited tasks to designated unlicensed assistive personnel, Medication Assistant Certified (MAC) workers, employed by the entity.

2. The entity shall designate a nurse, who has passed the Medication Assistance Supervising (MAS) Training test, with responsibility for determining tasks that may be safely performed by each MAC worker employed by the agency, respectively.

3. Prior to the assumption of any medication assistance duties, each Mac worker shall:

   (i) Receive a minimum of twelve hours of Alabama Board of Nursing approved relevant classroom training;

   (ii) Receive twelve hours of practical training at the facility in which he/she is employed;

(iii) Pass a written DMH authorized MAC worker knowledge competency test; and

(iv) Demonstrate competency in the performance of tasks expected to be delegated at the site of planned service delivery in the presence of a MAS nurse.

4. Specific tasks delegated by the MAS nurse shall not require the exercise of independent nursing judgment or intervention by the MAC worker. Dependent upon the demonstrated competency of the MAC worker, assigned tasks may include but are not limited to the following responsibilities:

(i) Assist in the administration of oral, topical, inhalant, eye or ear medications that are readily identifiable and labeled at the time of delivery.

(ii) Basic first aid, i. e., dressing simple scratches, bite marks, or other superficial injuries.

(iii) Administer Epinephrine injectors, Epi-pins, routinely carried for persons with allergic reaction.

(iv) Clean and monitor devices such as C-Pap machines, nebulizers, and other durable medical goods routinely used in the home environment.

5. Specific tasks requiring the exercise of independent nursing judgment shall not be delegated by a MAS nurse to a MAC worker shall include, but shall not be limited to:

(i) Administration of injectable medications, with the exception of injectable medications for anaphylaxis such as the Epipen.

(ii) Catheterization, clean or sterile.

(iii) Administration of rectal or vaginal medications.

(iv) Tracheotomy care, including suctioning.

(v) Gastric tube insertion, replacement, or feedings.

(vi) Invasive procedures or techniques.

(vii) Sterile procedures.

(viii) Ventilator care.

(ix) Calculation of medication dosages other than measuring a prescribed amount of liquid medication or breaking a scored tablet; and

(x) Receipt of verbal or telephone orders from a licensed prescriber.

(xi) Independent administration of standing order PRN medication.

6. The entity shall maintain current written documentation identifying:

(i) Each MAC worker employed by the agency.

(ii) The specific delegated tasks of each MAC worker.

(iii) Documentation of training and competency to perform duties.

7. The entity's MAC workers shall have access to consultation with a MAS nurse 24 hours a day, 7 days a week.

8. The MAS nurse shall conduct, at a minimum, quarterly quality monitoring reviews of the job performance of each MAC worker, including, but not limited to the following areas:

(i) Fulfillment of training/continued education requirements.

(ii) Competency relative to the performance of delegated tasks.

(ii) Specific skills in regard to:

(I) Documentation.

(II) Error reporting.

(III) Methods of identification of the right client, the right task, the right method, and the right quantity at the right time.

9. The MAS nurse may suspend or withdraw the delegation of specific tasks to a MAC worker(s) at any time.

(g) **SELF-ADMINISTRATION OF MEDICATION:** Entities permitting clients to self-administer their own medication shall develop, maintain, and document implementation of written policies and procedures to govern this process that include, at a minimum, the following requirements:

1. A Medication Assistant Supervising Registered Nurse (MAS RN) shall evaluate the client and make a determination if the client can self-medicate, based upon the following criteria, at a minimum:

   (i) The client must be able to recognize their medications in order to be sure that he/she is not inadvertently given another client's medicine.

   (ii) The client must know the purpose for which he/she is taking the medicine.

   (iii) The client must be able to describe important side effects of the medicine.

2. The MAS RN shall provide written documentation in the clinical record specifying:

   (i) The date of evaluation for self-administration of medication.

   (ii) Identification of all persons involved in the evaluation process and the nature of their involvement.

   (iii) The results of the evaluation, to include the following findings, at a minimum:

   (iv) The client is able to self-medicate.

   (v) The client is able to receive medications from a Medications Assistant Certified (MAC) worker.

   (iii) The client has a complex medication routine that requires medication administration by an RN or LPN.

(iv) Any special instructions relative to the client's medication administration needs.

3. The entity shall establish criteria for the MAS RN to provide periodic reassessment of each client's continued capabilities to self-administer medications.

(h) **MEDICATION DISPOSAL AND DESTRUCTION:** The entity shall develop, maintain, and document implementation of written policies and procedures to govern medication disposal and destruction that shall, at a minimum, include the following specifications:

1. Any discontinued, contaminated, or expired medication shall be destroyed by incineration or by flushing into the waste water system within (7) seven days of being discontinued, contaminated, or expired.

2. Destruction of medication shall include all of the following:

(i) Be accomplished only by a nurse, pharmacist, or physician.

(ii) Be witnessed by one staff member.

(iii) The amount and name of medication must be recorded and signed by the two staff individuals.

(iv) The destruction record shall be maintained in the clinical record of the client for whom the medication was prescribed and maintained on a separate medication log for review.

(i) **TRAINING AND EDUCATION:** An entity providing pharmacotherapy shall develop a process to provide training and education regarding medications provided.

1. At a minimum, training and education shall be provided and documented for:

(i) Individuals receiving pharmacotherapy and their families/significant others.

(ii) The agency's staff, including medical, clinical, and support personnel.

2. Training and education should address, at a minimum:

(i) The biological principles associated with pharmacotherapy.

(ii) The risks associated with each medicine.

(iii) The intended benefits.

(iv) Side effects.

(v) Contraindications.

(vi) Appropriate knowledge of adverse interactions between multiple medications and food.

(vii) Risks associated with pregnancy.

(viii) The importance of taking medications as prescribed.

(ix) The need for laboratory monitoring.

(x) The rationale for each medication.

(xi) Alternatives to the use of medications.

(xii) Early signs of relapse.

(xiii) Signs of non-adherence to medication prescriptions.

(xix) Potential drug reactions when combining prescription and non-prescription medications.

(xx) Instructions on self-administration.

(xxi) Availability of financial supports and resources to assist the persons served with handling the costs associated with medications.

3. Training and education shall be provided in a format appropriate to the needs of the target population.

(26) DRUG TESTING.

(a) The program shall develop, maintain, and document compliance with written policies and procedures for testing clients for drug use. Policies and procedures shall specify, at a minimum:

1. The circumstances under which drug testing of clients will occur.

2. The specimens used for testing including, blood, urine, hair, and saliva.

3. A description of the collection process for each type of specimen utilized, including:

(i) Personnel authorized to request a specimen for drug testing.

(ii) Personnel authorized to collect a specimen for drug testing.

(iii) Procedures followed during testing that shall include, at a minimum:

(I) Procedures to protect against the falsification and/or contamination of any specimen.

(II) Procedures that support the individual's right to privacy while insuring the integrity of the test.

(III) Requirements for an observer of the same sex to supervise urine collection.

(IV) Documentation of use of a reliable on-site drug testing process or the use of a ******approved reference laboratory.

4. The process utilized to promptly address positive and negative drug testing results with clients.

(i) The results of a single drug test/discharge (revisit)

(ii) The entity shall document the use of drug testing to support identification of therapeutic interventions needed to assist clients in meeting service plan goals.

5. Procedures to address potentially false positive and false negative test results.

6. Procedures followed for test confirmations.

(b) The entity shall document all drug testing results, confirmation results, and related follow-up therapeutic interventions in the client record.

(27) TRANSPORTATION.

(a) The entity shall develop, maintain, and document compliance with written policies and procedures that govern client transportation, and include, at a minimum, the following specifications:

1. All vehicles used to transport clients shall have properly operating seat belts or child restraint seats, and provide for seasonal comfort with proper functioning heat and air.

2. All vehicles used for client transportation shall be in good repair and have documentation of regular maintenance inspections.

3. The number of clients permitted in any vehicle shall not exceed the number of seats, seat belts, and age appropriate child restraint seats in the vehicle.

4. Vehicles used to transport clients shall not be identifiable as a vehicle belonging to a substance abuse treatment program.

5. All entities operated by the entity shall carry proof of:

(i) Accident and liability insurance.

(ii) Documentation of the building's ownership.

(iii) A fire extinguisher and first aid kit.

(b) The driver of any vehicle used in client transportation shall be at least eighteen years old and in possession of a valid driver's license.

(c) The driver of any vehicle used in client transportation shall carry, at all times, the name and telephone number of the program's staff to notify in case of a medical or other emergency.

(d) The driver of any vehicle used in client transportation:

1. Shall be prohibited from the use of tobacco products, cellular phones or other mobile devices, or from eating while driving.

2. Shall be prohibited from leaving a minor unattended in the vehicle at any time.

3. Shall be prohibited from making stops between authorized destinations, altering destinations, and taking clients to unauthorized locations.

e. The entity shall provide an adequate number of staff for supervision of clients during transportation to ensure the safety of all passengers.

(28) **SMOKING.** The entity shall develop, maintain, and document compliance with written policies and procedures governing smoking by the program's staff and clientele that include, at a minimum, the following specifications:

(a) Tobacco use shall be prohibited by all clients, employees, volunteers, contractors, and visitors in all indoor areas of the facility.

(b) Tobacco use shall be prohibited by minors on the premises of programs that provide services to minors.

(c) Smoking shall not be allowed within fifty (50) feet of any entry to a facility that houses children or adolescents.

(d) Written guidelines for personnel in regard to smoking on the premises shall be established.

(e) The entity shall provide a continuum of services for all clients enrolled in each level of care that addresses tobacco use which shall include, at a minimum:

(i) Screening of all clients to determine tobacco use.

(ii) Assessment of tobacco users for willingness to quit.

(iii) Education on the risks of tobacco use and the benefits of non-use for all clients.

(iv) Assistance for in development of quit plans for tobacco users who desire to quit.

(v) Motivational enhancement strategies for all tobacco users.

(vi) Prevention strategies for all non-tobacco users.

(vii) Tobacco cessation resources, including medication, counseling, and relapse prevention.

(viii) Follow-up support as a part of continuing care.

(ix) Documentation in the client record of all activities specified in [illegible] (above).

(f) The opportunity to participate in a tobacco use cessation program shall be provided for each client who uses tobacco products and desires to quit. Each entity shall make available, at each level of care provided, the following tobacco cessation services and activities for clients who wish to stop smoking or using other tobacco products:

(i) All clients entering a level of care shall be routinely screened for tobacco use.

(ii) Tobacco users shall be advised of the harmful effects of tobacco use and the benefits associated with cessation and assessed to determine to their willingness to make a quit attempt.

(iii) Tobacco users willing to make a quit attempt shall be assisted in development of a quit plan that shall be integrated into the client's service plan.

(iv) The entity shall develop and implement a plan to insure the availability of onsite resources to assist clients in quit attempts, including but not limited to, over-the-counter and prescription medication.

(v) Plans for continued support of the client's quit efforts shall be integrated into plans for continuing care.

(g) For clients who use tobacco products but are unwilling to make a quit attempt at the time, the entity shall utilize motivational strategies, along with client education about the harmful effects of tobacco use and the benefits of cessation, to increase the chances of a future quit attempts.

(29) FOLLOW-UP.

580-9-43
LEVELS OF CARE

580-9-43.01
LEVEL 0.5
LEVEL 0.5: EARLY INTERVENTION

(1) **RULE COMPLIANCE.** Each Level 0.5 Early Intervention Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) **OPERATIONAL PLAN.** The entity shall develop, maintain, and document implementation of a written operational plan that defines its Level 0.5 Early Intervention Program. The Program description shall comply with all of the requirements specified in RULE??? and the following additional specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which Level .05 Early Intervention services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, meets the DMH facility certification standards, as appropriate. Service locations may include traditional clinical offices and behavioral health sites, residences, schools, shelters, work sites, community centers, and other locations as pre-authorized by DMH.

1. ADOLESCENT SPECIFIC CRITERIA.

(i) The entity shall document compliance with ???-a-above ; and

(ii) Shall not provide services in locations that would require shared services or significant contact with individuals receiving treatment for substance use disorders.

(b) **ADMISSION CRITERIA.** The entity shall develop, maintain, and document implementation of written criteria for admission to its Level .5 Outpatient Program, as according to Rule ????, and the following criteria:

1. The entity's admission criteria shall specify the target population for Level 0.5 services to include, at a minimum, individuals whose problems and risk factors appear to be related to substance use, but do not meet the diagnostic criteria for a substance-related disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 0.5 Early Intervention Services

meets the ASAM PPC2 diagnostic and dimensional criteria for this level of care.

3. **ADOLESCENT PROGRAM SPECIFIC CRITERIA.** The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level 0.5 Early Intervention Services meets the ASAM PPC2 adolescent diagnostic and dimensional criteria for this level of care.

(c) CORE SERVICES. Each Level 0.5 Early Intervention Program shall demonstrate the capacity to provide a basic level of skilled services appropriate to the needs of its clientele:

1. Assessment sufficient to screen for, and rule in or out, substance-related disorders.
2. Individual counseling.
3. Group counseling.
4. Family counseling.
5. Psychoeducation.
6. Case Management:
   (i) Case planning;
   (ii) Linkage;
   (iii) Advocacy; and
   (iv) Monitoring.

(d) SERVICE INTENSITY. The entity shall document that the amount and frequency of services is established on the basis of the unique needs of each client served.

(e) DOCUMENTATION: In addition to meeting the requirements of [redacted], each Level 0.5 Early Intervention Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 0.5 Services.

2. A staffing report summarizing the client's status relative to service goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 0.5 Services.

(f) SUPPORT SYSTEMS.

1. At a minimum, the Early Intervention program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to insure the availability of, and provide referrals as needed for:

   (i) Treatment of substance use disorders;

   (ii) Medical, psychological or psychiatric services, including assessment; and

   (iii) Community social services.

2. The entity shall maintain up-to-date, written MOU's, collaborative agreements, or referral agreements with support systems, which shall, minimally include:

   (i) Vocational and Educational Services.

   (ii) Transportation Services

   (iii)

(g) PROGRAM PERSONNEL. Each Level 0.5 Early Intervention Program shall employ an adequate number of qualified individual to ensure the provision of personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: There shall be a full time program coordinator that meets the requirements specified in [redacted].

2. Direct Care Personnel. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational procedures for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level 0.5 Early Intervention Program as delineated in its operational procedures.

4. **Administrative Support Personnel.** The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. **Maintenance Personnel.** The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

6. Every client in a Level 0.5 program shall be assigned to a specific Primary Counselor for care management.

(h) **TRAINING.** The entity shall provide written documentation that all Level 0.5 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall document that the amount and frequency of Level 0.5 Early Intervention Services are established on the basis of the unique needs of each client served.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 0.5 Program shall vary as determined by:

1. The client's ability to comprehend the information provided and use that information to make behavior changes, or

2. The appearance of new problems which require another modality of service.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 0.5 Early Intervention Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.02
LEVEL 1.1:
OUTPATIENT TREATMENT

(1) **RULE COMPLIANCE.** Each Level 1.1 Outpatient Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and document implementation of a written operational plan that defines its Level 1.1 Outpatient Program. The Program description shall comply with all of the requirements specified in RULE???? and the following additional specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which Level 1.1 Outpatient Services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, including but not limited to, traditional clinical offices and behavioral health sites, residences, schools, shelters, work sites, community centers, and other locations, as pre-authorized by DMH.

(b) **ADMISSION CRITERIA:** The entity shall develop, maintain, and implement written criteria for admission to its Level 1.1 Outpatient Program, in compliance with the requirements of Rules ????, and the following specifications:

1. The entity's admission criteria shall specify the target population for the Level1.1 Program, which shall include, at a minimum:

   i. Individuals whose assessed severity of illness initially warrants this level of care.

   ii. Individuals whose progress in a more intensive level of care warrants a step-down to a less intensive level of care.

   iii. Individuals who are in the early stages of change and who are not yet ready to commit to full recovery.

   iv. Individuals who are experiencing increased conflict, demonstrating passive compliance, or considering leaving treatment.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 1.1 Outpatient Services meets:

i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **ADOLESCENT PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level 1.1 Outpatient Services meets:

i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The adolescent dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA**: The entity shall provide written documentation in individual case records that each client admitted to receive Level 1.1 Outpatient Services in a Co-occurring Enhanced Treatment Program meets:

i. The diagnostic criteria for a substance use and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

5. **WOMEN AND DEPENDENT CHILDREN'S PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to receive Level 1.1 Outpatient Services in a Women and Children's Program:

i. Meets the diagnostic criteria for a substance use disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

iii. Is pregnant; or

iv. Has care and custody of dependent children; or

v. Has lost custody of dependent children and has the potential for family reunification.

(c) **CORE SERVICES.** Each Level 1.1 Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

1. At a minimum, the entity shall the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Family counseling.

v. Psychoeducation.

vi. Mental health consultation.

vii. Recovery support services.

viii. Peer counseling services.

ix. Medication management.

x. Drug use screening.

xi. Smoking cessation.

xii. Sign language and oral interpreter services.

xiii. HIV early intervention services.

xiv. Case management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

2. Medical services, including a physical examination, shall be provided as specified by the entity's medical protocols established as required by [redacted].

3. **Adolescent Program Specific Criteria:** Each Level 1.1 Adolescent Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Activity therapy.

ii. Parenting skills development.

4. **Co-occurring Disorders Program Specific Criteria:** Each level 1.1 Co-occurring Disorders Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Basic living skills.

ii. Crisis intervention services.

iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 1.1 Women and Dependent Children Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Transportation.

ii. Child sitting services.

iii. Developmental delay, prevention services.

iv. Activity therapy.

v. Parenting skills development.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 1.1 Outpatient Program shall include, at a minimum:

i. Implementation of individualized treatment plan strategies.

ii. Ongoing individualized assessment.

iii. Motivational enhancement and engagement strategies.

iv. Relapse prevention strategies.

v. Interpersonal choice/decision-making skill development.

vi. Health education.

vii. Random drug screening.

viii. Medication administration and monitoring.

ix. Family education.

2. **Adolescent Program Specific Criteria:** Each Level 1.1 Adolescent Outpatient Program shall document the capacity to provide the service strategies specified in ????? and the following therapeutic components:

i. Adolescent specific evidence based therapeutic interventions.

ii. Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality, and self esteem.

iii. Recreation and leisure time skills training.

iv. Gender specific treatment.

v. Family, community, and school reintegration services.

3. **Co-occurring Disorders Program Specific Criteria**: Each Level 1.1 Co-occurring Disorders Outpatient Program shall document the capacity to provide the service strategies specified in ?????? and the following therapeutic components:

i. Groups and classes that address the signs and symptoms of mental health and substance use disorders.

ii. Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation, and to aid in development of alternative coping responses to those cues.

iii. Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

4. **Women and Dependent Children's Program Specific Criteria:** Each Level 1.1 Women and Dependent Children Outpatient Program shall document the capacity to provide the service strategies specified in ?????? and the following therapeutic components:

i. Gender specific services which address issues of relationships, parenting, abuse, and trauma.

ii. Primary medical care, including prenatal care.

iii. Primary pediatric care for children.

iv. Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

v. Outreach to inform pregnant women of the services and priorities.

vi. Interim services while awaiting admission to this level of care.

vii. Recreation and leisure time skills training.

(e) **DOCUMENTATION:** In addition to meeting the requirements of [redacted], each Level 1.1 Outpatient Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 1.1 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 1.1 Services.

(f) **SUPPORT SYSTEMS.** Each Level 1.1 Outpatient Program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Medical, psychiatric, psychological, laboratory and toxicology services.

2. Medical and psychiatric consultation shall be available within 24 hours by telephone or if in person, within a timeframe appropriate to the severity and urgency of the consultation requested.

3. Direct affiliation with or coordination through referral to more intensive levels of care and medication management.

4. Emergency services shall be available by telephone twenty-four 24 hours a day, seven (7) days a week.

5. Mutual self help groups that are tailored to the needs of the specific client population.

6. Referral for other services as according to the client's assessed needs.

7. **Adolescent Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted] each Level 1.1 Adolescent Outpatient Program shall provide client access to academic or vocational services as according to assessed needs.

8. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in [redacted], each Level 1.1 Co-occurring Enhanced Outpatient Program shall provide client access to intensive case management services.

9. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], the entity shall provide client access to the following support services:

   i. Academic services.

   ii. Financial resource development and planning.

   iii. Family planning services.

(g) **PROGRAM PERSONNEL.** Each level 1.1 Outpatient Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: Each Level 1.1 Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.

2. Direct Care Personnel. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level 1.1 Outpatient program as delineated in its operational plan.

4. Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. Maintenance Personnel. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

6. Every client in a Level 1.1 program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed forty (40) clients with active cases at any one time.

8. Adolescent Program Specific Criteria Adolescent Program Specific Criteria.

   i. Each Level 1.1 Adolescent Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

   ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

   iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 1.1 Adolescent Outpatient program as delineated in its operational plan.

   iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

   v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

   vi. Every client in a Level 1.1 adolescent program shall be assigned to a specific Primary Counselor for care management.

   vii. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

9. Co-occurring Disorders Program Specific Criteria.

i. The Level 1.1 Co-occurring Enhanced Outpatient Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

ii. The Level 1.1 Co-occurring Enhanced Outpatient Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 1.1 Co-occurring Enhanced program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 1.1 Co-occurring Enhanced Outpatient program as delineated in its operational plan.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

x. Every client in a Level 1.1 Enhanced Co-occurring Outpatient Program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

10. **Women and Dependent Children Program Specific Criteria:**

i. Each Level 1.1 Women and Dependent Children Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 1.1 Women and Dependent Children Outpatient program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

vi. Every client in a Level 1.1 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 1.1 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall document that the amount and frequency of Level 1.1 Outpatient services are established on the basis of the unique needs of each client served, not to exceed eight (8) contact hours weekly.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 1.1 Outpatient Program shall vary as determined by:

1. The severity of the client's illness.
2. The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals; or
3. The appearance of new problems that require another level of care; or
4. The availability of services at an assessed level of need, when Level 1.1 services have been utilized as interim services.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 1.1 Outpatient Programs. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.
2. Include consideration of transportation accessibility.
3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.03 LEVEL 1.4: AMBULATORY DETOXIFICATION WITHOUT EXTENDED ON-SITE MONITORING

(1) **RULE COMPLIANCE.** Each Level 1.4 Detoxification Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) PR**OGRAM DESCRIPTION**: The entity shall develop, maintain, and implement a written program description that defines the Level 1.4 Ambulatory Detoxification Without Onsite Monitoring Program it provides, as according to rule ****** and the following specifications:

(a) **LOCATION:** The entity shall specifically identify and describe the setting in which Level 1.4 Ambulatory Detoxification Without Extended On-Site Monitoring services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, including but not limited to, a general healthcare facility, a physician's office, or an addiction or mental health treatment facility., as pre-authorized by DMH.

(b) ADMISSION CRITERIA: The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 1.4 Ambulatory Detoxification Without Extended On-Site Monitoring Program, in compliance with the requirements of rule ****** and the following specifications:

1. The entity's admission criteria shall specify the target population for the Level 1.4 program, which shall include, at a minimum, individuals:

   i. Experiencing mild withdrawal or at risk of experiencing withdrawal from alcohol and/or other drugs at a level of assessed severity appropriate for outpatient care; and

   ii. Who have adequate family or other service systems in place to support the outpatient detoxification process.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 1.4 Ambulatory Detoxification Without Extended On-Site Monitoring Services meets the:

   i. The diagnostic criteria for a Substance Induced Disorder as defined in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

ii. The dimensional criteria for admission to this level of care as defined in the ASAM PPC-2R.

(c) **CORE SERVICES:** Each Level 1.4 Detoxification Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

1. At a minimum, the Level 1.4 Ambulatory Detoxification Program shall document the capacity to provide the following core services:

i. Assessment.

ii. Individual counseling.

iii. Psychoeducation.

iv. Family counseling.

v. Peer support

vi. Medication administration

vii. Medication monitoring

viii. Drug screening

ix. Case management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of medical and other clinical services organized to enhance the client's understanding of addiction, support completion of the detoxification process, and initiate transfer to an appropriate level of care for continued treatment.

1. Service strategies for each Level 1.4 Detoxification program shall include, at a minimum:

   i. Implementation of individualized treatment plan strategies.

   ii. Completion of a comprehensive medical history and physical examination of the client at admission.

   iii. Protocols and/or standing orders, established by the entity's medical director, for management of detoxification from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations, including but not limited to, SAMHSA, ASAM, the American Psychiatric Association, and the American Academy of Addiction Psychology.

      I. Level 1.4 Ambulatory Detoxification Programs that utilize Benzodiazepines in the detoxification protocol:

         (i) Shall have written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate; and

         (ii) Shall have written longer-term detoxification protocols and procedures that adhere to general principles of management, including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review, and methods to prevent diversion from the plan.

   iv. Individual ongoing assessment, including, but not limited to:
      I. Physical examination by a physician, physician assistant, or nurse practitioner.

      II. Human services needs assessment by a case manager.

   v. Medication administration and monitoring services, including specific procedures for pregnant women.

   vi. Motivational enhancement therapy.

vii. Direct affiliation with other levels of care.

(e) **DOCUMENTATION:** In addition to meeting the requirements of [redacted] Level 1.4 Ambulatory Detoxification Programs shall provide the following clinical record documentation:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 1.4 Services.

2. Daily assessment of progress, including response to medication, which also notes any treatment regimen changes.

2. Regular and frequent monitoring of vital signs.

3. The use of detoxification rating scale tables and flow sheets; and

4. Physician review of all clinical assessments.

(f) **SUPPORT SYSTEMS.** The Level 1.4 Ambulatory Detoxification Program shall develop, maintain, and document implementation of written policies and procedures utilized to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.

2. Appropriate laboratory and toxicology testing.

3. Psychological and psychiatric services.

4. Twenty-four (24) hour access to emergency services.

5. Transportation.

(g) **PROGRAM PERSONNEL.** Each level 1.4 Detoxification Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: Each Level 1.4 Ambulatory Detoxification Program shall be coordinated by a full-time employee who is an Alabama licensed

Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, with two years direct care experience treating persons with substance induced disorders.

2. **Medical Director:** The Level 1.4 Detoxification Program shall have a medical director who is a physician licensed to practice in the state of Alabama, with a minimum of one year experience treating persons with substance induced disorders. The medical director shall be responsible for admission, diagnosis, medication management, and client care.

3. **Nursing Services Director:** The Level 1.4 program shall have a nursing services director who shall be a Registered nurse licensed according to Alabama law, with training and work experience in behavioral health, and who shall, at a minimum, fulfill the following responsibilities:

   i. Shall be accountable and responsible for the nursing care delivered to clients in Level 1.4 Ambulatory Detoxification Programs.

   ii. Supervise and delegate responsibilities to the LPNs on staff.

   iii. Assist the Medical Director as required.

4. **Nursing Personnel:** The entity shall have an adequate number of Alabama licensed nurses to assure that the administration of medications during Level 1.4 services complies with applicable state and federal regulations.

5. **Case Manager Coordinator**: The entity shall have a case manager coordinator who shall be available to the Level 1.4 program on at least a 50% FTE basis, and shall, at a minimum:

   i. Have a Bachelor's Degree in a behavioral science, at least two years case management experience relative to substance related disorders, and completed DMH/SASD approved case management training.

   ii. Supervise and delegate responsibilities to case managers working in the Level 1.4 program.

   iii. Insure to the availability of person centered case management services to facilitate Level 1.4 clients' transition into ongoing treatment and recovery.

6. Each client shall be assigned to a case manager for care management.

7. All direct care personnel shall have the qualifications, as specified in [redacted], to provide the specific services delineated in the entity's program description for this level of care.

8. The entity shall maintain an adequate number of physicians, nurses, counselors, and case managers to sustain the Level 1.4 Ambulatory Detoxification Outpatient program as delineated in its program operational procedures.

9. The entity shall maintain an adequate number of administrative support personnel to sustain the program's administrative functions.

10. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

(h) **TRAINING.** The entity shall provide written documentation that all Level 1.4 program personnel satisfy the competency and training requirements as specified in rule [redacted].

(i) **SERVICE INTENSITY.** The entity shall document in the clinical record that Level 1.4 services are provided in regularly scheduled sessions, and that the frequency and amount of these services are established on the basis of the unique needs of each client served.

(j) **LENGTH OF SERVICE.** The entity shall provide written documentation in the clinical record that the duration of treatment in a Level 1.4 program shall vary as determined by the client's assessed needs, and that the client continues in treatment until:

i. Withdrawal signs and symptoms are sufficiently resolved; or

ii. Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

iii. The client is, otherwise, unable to complete detoxification at this level of care.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 1.4 Ambulatory Detoxification Programs. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.04
LEVEL 2.1
INTENSIVE OUTPATIENT TREATMENT

1) **RULE COMPLIANCE.** Each Level 2.1 Intensive Outpatient Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) **OPERATIONAL PLAN.** The entity shall develop, maintain, and implement a written operational plan that defines the Level 2.1 Intensive Outpatient Program it provides, as according to rule [illegible] and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which Level 2.1 Intensive outpatient services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, and meets the DMH facility certification standards.

(b) **ADMISSION CRITERIA.** The entity shall develop, maintain, and implement written criteria for admission to its Level 2.1 Outpatient Program, in compliance with the requirements of [illegible], and the following specifications:

1. The entity's admission criteria shall specify the target population for the Level 2.1 Program, which shall include at a minimum:

   i. Individuals whose assessed severity of illness initially warrants this level of care;

   ii. Individuals who have fairly stable to stable mental and/or physical health problems; and

   iii. Individuals who have supportive living arrangements.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.1 Intensive Outpatient Services meets:

   i. The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **ADOLESCENT PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level 2.1 Intensive Outpatient Services meets:

   i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The adolescent dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA**: The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.1 Intensive Outpatient Services in a Co-occurring Enhanced Treatment Program meets:

   i. The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

5. **WOMEN AND DEPENDENT CHILDREN'S PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.1 Intensive Outpatient Services in a Women and Children's Program:

   i. Meets the diagnostic criteria for a substance dependence disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

   iii. Is pregnant; or

   iv. Has care and custody of dependent children; or

   v. Has lost custody of dependent children and has the potential for family reunification.

(c) **CORE SERVICES.** Each Level 2.1 Intensive Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

1. At a minimum, the Level 2.1 Intensive Outpatient Program shall provide the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Family counseling and psychoeducation.

v. Psychoeducation.

vi. Mental health consultation.

vii. Recovery support services.

viii. Peer counseling services.

ix. Medication management.

x. Drug use screening.

xi. Smoking cessation.

xii. Sign language and oral interpreter services.

xiii. HIV early intervention services.

xiv. Case management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

2. Medical services, including a physical examination, shall be provided as specified by the entity's medical protocols established as required by [redacted].

3. **Adolescent Program Specific Criteria:** Each Level 2.1 Intensive Adolescent Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Activity therapy.

ii. Parenting skills development.

4. **Co-occurring Disorders Program Specific Criteria:** Each level 2.1 Co-occurring Disorders Intensive Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Basic living skills.

ii. Crisis intervention services.

iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 2.1 Women and Dependent Children Intensive Outpatient Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Transportation.

ii. Child sitting services.

iii. Developmental delay, prevention services.

iv. Activity therapy.

v. Parenting skills development.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 2.1 Intensive Outpatient Program shall include, at a minimum:

   i. Implementation of individualized treatment plan strategies.

   ii. Ongoing individualized assessment.

   iii. Motivational enhancement and engagement strategies.

   iv. Relapse prevention strategies.

   v. Interpersonal choice/decision-making skill development.

   vi. Health education.

   vii. Random drug screening.

   viii. Medication administration and monitoring.

2. **Adolescent Program Specific Criteria:** Each Level 2.1 Adolescent Intensive Outpatient Program shall document the capacity to provide the service strategies specified in ?????? and the following therapeutic components:

   i. Adolescent specific evidence based therapeutic interventions.

   ii. Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality, and self esteem.

   iii. Recreation and leisure time skills training.

   iv. Gender specific treatment.

v. Family, community, and school reintegration services.

3. **Co-occurring Disorders Program Specific Criteria**: Each Level 2.1 Co-occurring Disorders Outpatient Program shall document the capacity to provide the service strategies specified in ????? and the following therapeutic components:

i. Groups and classes that address the signs and symptoms of mental health and substance use disorders.

ii. Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation, and to aid in development of alternative coping responses to those cues.

iii. Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

4. **Women and Dependent Children's Program Specific Criteria:** Each Level 2.1 Women and Dependent Children Intensive Outpatient Program shall document the capacity to provide the service strategies specified in ????? and the following therapeutic components:

i. Gender specific services which address issues of relationships, parenting, abuse, and trauma.

ii. Primary medical care, including prenatal care.

iii. Primary pediatric care for children.

iv. Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

v. Outreach to inform pregnant women of the services and priorities.

vi. Interim services while awaiting admission to this level of care.

vii. Recreation and leisure time skills training.

(e) **DOCUMENTATION:** In addition to meeting the requirements of rule ****, each Level 2.1 Intensive Outpatient Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 2.1 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 2.1 Services.

(f) **SUPPORT SYSTEMS.** Each Level 2.1 Intensive Outpatient Program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Medical, psychiatric, psychological, laboratory and toxicology services.

2. Medical and psychiatric consultation shall be available within twenty-four (24) hours by telephone or, if in person, within seventy-two (72) hours.

3. Direct affiliation with or coordination through referral to more and less intensive levels of care and supportive housing services.

4. Emergency services shall be available by telephone twenty-four (24) hours a day, seven (7) days a week.

5. Mutual self help groups that are tailored to the needs of the specific client population.

6. Referral for other services as according to the client's assessed needs.

7. **Adolescent Program Specific Criteria:** In addition to compliance with the criteria specified in **** each Level 2.1 Intensive Adolescent Outpatient Program shall provide client access to academic or vocational services as according to assessed needs.

8. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in ****, each Level 2.1 Co-

occurring Enhanced Intensive Outpatient Program shall provide client access to intensive case management services.

9. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], the entity shall provide client access to the following support services:

   i. Academic services.

   ii. Financial resource development and planning.

   iii. Family planning services.

(g) PROGRAM PERSONNEL. Each level 2.1 Intensive Outpatient Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: Each Level 2.1 Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.

2. Direct Care Personnel. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational procedures for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.1 Intensive Outpatient program as delineated in its operational procedures.

4. Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. Maintenance Personnel. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

6. Every client in a Level 2.1 program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

8. Adolescent Program Specific Criteria Adolescent Program Specific Criteria.

   i. Each Level 2.1 Adolescent Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

   ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

   iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.1 Adolescent Intensive Outpatient program as delineated in its operational plan.

   iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

   v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

   vi. Every client in a Level 2.1 Adolescent Intensive Outpatient Program shall be assigned to a specific Primary Counselor for care management.

   vii. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

9. Co-occurring Disorders Program Specific Criteria.

i. The Level 2.1 Co-occurring Enhanced Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

ii. The Level 2.1 Co-occurring Enhanced Intensive Outpatient Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 2.1 Co-occurring Enhanced Intensive Outpatient Program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.1 Co-occurring Enhanced Outpatient program as delineated in its operational plan.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

x. Every client in a Level 2.1 Co-occurring Intensive Outpatient program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

10. **Women and Dependent Children Program Specific Criteria:**

i. Each Level 2.1 Women and Dependent Children Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.1 Women and Dependent Children Intensive Outpatient program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

vi. Every client in a Level 2.1 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 2.1 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall document that the amount and frequency of Level 2.1 Intensive Outpatient services are established on the basis of the unique needs of each client served, shall be available a minimum of nine (9) hours but no greater than nineteen (19) hours each week.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 2.1 Intensive Outpatient Program shall vary as determined by:

1. The severity of the client's illness.
2. The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.
3. The appearance of new problems that require another level of care; or
4. The availability of services at an assessed level of need, when Level 2.1 services have been utilized as interim services.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 2.1 Intensive Outpatient Programs. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.
2. Include consideration of transportation accessibility.
3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-40.05
LEVEL 2.2
PARTIAL HOSPITALIZATION TREATMENT PROGRAM

1) **RULE COMPLIANCE.** Each Level 2.2 Partial Hospitalization Program shall comply with the following rules, and the rules specified in this chapter: [list applicable rules found throughout the standards]

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and implement a written program description that defines the Level 2.2 Partial Hospitalization Program it provides, as according to rule [redacted] and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which Level 2.2 Partial Hospitalization services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, and meets DMH/MR facility certification criteria.

(b) **ADMISSION CRITERIA.** The entity shall develop, maintain, and implement written criteria for admission to its Level 2.2 Partial Hospitalization Program, in compliance with the requirements of rule [redacted], and the following specifications:

1. The entity's admission criteria shall specify the target population for the Level 2.2 Program, which shall include at a minimum:

   i. Individuals whose assessed severity of illness initially warrants this level of care;

   ii. Individuals who have fairly unstable mental and/or physical health problems; and

   iii. Individuals who have unstable or dysfunctional but adequate living arrangements.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.2 Partial Hospitalization Services meets:

   i. The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **ADOLESCENT PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level 2.2 Partial Hospitalization Services meets:

i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The adolescent dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA**: The entity shall provide written documentation in individual case records that each individual admitted to receive Level 2.2 Partial Hospitalization Services in a Co-occurring Enhanced Treatment Program meets:

i. The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

5. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.2 Partial Hospitalization Services in a Women and Dependent Children Program:

i. Meets the diagnostic criteria for a substance dependence disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

iii. Is pregnant; or

iv. Has care and custody of dependent children; or

v. Has lost custody of dependent children and has the potential for family reunification.

(c) **CORE SERVICES.** Each Level 2.2 Partial Hospitalization Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

2. At a minimum, the Level 2.2 Partial Hospitalization Program shall provide the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Family counseling.

v. Psychoeducation.

vi. Mental health consultation.

vii. Recovery support services.

viii. Peer counseling services.

ix. Medication management.

x. Drug use screening.

xi. Smoking cessation.

xii. Sign language and oral interpreter services.

xiii. HIV early intervention services.

xiv. Case management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

2. Medical services, including a physical examination, shall be provided as specified by the entity's medical protocols established as required by [redacted].

3. **Adolescent Program Specific Criteria:** Each Level 2.2 Partial Hospitalization Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Activity therapy.

ii. Parenting skills development.

4. **Co-occurring Disorders Program Specific Criteria:** Each Level 2.2 Partial Hospitalization Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Basic living skills.

ii. Crisis intervention services.

iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 2.2 Women and Dependent Children Partial Hospitalization Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Transportation.

ii. Child sitting services.

iii. Developmental delay, prevention services.

iv. Activity therapy.

v. Parenting skills development.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 2.2 Partial Hospitalization Program shall include, at a minimum:

   i. Implementation of individualized treatment plan strategies.

   ii. Ongoing individualized assessment.

   iii. Motivational enhancement and engagement strategies.

   iv. Relapse prevention strategies.

   v. Interpersonal choice/decision-making skill development.

   vi. Health education.

   vii. Random drug screening.

   viii. Medication administration and monitoring.

   ix. Family education.

2. **Adolescent Program Specific Criteria:** Each Level 2.2 Adolescent Partial Hospitalization Program shall document the capacity to provide the service strategies specified in [redacted] and the following therapeutic components:

   i. Adolescent specific evidence based therapeutic interventions.

   ii. Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality, and self esteem.

   iii. Recreation and leisure time skills training.

   iv. Gender specific treatment.

v. Family, community, and school reintegration services.

3. **Co-occurring Disorders Program Specific Criteria**: Each Level 2.2 Co-occurring Enhanced Partial Hospitalization Program shall document the capacity to provide the service strategies specified in ?????? and the following therapeutic components:

i. Groups and classes that address the signs and symptoms of mental health and substance use disorders.

ii. Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation, and to aid in development of alternative coping responses to those cues.

iii. Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

4. **Women and Dependent Children Program Specific Criteria:** Each Level 2.2 Women and Dependent Children Partial Hospitalization Program shall document the capacity to provide the service strategies specified in ?????? and the following therapeutic components:

i. Gender specific services which address issues of relationships, parenting, abuse, and trauma.

ii. Primary medical care, including prenatal care.

iii. Primary pediatric care for children.

iv. Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

v. Outreach to inform pregnant women of the services and priorities.

vi. Interim services while awaiting admission to this level of care.

vii. Recreation and leisure time skills training.

(e) **DOCUMENTATION:** In addition to meeting the requirements of [redacted], each Level 2.2 Partial Hospitalization Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 2.1 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty (30) days for Level 2.1 Services.

(f) **SUPPORT SYSTEMS.** Each Level 2.2 Partial Hospitalization Program shall develop, maintain, and document implementation of written policies and procedures that govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Medical, psychiatric, psychological, laboratory and toxicology services.

2. Medical and psychiatric consultation shall be available within twenty-four (24) hours by telephone or, if in person, within forty-eight (48) hours.

3. Direct affiliation with, or coordination through referral to more and less intensive levels of care and supportive housing services.

4. Emergency services shall be available by telephone twenty-four (24) hours a day, seven (7) days a week.

5. Mutual self help groups that are tailored to the needs of the specific client population.

6. Referral for other services as according to the client's assessed needs.

7. **Adolescent Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted] each Level 2.2 Adolescent Partial Hospitalization Program shall provide client access to academic or vocational services as according to assessed needs.

8. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in [redacted], each Level 2.2 Co-

occurring Enhanced Partial Hospitalization Program shall provide client access to intensive case management services.

9. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], each Level 2.2 Women and Dependent Children Partial Hospitalization Program shall provide client access to the following support services:

   i. Academic services.

   ii. Financial resource development and planning.

   iii. Family planning services.

(g) **PROGRAM PERSONNEL.** Each Level 2.2 Partial Hospitalization Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: Each Level 2.2 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental health and substance use disorders.

2. Direct Care Personnel. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational procedures for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.2 Partial Hospitalization Program as delineated in its operational procedures.

4. Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. Maintenance Personnel. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

6. Every client in a Level 2.2 Partial Hospitalization Program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

8. Adolescent Program Specific Criteria Adolescent Program Specific Criteria.

   i. Each Level 2.2 Adolescent Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

   ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

   iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.2 Partial Hospitalization Program as delineated in its operational plan.

   iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

   v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

   vi. Every client in a Level 2.2 Adolescent Partial Hospitalization Program shall be assigned to a specific Primary Counselor for care management.

   vii. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

9. Co-occurring Disorders Program Specific Criteria.

i. The Level 2.2 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

ii. The Level 2.2 Co-occurring Enhanced Partial Hospitalization Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 2.2 Co-occurring Enhanced Partial Hospitalization Program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational procedures for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.2 Co-occurring Enhanced Partial Hospitalization Program as delineated in its operational procedures.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

x. Every client in a Level 2.2 Co-occurring Enhanced Partial Hospitalization Program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

10. Women and Dependent Children Program Specific Criteria:

i. Each Level 2.2 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 2.2 Women and Dependent Children Partial Hospitalization Program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

vi. Every client in a Level 2.2 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 2.2 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall document that the amount and frequency of Level 2.2 Partial Hospitalization services are established on the basis of the unique needs of each client served, and shall be available a minimum of twenty (20) hours each week.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 2.2 Partial Hospitalization Program shall vary as determined by:

1. The severity of the client's illness.
2. The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.
3. The appearance of new problems that require another level of care; or
4. The availability of services at an assessed level of need, when Level 2.2 services have been utilized as interim services.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 2.2 Partial Hospitalization Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.
2. Include consideration of transportation accessibility.
3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.06
LEVEL 2.4
AMBULATORY DETOXIFICATION WITH EXTENDED ON-SITE MONITORING

(1) **RULE COMPLIANCE.** Each Level 2.4 Ambulatory Detoxification Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and implement a written program description that defines the Level 2.4 Ambulatory Detoxification Program it provides, as according to rule [redacted] and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which Level 2.4 Ambulatory Detoxification With Extended On-Site Monitoring services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, and safety, and meets the DMH facility certification standards.

(b) **ADMISSION CRITERIA**: The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 2.4 Ambulatory Detoxification With Extended On-Site Monitoring Program, in compliance with the requirements of rule [redacted] and the following specifications:

1. The entity's admission criteria shall specify the target population for the Level 2.4 program, which shall include, at a minimum, individuals who:

   i. Have been assessed as being at moderate risk of severe withdrawal syndrome outside of the program setting;

   ii. Are free of severe, unstabilized physical and psychiatric complications; and

   iii. Who do not have adequate family or other service systems in place to support an outpatient detoxification process.

2. The entity shall provide written documentation in individual case records that each client admitted to receive Level 2.4 Ambulatory Detoxification With Extended On-Site Monitoring Services meets the:

   1. The diagnostic criteria for Substance Induced Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders.

2. The dimensional criteria for admission to this level of care as defined in the ASAM PPC-2R.

(c) **CORE SERVICES**: Each Level 2.4 Ambulatory Detoxification Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

1. At a minimum, the Level 2.4 Ambulatory Detoxification Program shall document the capacity to provide the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Psychoeducation.

v. Family counseling.

vi. Peer support.

vii. Medical and somatic services.

viii. Medication administration.

ix. Medication monitoring.

x. Drug screening.

xi. Case management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION:** The entity shall document implementation of medical and other clinical services organized to enhance the

client's understanding of addiction, support completion of the detoxification process, and initiate transfer to an appropriate level of care for continued treatment. The entity's Level 2.4 program shall, at a minimum, consist of the following components:

1. Completion of a comprehensive medical history and physical examination of the client at admission.

2. Protocols and/or standing orders, established by the entity's medical director, for management of detoxification from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations (e.g., SAMHSA, ASAM, American Academy of Addiction Psychology).

    i. Level 2.4 Ambulatory Detoxification Programs that utilize Benzodiazepines in the detoxification protocol:

        I. Shall have written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate; and

        II. Shall have written longer-term detoxification protocols and procedures that adhere to general principles of management, including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review, and methods to prevent diversion from the plan.

3. On-site physician and /or nurse monitoring, assessment, and management of signs and symptoms of intoxication and withdrawal.

4. Medication administration and monitoring services, including specific procedures for pregnant women.

5. Concurrent structured Level 2.1 or Level 2.2 services.

6. Ongoing biopsychosocial assessment.

7. Motivational enhancement therapy.

8. Direct affiliation with other levels of care.

(e) **DOCUMENTATION:** In addition to the documentation requirements in rule [redacted], Level 2.4 Ambulatory Detoxification Programs shall provide the following clinical record documentation:

1. Documentation of each clinical/therapeutic intervention provided.

2. Daily assessment of progress, including response to medication, which also notes any treatment changes;

3. Monitoring of vital signs each day the client is on site;

4. The use of detoxification rating scale tables and flow sheets; and

5. Physician review of all clinical assessments.

(f) **SUPPORT SYSTEMS.** The Level 2.4 Ambulatory Detoxification Program shall develop, maintain, and document implementation of written policies and procedures utilized to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.

2. Appropriate laboratory and toxicology testing.

3. Psychological and psychiatric services.

4. Transportation.

5. 24-hour access to emergency medical services.

(g) **PROGRAM PERSONNEL:** Each level 2.4 Ambulatory Detoxification Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

i. Program Coordinator: Each Level 2.4 Ambulatory Detoxification Program shall be coordinated by a full-time employee who is an Alabama licensed Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, with two years direct care experience treating persons with substance induced disorders.

2. Medical Director: The Level 1.4 Detoxification Program shall have a medical director who is a physician licensed to practice in the state of Alabama, with a minimum of one year experience treating persons with substance induced disorders. The medical director shall be responsible for admission, diagnosis, medication management, and client care.

3. Nursing Services Director: The Level 1.4 program shall have a nursing services director who shall be a Registered nurse licensed according to Alabama law, with training and work experience in behavioral health, and who shall, at a minimum, fulfill the following responsibilities:

   i. Shall be accountable and responsible for the nursing care delivered to clients in Level 1.4 Ambulatory Detoxification Programs.

   ii. Supervise and delegate responsibilities to the LPNs on staff.

   iii. Assist the Medical Director as required.

4. Nursing Personnel: The entity shall have an adequate number of Alabama licensed nurses to assure that the administration of medications during Level 1.4 services complies with applicable state and federal regulations.

5. There shall be a Registered Nurse (RN) or Licensed Practical Nurse on site during all hours of the Level 2.4 program's operation.

6. Staff providing concurrent structured Level 2.1 or Level 2.2 services shall have access to a full-time clinical director who shall provide routine clinical supervision as according to [redacted], and shall adhere to the guidelines for each respective level of care.

7. All direct care personnel shall have the qualifications, as specified in [redacted], to provide the specific services delineated in the entity's program description for this level of care.

8. The entity shall maintain an adequate number of physicians, nurses, counselors, and case managers to sustain the Level 1.4 Ambulatory Detoxification Outpatient program as delineated in its program operational procedures.

9. The entity shall maintain an adequate number of administrative support personnel to sustain the program's administrative functions.

10. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

(h) **TRAINING.** The entity shall provide written documentation that all Level 2.4 program personnel satisfy the competency and training requirements as specified in rule [redacted]

:

(I) **SERVICE INTENSITY.** The entity shall document in the clinical record that Level 2.4 services are provided in regularly scheduled sessions, and that:

1. The entity has the demonstrated capacity to provide a structured program of clinical services for a minimum of nine (9) hours per week.

2. The frequency and amount of Level 2.4 services are established on the basis of the unique needs of each client served.

(j) **LENGTH OF SERVICE.** The entity shall provide written documentation in the clinical record that the duration of treatment in a Level 2.4 program varies as determined by the client's assessed needs, and that the client continues in treatment until:

1. Withdrawal signs and symptoms are sufficiently resolved; or

2. Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

3. The client is, otherwise, unable to complete detoxification at this level of care.

(k) **SERVICE AVAILABILITY:**

580-9-43-07
LEVEL 3.01
TRANSITIONAL RESIDENTIAL PROGRAM

(1) **RULE COMPLIANCE.** Each Level 3.01 Transitional Residential Program shall comply with the following rules, and the rules specified in this chapter: (List applicable rules found throughout the standards)

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and implement a written program description that defines the Level 3.01 Transitional Residential Program it provides, as according to rule ****** and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which the Level 3.01 Transitional Residential Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health, and zoning regulations, including the DMH facility certification standards.

(b) **ADMISSION CRITERIA:** The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 3.01 Transitional Residential Program, in compliance with the requirements of rule ****** and the following specifications:

1. The entity's admission criteria shall specify the target population for its Level 3.01 services, which shall include, at a minimum, individuals who have been assessed to have:

    i. A substance use disorder; and

    ii. A need for support in a twenty-four hour drug-free environment:

        I. In order to reintegrate into the community after treatment in a more intense level of care;

        II. To assist in enhancing motivation for a more intense level of care; or

        iii. To assist in community reintegration after a period of incarceration.

2. The entity shall provide written documentation in individual case records that each client admitted to a Level 3.01 Program meets the following

diagnostic and modified ASAM PPC2R dimensional criteria for this level of care:

i. The client shall meet the criteria for a substance use disorder, as according to the specific diagnostic criteria given in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

ii. Acute Intoxication and/or Withdrawal: The client shall not report experiencing or display any signs or symptoms of alcohol or other drug withdrawal.

iii. Biomedical Conditions and Complications:

I. The client's biomedical problems, if any, shall be stable, and shall not require medical or nurse monitoring by the transitional program.

II. The client shall be capable of self-administering any prescribed or required over the counter medication.

iv. Emotional, Behavioral, or Cognitive Conditions and Complications:

I. The client shall not report or display symptoms of a co-occurring psychiatric, emotional, behavioral, or behavioral condition; or

II. The client's co-occurring psychiatric, emotional, behavioral, or cognitive disorder shall be:

a) Stable;

b) Self-manageable; and

c) Addressed concurrently through appropriate psychiatric services.

III. The client shall be assessed as not posing a risk of harm to self or others.

v. Readiness to Change: The client shall acknowledge the existence of a substance use disorder, or a co-occurring substance use and psychiatric, emotional, behavioral, or cognitive disorder, and expresses and demonstrates a desire to make needed changes to support recovery.

vi. Relapse, Continued Use, or Continued Problem Potential:

I. The client's history indicates a high risk of relapse in a less structured level of care; or

II. The client needs regimented support to maintain engagement in a recovery focused process on community reintegration.

vii. Recovery environment: The client has insufficient resources and skills to maintain a recovery oriented lifestyle outside of a twenty-four hour supportive environment.

(c) **CORE SERVICES**: Each Level 3.01 Transitional Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

1. At a minimum, the entity shall demonstrate and document its capacity to provide a 24-hour structured residential treatment environment with the following core services:

i. Assessment.

ii. Psychoeducation;

iii. Peer support.

iv. Daily living skills.

v. Drug screening.

vi. Transportation.

vii. Case Management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 3.01 Transitional Residential Program shall include, at a minimum:

i. Maintenance of an alcohol and illicit drug free environment.

ii. Implementation of individualized service plan strategies.

iii. On duty, awake staff shall provide supervision of client's health, welfare, and safety 24 hours a day.

iv. All clients enrolled in Level 3.01 programs shall have access to clinical services twenty-four hours a day, seven days a week.

v. The entity shall document the provision of planned recovery support services and activities that shall, at a minimum, include:

I. Motivational strategies.

II. Relapse prevention counseling.

III. Interpersonal choices/decision making skills development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

(e) **DOCUMENTATION.** In addition to compliance with the requirements of rule ***, each Level 3.01 Transitional Residential Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 3.01 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty (30) days for Level 3.01 Services.

(f) **SUPPORT SYSTEMS.** Each level 3.01 Transitional Residential Program shall develop, maintain, and document implementation of written policies and procedures that govern the process used to provide client access to support services at the Level 3.01 program site, or through consultation or referral, which shall minimally include::

i. Telephone or in person consultation with a physician available twenty four (24) hours a day, seven (7) days a week.

ii. Telephone or in person consultation with emergency services twenty four (24) hours a day, (7) seven days a week.

iii. Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

iv. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

v. Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training, and adult education.

vi. Mutual self help groups which are tailored to the needs of the specific client population.

(g) **PROGRAM PERSONNEL.** Each Level 3.01 Transitional Residential Program shall employ an adequate number of qualified individual to ensure the provision of personalized care for its clientele and to meet the program's goals and objectives.

1. **Program Coordinator**: Level 3.01 Transitional Program shall have a full-time program coordinator or manager who shall have a minimum of three years work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

2. **Direct Care Personnel**: All direct care personnel shall have the qualifications, as specified in [redacted], to provide the specific services delineated in the entity's program description for this level of care.

3. **Clinical Personnel.** The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.01 program as delineated in its operational procedures.

4. **Administrative Support Personnel**: The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. **Maintenance Personnel**: The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which the Level 3.01 services are provided.

6. Every client in a Level 3.01 Transitional Residential Program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 3.01 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY.** The entity shall document that the amount and frequency of Level 3.0 services are established on the basis of the unique needs of each client served.

(j) **LENGTH OF SERVICE.** The entity shall provide written documentation that the duration of treatment in its Level 3.01 program is variable as determined by:

1. The severity of the client's illness.

2. The client's ability to comprehend the information provided and use that information to meet treatment goals and strategies. or

3. The appearance of new problems that require another level of care, or

4. The availability of services at an assessed level of need, when a Level 3.01 Transitional Residential program has been utilized as an interim level of care.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish hours of availability for assessment, intake, admission, and counseling services at its Level 3.01 Transitional Residential Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.08
LEVEL 3.1
CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL TREATMENT PROGRAM

(1) **RULE COMPLIANCE.** In addition to compliance with the rules as specified in this chapter, each Level 3.1 Clinically Managed Low Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters: (List applicable rules found throughout the standards)

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and implement a written program description that defines the Level 3.1 Clinically Managed Low Intensity Residential Treatment Program it provides, as according to rule [redacted] and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which the Level 3.1 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health, and zoning regulations, including the DMH facility certification standards.

(b) **ADMISSION CRITERIA:** The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 3.1 Program, in compliance with the requirements of rule [redacted] and the following specifications:

1. The entity's admission criteria shall specify the target population for its Level 3.1 services, which shall include, at a minimum, individuals who have been assessed to have:

   i. A need for structure and support in a twenty-four hour drug-free environment in order to:

      I. Engage in treatment.

      II. Sustain participation in regular productive, daily activities or current treatment for physical or mental disorders.

   ii. Develop, integrate, and practice recovery and coping skills.

   iii. Continue treatment for a substance use disorder as a step-down from a more intense level of care.

2. The entity shall provide written documentation in individual case records that each client admitted to a Level 3.1 Program meets:

   i. The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **ADOLESCENT PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each adolescent admitted to a level 3.1 Program meets:

   i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The adolescent dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA**: The entity shall provide written documentation in individual case records that each individual admitted to a Level 3.1 Co-occurring Enhanced Treatment Program meets:

   i. The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

5. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to a Level 3.1 Program for Women and Dependent Children:

   i. Meets the diagnostic criteria for a substance dependence disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

iii. Is pregnant; or

iv. Has care and custody of dependent children; or

v. Has lost custody of dependent children and has the potential for family reunification.

(c) **CORE SERVICES**: Each Level 3.1 Low-Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

1. At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Family counseling/psychoeducation.

v. Psychoeducation.

vi. Peer support.

vii. Daily living skills.

viii. Medication Management.

ix. Drug screening.

x. Transportation.

xi. Case Management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

2. **Medical Services**. Medical services, including a physical examination, shall be provided as specified by the entity's medical protocols established as required by [redacted]

3. **Adolescent Program Specific Criteria:** Each Level 3.1 Adolescent Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Activity therapy.

ii. Parenting skills development.

4. **Co-occurring Disorders Program Specific Criteria:** Each Level 3.1 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Basic living skills.

ii. Crisis intervention services.

iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 3.1 Women and Dependent Children Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Transportation.

ii. Child sitting services.

iii. Developmental delay, prevention services.

iv. Activity therapy.

v. Parenting skills development.

(e) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 3.1 Residential Program shall include, at a minimum:

i. Maintenance of an alcohol and illicit drug-free residential environment.

ii. Implementation of individualized treatment plan strategies.

iii. On duty, awake staff shall provide supervision of client's health, welfare, and safety 24 hours a day.

iv. All clients enrolled in Level 3.1 programs shall have access to clinical services twenty-four (24) hours a day, seven days a week.

iv. The entity shall document the provision of planned counseling and recovery support services and activities that shall, at a minimum, include:

I. Motivational and engagement strategies.

II. Relapse prevention.

III. Interpersonal choice/decision making skill development.

iv. Development of a social network supportive of recovery.

v. Daily living and recovery skills development.

vi. Random drug screening.

vii. Health education.

viii. Medication management and administration.

2. **Adolescent Program Specific Criteria:** Each Level 3.1 Adolescent Low Intensity Residential Treatment Program shall document the capacity to provide the service strategies specified in [redacted] and the following therapeutic components:

   i. Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality, and self esteem.

   ii. Recreation and leisure time skills training.

   iii. Gender specific treatment.

   iv. Family, community, and school reintegration services.

3. **Co-occurring Disorders Program Specific Criteria**: Each Level 3.1 Co-occurring Disorders Low Intensity Residential Program shall document the capacity to provide the service strategies specified in [redacted] and the following therapeutic components:

   i. Groups and classes that address the signs and symptoms of mental health and substance use disorders.

   ii. Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation, and to aid in development of alternative coping responses to those cues.

   iii. Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

4. **Women and Dependent Children's Program Specific Criteria:** Each Level 3.1 Low Intensity Residential Treatment Women and Dependent Children Program shall document the capacity to provide the service strategies specified in [redacted] and the following therapeutic components:

   i. Gender specific services which address issues of relationships, parenting, abuse, and trauma.

ii. Primary medical care, including prenatal care.

iii. Primary pediatric care for children.

iv. Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

v. Outreach to inform pregnant women of the services and priorities.

vi. Interim services while awaiting admission to this level of care.

vii. Recreation and leisure time skills training.

(e) **DOCUMENTATION:** In addition to meeting the requirements of [redacted], each Level 3.1 Intensive Outpatient Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 3.1 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 3.1 Services.

(f) **SUPPORT SYSTEMS.** Each Level 3.1 Program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

2. Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

3. Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

4. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

5. Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training, and adult education.

6. Mutual self help groups which are tailored to the needs of the specific client population.

7. **Adolescent Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted] each Level 3.1 Adolescent Low Intensity Residential Program shall provide client access to age appropriate tutorial, academic or vocational services as according to assessed needs.

8. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in [redacted], each Level 3.1 Co-occurring Enhanced Low Intensity Residential Program shall provide client access to intensive case management services.

9. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], the each Level 3.1 Low Intensity Residential Treatment Program for Women and Dependent Children shall provide client access to the following support services:

   i. Academic services.

   ii. Financial resource development and planning.

   iii. Family planning services.

(g) PROGRAM PERSONNEL. Each level 3.1 Low Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator. Each Level 3.1 Low-Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum of three years work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

2. Direct Care Personnel. All direct care personnel shall have the qualifications, as specified in [redacted], to provide the specific services delineated in the entity's program description for this level of care.

3. **Clinical Personnel.** The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.1 program as delineated in its operational procedures.

4. **Administrative Support Personnel.** The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. **Maintenance Personnel.** The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which Level 3.1 service are provided.

6. Every client in a Level 3.1 program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

8. **Adolescent Program Specific Criteria** Adolescent Program Specific Criteria.

   i. Each Level 3.1 Low Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

   ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

   iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.1 Low Intensity Residential Program as delineated in its operational plan.

   iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

   v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and

therapeutic environment at the facility in which Level 3.1 services are provided.

vi. Every client in a Level 3.1 Adolescent Low Intensity Residential Treatment Program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

9. Co-occurring Disorders Program Specific Criteria.

i. Each Level 3.1 Co-occurring Enhanced Low Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

ii. Each Level 3.1 Co-occurring Enhanced Low Intensity Residential Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 3.1 Co-occurring Enhanced Low Intensity Residential Program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.1 Co-occurring Enhanced Residential Program as delineated in its operational plan.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which Level 3.1 services are provided.

x. Every client in a Level 3.1 Residential Program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

10. **Women and Dependent Children Program Specific Criteria:**

i. Each Level 3.1 Low Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.1 Low Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which Level 3.1 Services are provided.

vi. Every client in a Level 3.1 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 3.1 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall document that the amount and frequency of Level 3.1 Low Intensity Residential Treatment services are established on the basis of the unique needs of each client served. To assist in addressing these needs, the entity shall ensure the availability of no less than five (5) hours of structured services each week.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 3.1 Low Intensity Residential Program shall vary as determined by:

1. The severity of the client's illness.

2. The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

3. The appearance of new problems that require another level of care; or

4. The availability of services at an assessed level of need, when a Level 3.1 Residential Program have been utilized to provide interim services.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish hours of availability for assessment, intake, admission, and counseling services at its Level 3.1 Low Intensity Residential Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.09
LEVEL 3.3 CLINICALLY MANAGED
MEDIUM INTENSITY RESIDENTIAL TREATMENT PROGRAM
FOR ADULTS

(1) RULE COMPLIANCE. In addition to compliance with the rules as specified in this chapter, each Level 3.3 Clinically Managed Medium Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters: [list applicable rules found throughout the standards]

(2) PROGRAM DESCRIPTION. The entity shall develop, maintain, and implement a written program description that defines the Level 3.3 Clinically Managed Medium Intensity Residential Treatment Program it provides, as according to rule [redacted] and the following specifications:

(a) LOCATION. The entity shall specifically identify and describe the setting in which the Level 3.3 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health, and zoning regulations, including the DMH facility certification standards.

(b) ADMISSION CRITERIA: The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 3.3 Program, in compliance with the requirements of rule [redacted] and the following specifications:

1. The entity's admission criteria shall specify the target population for its Level 3.3 services, which shall include, at a minimum, individuals who are at least nineteen (19) years old and who have been assessed to have:

   i. A substance dependence disorder and concomitant cognitive impairments, developmental delays, emotional, and/or behavioral problems; and

   ii. Significant functional deficits in regard to management of activities of daily living.

2. The entity shall provide written documentation in individual case records that each client admitted to a Level 3.3 Program meets:

   i. The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA.** The entity shall provide written documentation in individual case records that each individual admitted to a Level 3.3 Co-occurring Enhanced Treatment Program meets:

i. The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to a Level 3.3 Program for Women and Dependent Children:

i. Meets the diagnostic criteria for a substance dependence disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

iii. Is pregnant; or

iv. Has care and custody of dependent children; or

v. Has lost custody of dependent children and has the potential for family reunification.

(c) CORE SERVICES: Each Level 3.3 Medium-Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

1. At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

i. Assessment.

ii. Individual counseling.

iii. Group counseling.

iv. Family counseling/psychoeducation.

v. Psychoeducation.

vi. Peer support.

vii. Medical and somatic services.

vii. Daily living skills.

viii. Medication Management.

ix. Drug screening.

x. Transportation.

xi. Case Management:

I. Case planning;

II. Linkage;

III. Advocacy; and

IV. Monitoring.

2. **Medical Services.** Medical services shall be provided as specified by the entity's medical protocols established as required by [redacted]

i. Clients who have not had a physical examination within the last twelve months shall be provided a physical examination within two weeks of admission.

ii. Pregnant clients who are not receiving routine prenatal care, shall be seen by physician within two weeks of admission.

3. **Family Support.** The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

4. **Co-occurring Disorders Program Specific Criteria:** Each Level 3.3 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in ?????? and the following services:

   i. Mental health consultation.

   ii. Crisis intervention services.

   iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 3.3 Women and Dependent Children Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in ?????? and the following services:

   i. Child sitting services.

   ii. Developmental delay, prevention services.

   iii. Activity therapy.

   iv. Parenting skills development.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to the client's assessed needs and expressed desires for care.

1. Service strategies for each Level 3.3 Residential Program shall include, at a minimum:

   i. On duty, awake staff shall provide supervision of client's health, welfare, and safety twenty-four (24) hours a day.

   ii. Client shall have access to clinical services personnel twenty-four (24) hours a day, seven days a week.

iii. Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

iv. The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

I. Implementation of individualized service plan strategies.

II. Relapse prevention.

III. Interpersonal choice/decision making skill development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

VIII. Medication administration and monitoring.

(e) **DOCUMENTATION:** In addition to meeting the requirements of rule ***, each Level 3.3 Medium Intensity Residential Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 3.3 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 3.3 Services.

(f) **SUPPORT SYSTEMS.** Each Level 3.3 Program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

2. Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

3. Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

4. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

5. Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training, and sheltered workshops.

6. Mutual self help groups which are tailored to the needs of the specific client population.

7. Appropriate laboratory and toxicology testing.

8. Psychological and psychiatric services.

9. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

10. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in [redacted], each Level 3.3 Co-occurring Enhanced Medium Intensity Residential Program shall provide client access to intensive case management services.

11. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], the each Level 3.3 Medium Intensity Residential Treatment Program for Women and Dependent Children shall provide client access to the following support services:

    i. Academic services.

    ii. Financial resource development and planning.

    iii. Family planning services.

(g) **PROGRAM PERSONNEL.** Each level 3.3 Medium Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator. Each Level 3.3 Medium-Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum of three (3) years work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

2. Direct Care Personnel. All direct care personnel shall have the qualifications, as specified in [redacted], to provide the specific services delineated in the entity's program description for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the level 3.3 program as delineated in its operational procedures.

4. Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. Maintenance Personnel. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which Level 3.1 service are provided.

6. Every client in a Level 3.3 program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

8. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA.**

   i. Each Level 3.3 Co-occurring Enhanced Medium Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's

supervised experience in a direct service area treating clients with co-occurring disorders.

ii. Each Level 3.3 Co-occurring Enhanced Medium Intensity Residential Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 3.3 Co-occurring Enhanced Medium Intensity Residential Program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.3 Co-occurring Enhanced Residential Program as delineated in its operational plan.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic

environment at the facility in which Level 3.3 services are provided.

x. Every client in a Level 3.3 Residential Program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

10. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA.**

i. Each Level 3.3 Medium Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.3 Medium Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, therapeutic environment at the facility in which Level 3.3 Services are provided.

vi. Every client in a Level 3.3 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 3.3 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:**

1. The entity shall document that the amount and frequency of Level 3.3 Medium Intensity Residential Treatment services are established on the basis of the unique needs of each client served. To assist in addressing these needs, the entity shall ensure the availability of no less than fifteen (15) hours of structured services each week.

2. The entity shall provide written documentation describing the procedures utilized to:

   i. Assure the provision of services in a manner that is slow-paced, repetitive, concrete, and repetitive, when client's needs indicate.

   ii. Adapt services to the client's developmental stage and level of comprehension.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in each Level 3.3 Medium Intensity Residential Program shall vary as determined by:

1. The severity of the client's illness.

2. The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

3. The appearance of new problems that require another level of care; or

4. The availability of services at an assessed level of need, when a Level 3.1 Residential Program have been utilized to provide interim services.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish hours of availability for assessment, intake, admission, and counseling services at its Level 3.3 Medium Intensity Residential Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

580-9-43.10
LEVEL 3.5
CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT PROGRAM

(1) **RULE COMPLIANCE.** In addition to compliance with the rules as specified in this chapter, each Level 3.5 Clinically Managed High Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters: (List applicable rules found throughout the standards)

(2) **PROGRAM DESCRIPTION.** The entity shall develop, maintain, and implement a written program description that defines the Level 3.5 Clinically Managed High Intensity Residential Treatment Program it provides, as according to rule [illegible] and the following specifications:

(a) **LOCATION.** The entity shall specifically identify and describe the setting in which the Level 3.5 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health, and zoning regulations, including the DMH facility certification standards.

(b) **ADMISSION CRITERIA:** The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 3.5 Program, in compliance with the requirements of rule [illegible] and the following specifications:

1. The entity's admission criteria shall specify the target population for its Level 3.5 services, which shall include, at a minimum, individuals who have been assessed to have multiple, significant social and psychological functional deficits (that cannot be adequately addressed on an outpatient basis);

2. The entity shall provide written documentation in individual case records that each client admitted to a Level 3.5 Program meets:

   i. The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

3. **CO-OCCURRING DISORDERS PROGRAM SPECIFIC CRITERIA**. The entity shall provide written documentation in individual case records that each individual admitted to a Level 3.5 Co-occurring Enhanced Treatment Program meets:

   i. The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

4. **ADOLESCENT PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each adolescent admitted to a level 3.5 Program meets:

   i. The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The adolescent dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R.

5. **WOMEN AND DEPENDENT CHILDREN PROGRAM SPECIFIC CRITERIA:** The entity shall provide written documentation in individual case records that each client admitted to a Level 3.5 Program for Women and Dependent Children:

   i. Meets the diagnostic criteria for a substance dependence disorder as defined in the latest edition Diagnostic and Statistical Manual for Mental Disorders; and

   ii. The dimensional criteria for admission to this level of care as defined in the latest edition of the ASAM PPC-2R; and

   iii. Is pregnant; or

   iv. Has care and custody of dependent children; or

   v. Has lost custody of dependent children and has the potential for family reunification.

(c) **CORE SERVICES**: Each Level 3.5 High-Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

1. At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

   i. Assessment.

   ii. Individual counseling.

   iii. Group counseling.

   iv. Family counseling/psychoeducation.

   v. Psychoeducation.

   vi. Peer support.

   vii. Medical and somatic services.

   vii. Daily living skills.

   viii. Medication Management.

   ix. Drug screening.

   x. Transportation.

   xi. Case Management:

      I. Case planning;

      II. Linkage;

      III. Advocacy; and

      IV. Monitoring.

2. **Medical Services**. Medical services shall be provided as specified by the entity's medical protocols established as required by [redacted]

i. Clients who have not had a physical examination within the last twelve months shall be provided a physical examination within two weeks of admission.

ii. Pregnant clients who are not receiving routine prenatal care, shall be seen by physician within two weeks of admission.

3. **Family Support.** The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

4. **Co-occurring Disorders Program Specific Criteria:** Each Level 3.5 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Mental health consultation.

ii. Crisis intervention services.

iii. Activity therapy.

5. **Women and Dependent Children Program Specific Criteria:** Each Level 3.5 Women and Dependent Children Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services specified in [redacted] and the following services:

i. Child sitting services.

ii. Developmental delay, prevention services.

iii. Activity therapy.

iv. Parenting skills development.

(d) **THERAPEUTIC COMPONENT IMPLEMENTATION.** The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency, and intensity appropriate to each client's assessed needs and expressed desires for care.

1. Service strategies for each Level 3.5 Residential Program shall include, at a minimum:

   i. On duty, awake staff shall provide supervision of client's health, welfare, and safety twenty-four (24) hours a day.

   ii. Client shall have access to clinical services personnel twenty-four (24) hours a day, seven days a week.

   iii. Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

   iv. The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

      I. Implementation of individualized service plan strategies.

      II. Relapse prevention.

      III. Interpersonal choice/decision making skill development.

      IV. Development of a social network supportive of recovery.

      V. Daily living and recovery skills development.

      VI. Random drug screening.

      VII. Health education.

      VIII. Medication administration and monitoring.

2. **Adolescent Program Specific Criteria:** Each Level 3.5 Adolescent High Intensity Program shall document the capacity to provide the service strategies specified in [redacted] and the following therapeutic components:

   i. Adolescent specific evidence based therapeutic interventions.

   ii. Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior,

value system development, puberty/physical development, sexuality, and self esteem.

iii. Recreation and leisure time skills training.

iv. Gender specific treatment.

v. Family, community, and school reintegration services.

3. **Co-occurring Disorders Program Specific Criteria**: Each Level 3.5 Co-occurring Enhanced Program shall document the capacity to provide the service strategies specified in ?????and the following therapeutic components:

i. Groups and classes that address the signs and symptoms of mental health and substance use disorders.

ii. Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation, and to aid in development of alternative coping responses to those cues.

iii. Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

4. **Women and Dependent Children's Program Specific Criteria:** Each Level 3.5 Women and Dependent Children Program shall document the capacity to provide the service strategies specified in ?????and the following therapeutic components:

i. Gender specific services which address issues of relationships, parenting, abuse, and trauma.

ii. Primary medical care, including prenatal care.

iii. Primary pediatric care for children.

iv. Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

v. Outreach to inform pregnant women of the services and priorities.

vi. Interim services while awaiting admission to this level of care.

vii. Recreation and leisure time skills training.

(e) **DOCUMENTATION:** In addition to meeting the requirements of rule [redacted], each Level 3.5 High Intensity Residential Program shall provide the following documentation in each client record:

1. Individualized progress notes shall be recorded each day for each respective service provided in Level 3.5 Services.

2. A staffing report summarizing the client's status relative to treatment goal attainment and continued stay criteria shall be developed in partnership with the client, discussed at case staffings, and entered into the client record as often as the clients needs indicate, but no later than every thirty days for Level 3.5 Services.

(f) **SUPPORT SYSTEMS.** Each Level 3.5 Program shall develop, maintain, and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

1. Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

2. Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

3. Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

4. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

5. Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training, and adult education.

6. Mutual self help groups which are tailored to the needs of the specific client population.

7. Appropriate laboratory and toxicology testing.

8. Psychological and psychiatric services.

10. Direct affiliation with, or coordination through referral to more and less intensive levels of care.

11. **Adolescent Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted] each Level 3.5 Adolescent High Intensity Residential Program shall provide client access to academic or vocational services as according to assessed needs.

12. **Co-occurring Disorders Program Specific Criteria**: In addition to compliance with the criteria specified in [redacted], each Level 3.5 Co-occurring Enhanced High Intensity Residential Program shall provide client access to intensive case management services.

13. **Women and Dependent Children's Program Specific Criteria:** In addition to compliance with the criteria specified in [redacted], the each Level 3.5 High Intensity Residential Treatment Program for Women and Dependent Children shall provide client access to the following support services:

    i. Academic services.

    ii. Financial resource development and planning.

    iii. Family planning services.

(g) **PROGRAM PERSONNEL.** Each level 3.5 High Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

1. Program Coordinator: Each Level 3.5 High Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.

2. Direct Care Personnel. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational procedures for this level of care.

3. Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.5 High Intensity Residential Program as delineated in its operational procedures.

4. Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

5. Maintenance Personnel. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

6. Every client in a Level 3.5 Program shall be assigned to a specific Primary Counselor for care management.

7. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Adolescent Program Specific Criteria Adolescent Program Specific Criteria.

   i. Each Level 3.5 Adolescent Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

   ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

   iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.5 Adolescent High Intensity Residential Program as delineated in its operational plan.

   iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

   v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and

therapeutic environment for services provided at a facility operated by the entity.

vi. Every client in a Level 3.5 Adolescent Program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

9. Co-occurring Disorders Program Specific Criteria.

i. The Level 3.5 Co-occurring Enhanced High Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a Master's degree in a mental health related field and at least two years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

ii. The Level 3.5 Co-occurring Enhanced Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

iii. The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

iv. Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A Master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders; and

II. Specialized training to work with individuals who have co-occurring disorders.

vi. All other direct care personnel in a Level 3.5 Co-occurring Enhanced Program shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

vii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.5 Enhanced High Intensity Residential Program as delineated in its operational plan.

viii. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

ix. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

x. Every client in a Level 3.5 Co-occurring Program shall be assigned to a specific Primary Counselor for care management.

xi. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

10. **Women and Dependent Children Program Specific Criteria:**

i. Each Level 3.5 Women and Dependent Children High Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a Master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

ii. All direct care personnel shall be qualified, as specified in [redacted], to provide the specific services delineated in the entity's operational plan for this level of care.

iii. The entity shall maintain an adequate number of clinical personnel to sustain the Level 3.5 Women and Dependent Children Program as delineated in its operational plan.

iv. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

v. The entity shall maintain an adequate number of maintenance personnel to ensure the operations of a clean, safe, and therapeutic environment for services provided at a facility operated by the entity.

vi. Every client in a Level 3.5 Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

vii. Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(h) **TRAINING.** The entity shall provide written documentation that all Level 3.5 program personnel satisfy the competency and training requirements as specified in rule [redacted]

(i) **SERVICE INTENSITY:** The entity shall develop, maintain, and document implementation of policies and procedures in regard to service intensity for its Level 3.5 residential program, which shall at a minimum specify:

1. The amount and frequency of Level 3.5 services are established on the basis of the unique needs of each client served.

2. The program has the capacity to provide a minimum of twenty-five (25) contact hours of clinical services weekly for each client.

(j) **LENGTH OF SERVICE:** The entity shall provide written documentation that the duration of treatment in its Level 3.5 program is variable as determined by:

1. The severity of the client's illness;

2. The client's ability to comprehend the information provided and use that information to meet treatment goals and strategies; or

3. The appearance of new problems that require another level of care, or

4. The availability of services at an assessed level of need, when a Level 3.5 High Intensity Residential program has been utilized as an interim level of care.

(k) **SERVICE AVAILABILITY:** The entity shall provide written documentation describing the process utilized to establish hours of availability for assessment, intake, admission, and counseling services at its Level 3.5 High Intensity Residential Program. At a minimum, this process shall:

1. Include consideration of the needs of the target population, including work, school, and parenting responsibilities.

2. Include consideration of transportation accessibility.

3. Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Goal #5 Program Compliance Monitoring Attachment #3

ASAIS ID: _____ Last Name: _____ First Name: _____ MI: _____

SASD Adult Integrated Placement Assessment

DIMENSION 1. ACUTE INTOXICATION AND / OR WITHDRAWAL POTENTIAL

Do you have a history of withdrawal symptoms? ☐ Yes ☐ No

When you haven't been able to obtain alcohol and/or other drugs (AOD), cut down on your use, or stopped using; have you experienced any of the following:

☐ Diarrhea ☐ Seizures ☐ Fever ☐ Agitated (fidget, pace, etc.)
☐ Hand Tremors ☐ Nausea / Vomiting ☐ Sweating or heart racing ☐ Yawning
☐ Fatigue ☐ Insomnia or Hypersomnia ☐ Anxiety ☐ Muscle aches
☐ Vivid, unpleasant dreams ☐ Memory Loss ☐ Increased appetite ☐ Move and talk slower than usual
☐ See, feel, or hear things that aren't there ☐ Feeling sad, tense, or angry ☐ Runny nose / watery eyes

Are you currently experiencing any of the above? ☐ Yes ☐ No Explain: _____

Have any of these symptoms kept you from doing social, family, job or other activities? ☐ Yes ☐ No

Have you used AOD to stop or avoid having these symptoms? ☐ Yes ☐ No

Are the symptoms due to a medical condition or some other problem? ☐ Yes ☐ No

Substance Use Background Please use the following codes on the tables below:

Route of Administration:

1- Oral 2 - Smoking 3 - Inhalation 4 - Injection-IV 5 - Injection-Intramuscular 8 - Other (Specify) _____

Frequency of Use: 1 – No use in the past month 2 – 1-3 times in the past month 3 -1-2 times in the past week 4 – 3-6 times in the past week 5 - Daily 8 - Other

	Class of Substance	Specific Substance	Route of Admin.	Age First Used	Last Use	How Long Used	Amount of Use	Frequency of Use	Periods of Abstinence	Rank Substance in order of use
A	None									
B	Alcohol									
C	Cocaine/Crack									
D	Marijuana									
E	Heroin									
F	Non-Prescription Methadone									
G	Other Opiates and Synthetics									
H	PCP									
I	Other Hallucinogens									
J	Methamphetamine									
K	Other Amphetamines									
L	Other Stimulants									
M	Benzodiazepines									
N	Other Nonbenzodiazepine tranquilizers									
O	Barbiturates									
P	Other non-barbiturate sedatives or hypnotics									
Q	Inhalants									
R	Over-the-counter									
Y	Other									
U	Unknown									

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

Do you have / have you had any medical problems, including infectious communicable diseases? ☐ Yes ☐ No

Do you have any known allergies? ☐ Yes ☐ No Explain: _____

Does your chemical use affect your medical conditions in any way? ☐ Yes ☐ No _____

List any medications you currently take, have taken, or should take:

Medication	Prescribed For	Dosage	Frequency	Taking as Prescribed	
None				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

List previous hospitalizations:

Date	Facility	Length of Stay	Treated For
None			

Are you pregnant? ☐ Yes ☐ No ☐ NA Are you receiving prenatal care? ☐ Yes ☐ No ☐ NA # of Pregnancies 0

Pain Assessment Scale

Do you have pain now? ☐ Yes ☐ No If yes, where _____

Rate the pain in relation to what represents the amount of pain you are experiencing:

0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Worst pain imaginable

Is this pain related to withdrawal? ☐ Yes ☐ No ☐ NA If yes, explain: _____

How long have you been in pain? _____ What makes the pain better or worse? _____

What medications do you take to relieve the pain? _____

Have you had this same pain in the recent past? ☐ Yes ☐ No ☐ NA If yes, explain: _____

Are you under a doctor's care for this pain? ☐ Yes ☐ No ☐ NA If yes, explain: _____

TB Checklist Have you had TB or tested positive for TB in the past? ☐ Yes ☐ No

For more than ***two weeks*** do you....

Have sputum-producing cough?	☐ Yes	☐ No	Have night sweats?	☐ Yes	☐ No
Cough up blood	☐ Yes	☐ No	Have a fever	☐ Yes	☐ No
Have loss of appetite	☐ Yes	☐ No	Receive a TB medication	☐ Yes	☐ No

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

As a child, were there any serious physical injuries or mental illnesses causing trauma? ☐ Yes ☐ No

Describe: _____

Have you ever been diagnosed with a Mental Illness? ☐ Yes ☐ No Describe: _____

Have you ever had any treatment for mental/emotional problems? ☐ Yes ☐ No If yes,

When	Where	Level of Care	Length of Tx	Treated For

Have you ever been the victim or perpetrator of abuse: ☐ Sexual ☐ Domestic Violence ☐ Physical ☐ Emotional ☐ Neglect ☐ NA

When: _____ By Whom: _____

Did you receive intervention: ☐ Yes ☐ No Further Assessment Needed: ☐ Yes ☐ No

In the last year, have you felt like hurting or killing yourself? (suicidal ideation) ☐ Yes ☐ No Describe: _____

In the last year, have you felt like hurting or killing someone else? (homicidal ideation) ☐ Yes ☐ No Describe: _____

In the last year, have you experienced hallucinations or difficulty telling what is real from that which is not? (auditory, visual, olfactory, tactile) ☐ Yes ☐ No Describe: _____

In the last year, have you had trouble remembering, concentrating or following simple instructions? ☐ Yes ☐ No Describe: _____

Mental Status Examination

While prompts are provided below, the assessor should make sure to describe his/her observations and impressions of the person for each grouping below.

ORIENTATION

(capacity to identify and recall one's identity and place in time and space; ask directed questions)

Orientation:	☐ Normal	☐ Deficits:	☐ Person	☐ Place	☐ Time	☐ Situation

GENERAL APPEARANCE

(Include general observations about the person's appearance and expression)

Dress:	☐ Appropriate	☐ Meticulous	☐ Eccentric	☐ Seductive	☐ Disheveled
Grooming:	☐ Appropriate	☐ Meticulous	☐ Dirty	☐ Poor	☐ Bizarre
Facial Expression:	☐ Appropriate	☐ Flat	☐ Sad	☐ Angry	☐ Fearful

MOOD/AFFECT

(Mood: sustained emotional state; emotional tone the client subjectively feels i.e. what the client says / Affect: outward expression of person's current feeling state, how they appear to you i.e. facial expressions, body language, laughter, use of humor, tearfulness)

Mood:	☐ Appropriate	☐ Depressed	☐ Euphoric	☐ Anxious	☐ Irritable	☐ Euthymic (normal)
Affect:	☐ Appropriate	☐ Hostile	☐ Blunted	☐ Labile	☐ Broad	☐ Flat

SELF-CONCEPT

Self-concept:	☐ Self-assured	☐ Realistic	☐ Low self-esteem	☐ Inflated self-esteem

SPEECH

(comment on tone, volume and quantity)

Speech:	☐ Normal	☐ Pressured	☐ Stammering	☐ Mute	☐ Loud
	☐ Soft	☐ Rambling	☐ Slurred	☐ Echolalia (compulsive repletion of word)	

MEMORY

(could explain recent and past events in their history; recalls three words immediately after rehearsal then five minutes later; recalls your name after 30 minutes)

Immediate:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired
Recent:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired
Remote:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired

THOUGHT PROCESS

(the movement of thought, the dynamics of how one thought connects to the next; observe speech, some behavior; may need a few targeted questions)

Thought Process:	☐ Logical	☐ Relevant	☐ Coherent	☐ Goal Directed	☐ Illogical
	☐ Incoherent	☐ Circumstantial	☐ Rambling	☐ Flight of Ideas	
	☐ Loose Associations		☐ Tangential	☐ Grossly Disorganized	☐ Blocking
	☐ Neologisms	☐ Confused		☐ Perplexed	☐ Confabulating

THOUGHT CONTENT

(A description of the topics one is thinking about)

Thought Content:	☐ Normal	☐ Somatic Complaints	☐ Illogical Thinking	☐ Hopelessness	☐ Suspicious
	☐ Guilt	☐ Obsessions/Compulsions		☐ Phobias	☐ Poverty of Content
	☐ Suicidal or Homicidal Ideation		☐ Prejudices/Biases	☐ Hypochondriacal	☐ Depressive

JUDGMENT AND INSIGHT

(Judgment: ability to make wise decisions, especially in everyday activities and social matters; Insight: awareness of problems, what they are, and their implications)

Judgment:	☐ Good	☐ Partial	☐ Limited	☐ Poor
Insight:	☐ Good	☐ Partial	☐ Limited	☐ Poor

Notes: _____

DIMENSION 4. READINESS TO CHANGE

Do you have any behaviors that you need to change? (e.g. criminal activity, fighting, cursing) ☐ Yes ☐ No Describe: _____

Do you think you have a problem with AOD and/or mental health? ☐ Yes ☐ No Please explain your response below:

Have you tried to hide your AOD use? ☐ Yes ☐ No Has anyone ever complained about your AOD use? ☐ Yes ☐ No

Has your AOD use caused you to feel depressed, nervous, suspicious, decreased sexual desire, diminished your interest in normal activities or cause other psychological problems? ☐ Yes ☐ No If yes, circle what is indicated and explain:

Has your AOD use affected your health by causing numbness, blackouts, shakes, tingling, TB, STD's, or any other health problems? ☐ Yes ☐ No

Have you continued to use despite the negative consequences (at work, school, or home) of your use? ☐ Yes ☐ No

Have you continued to use despite placing yourself and others in dangerous or unsafe situations? ☐ Yes ☐ No

Have you had problems with the law because of your use? ☐ Yes ☐ No

Has your AOD use affected you socially (fights, problem relationships, etc.)? ☐ Yes ☐ No

Do you need more AOD to get the same high? ☐ Yes ☐ No

Do you spend a great deal of time in activities to obtain AOD and / or feeling it's affects? ☐ Yes ☐ No

Has your AOD use caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed? ☐ Yes ☐ No

Have you continued to use after knowing it caused or contributed to physical and psychological problems? ☐ Yes ☐ No

Have you used larger amounts of AOD than you intended? ☐ Yes ☐ No

Indicate the ***URICA*** score & stage of readiness:

Alcohol Use: _____ ☐ Pre contemplation ☐ Contemplation ☐ Preparation (Action) ☐ Maintenance

Drug Use: _____ ☐ Pre contemplation ☐ Contemplation ☐ Preparation (Action) ☐ Maintenance

DIMENSION 5. RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

How many times have you been treated for ***Alcohol Problems***:

When	Where	Level of Care	Type of Discharge
None			

How many times have you been treated for ***Drug Problems***:

When	Where	Level of Care	Type of Discharge
None			

How many times for detox only? ☐ Alcohol Use ☐ Drug Use

Have you had any periods of abstinence from AOD and / or periods with no mental health problems? ☐ Yes ☐ No

If yes, please describe and answer the next 3 questions: _____

How was that abstinence / maintenance achieved? _____

What would you consider your relapse triggers? _____

Are you aware of what caused you to relapse? ☐ Yes ☐ No _____

Are you participating in any support groups? (AA, NA, church, other) ☐ Yes ☐ No Do you have a sponsor? ☐ Yes ☐ No

Explain: _____

ASAIS ID: _____ Last Name: _____ First Name: _____ MI: _____

Have you ever participated in: ☐ AA ☐ NA ☐ Support Group ☐ Had a Sponsor ☐ No

In the past year, have you tried to reduce the effect of the current issues/problems? ☐ Yes ☐ No Explain:

DIMENSION 6. RECOVERY / LIVING ENVIRONMENT

Living Arrangement: _____ **years** _____ **months** **Number in Household:** _____

A ☐ Independent Living
B ☐ Reside with Family
C ☐ Homeless / Shelter
D ☐ Jail / Correctional Facility
E ☐ Other Institutional Setting (nursing home, etc)
F ☐ Center Operated / Contracted Residential Program
G ☐ Center Subsidized Housing
H ☐ Alabama Housing Finance Authority Housing
I ☐ Other: _____

Employment Status: A ☐ Full-time B ☐ Part-time C ☐ Unemployed, looking D ☐ Homemaker
E ☐ Student F ☐ Retired G ☐ Disabled
H ☐ Confined to Institution/Correction Facility I ☐ Unemployed, not looking for 30 days S ☐ Supported employment

Employment History:

Employer	Position	Dates Employed	Reason for Leaving

Education

Are you currently in school, enrolled in a GED program, or a vocational program? ☐ Yes ☐ No

Legal Status ☐ Voluntary ☐ Involuntary, Criminal ☐ Court Referral

Detailed Legal Status

☐ None ☐ State /Federal Court ☐ Formal Adjudication ☐ Probation/Parole ☐ Other Legal Situations

☐ Diversionary Program ☐ Prison ☐ DUI / DWI ☐ Other: _____

Current Charges: _____

Arrest History	# of Arrests:	Convicted:			# of Arrests:	Convicted:	
Assault		☐ Yes	☐ No	Public Intoxication		☐ Yes	☐ No
Auto Theft		☐ Yes	☐ No	Rape		☐ Yes	☐ No
Burglary		☐ Yes	☐ No	Receiving Stolen Property		☐ Yes	☐ No
Robbery		☐ Yes	☐ No	Fraudulent use of a credit card		☐ Yes	☐ No
Criminal Trespass		☐ Yes	☐ No	Shoplifting		☐ Yes	☐ No
Distribution		☐ Yes	☐ No	Theft of Property		☐ Yes	☐ No
DUI		☐ Yes	☐ No	Violation of Probation		☐ Yes	☐ No
Harassment		☐ Yes	☐ No	Domestic Violence		☐ Yes	☐ No
Minor in Possession		☐ Yes	☐ No	Child / Elder Abuse		☐ Yes	☐ No
Possession		☐ Yes	☐ No	Negotiating a Worthless Negotiable Instrument (NWNI)		☐ Yes	☐ No
Other						☐ Yes	☐ No

# of Arrests in 30 days Prior to Admission _____ Probation Officer: _____

Explanation of the above to include outcome: _____

Family

Do you have dependent children? ☐ Yes ☐ No ☐ NA Ages: _____

If yes, please answer the next 4 questions:

Who has custody of these children? _____

Is there childcare available for these children? ☐ Yes ☐ No ☐ NA Describe: _____

Do you feel you have adequate parenting skills? ☐ Yes ☐ No ☐ NA

Would you be interested in receiving more skills? ☐ Yes ☐ No ☐ NA

Quality of interaction with family: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Level of satisfaction with support system: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe your relationship with your:

Mother: _____

Father: _____

Siblings: _____

Others: _____

Children: _____

Is your current living environment drug free? ☐ Yes ☐ No Explain: _____

Who would you ask to take you to the hospital if you were to suddenly become ill? _____

Would you call the same person to tell some really good news? If not, why and who would you call? _____

Do you have reliable transportation? ☐ Yes ☐ No Describe: _____

ASAM PPC-2R Diagnostic Summary (summarize each dimension as assessed):

Risk Rating: 0 = Indicates full functioning; no severity; no risk in this Dimension. Risk Rating: 1-4 = Indicates various levels of functioning and severity and the level of risk in this Dimension. A: No Immediate Action Required and B: Immediate Action Required (NOTE: A higher number indicates a greater level of severity)
Source: ASAM PPC-2R, pgs 281-312

Dimension 1: Acute Intoxication and / or withdrawal potential: _____

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 2: Biomedical conditions and complications:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 3: Emotional / Behavioral / Cognitive Conditions and Complications:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 4: Readiness to Change:

SA Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

MH Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A ☐ B

Dimension 5: Relapse / Continued Use or Continued Problem Potential:

SA Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

MH Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A ☐ B

Dimension 6: Recovery / Living Environment:

SA Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

MH Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A ☐ B

LEVEL OF CARE PLACEMENT SUMMARY

Assessed Level of Care:
(Check one, unless also receiving OMT)

Population:

☐ Level 0.5 - Early Intervention Services — ☐ Adult ☐ Adolescent

☐ Level I – Outpatient Treatment — ☐ Adult ☐ Adolescent ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level I-D - Ambulatory Detoxification without Extended On-Site Monitoring

☐ Level I-O - Opioid Maintenance Therapy

☐ Level II.1 – Intensive Outpatient Treatment — ☐ Adult ☐ Adolescent ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

ASAIS ID: _____ Last Name: _____ First Name: _____ MI: _____

☐ Level II.5 – Partial Hospitalization ☐ Adult ☐ Adolescent ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level II-D - Ambulatory Detoxification with Extended On-Site Monitoring

☐ Level III.0I – Transitional Residential Treatment ☐ Adult ☐ Adolescent ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level III.I – Clinically Managed Low Intensity Residential Treatment ☐ Adult ☐ Adolescent ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level III.3 - Clinically Managed Medium Intensity Residential Treatment ☐ Adult ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level III.5 - Clinically Managed Medium Intensity Residential Treatment ☐ Adolescents ☐ Pregnant Adolescent Girls and Adolescent Girls with Dependent Children ☐ Adolescents with Co-occurring Substance use with Mental Illness Disorder

☐ Level III.5 - Clinically Managed High Intensity Residential Treatment ☐ Adult ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level III.7 – Medically Monitored Intensive Inpatient Treatment ☐ Adult ☐ Pregnant Women and Women with Dependent Children ☐ Co-occurring Substance use with Mental Illness Disorder

☐ Level III.7 – Medically Monitored High Intensity Inpatient Treatment ☐ Adolescents ☐ Pregnant Adolescent Girls and Adolescent Girls with Dependent Children ☐ Adolescents with Co-occurring Substance use with Mental Illness Disorder

☐ Level III.7-D – Medically Monitored Inpatient Detoxification

Placed Level of Care: _____

Reason for Difference:

1 ☐ N/A No Difference 2 ☐ Service not available 3 ☐ Waiting for Indicated Level
4 ☐ Clinician/Supervisor override 5 ☐ Consumer preference 6 ☐ Court Order
7 ☐ Transportation or Logistical problem 8 ☐ Other _____

Disposition:

1 ☐ Admitted to:_____ for assessed level of care **Date of Admission:** _____

2 ☐ Referred to _____ for assessed level of care

3 ☐ Assessed level not available, referred to _____ for interim care

4 ☐ No services available, referred to _____, _____,

_____ and placed on waiting list(s) in ASAIS

5 ☐ Refused further services. Client discharged.

Release of Information: ☐ An appropriate release for this information is on file for this client

Indigent Offender:	☐ Yes ☐ No	Special Women's Program:	☐ Yes ☐ No
Special Adolescent Program:	☐ Yes ☐ No	Pardons and Paroles Program:	☐ Yes ☐ No
HIV Early Intervention Program:	☐ Yes ☐ No	Special COD Program:	☐ Yes ☐ No

Medical provider review of LOC Assessment:

_____ Agree with the diagnostic impression
_____ Agree with the level of care determination
_____ Agree with the recommended admission to level of care
_____ Agree with the preliminary treatment plan
_____ Treatment authorization _____ Number of days / hours approved
_____ Recommended additional services _____
_____ Need additional information _____

_____ _____
Client Signature Date

_____ _____
Staff Signatures and Credentials Date

_____ _____
Staff Signatures and Credentials Date

_____ _____
Physician Signature Date

CLIENT CHARACTERISTIC DATA SUMMARY

ASAIS ID: _____ Date of Birth: ☐

Last Name: _____ First Name: _____ MI: _____

Co Dependent/Collateral: ☐ Yes ☐ No Principal Source of Referral: ☐ ☐

Client Transaction Type: ☐ Admission ☐ Transfer/Change in Service Fund Code: ☐ SA ☐ OR

Problem Substances

	Type	Detail	Route	Frequency	Age of First Use
Primary					

Secondary					
Tertiary					

Employment Status: ☐ Hearing Status: ☐ Linguistic Status: ☐

Living Arrangements: ☐ Pregnant at Time of Admission: ☐ N/A ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Co-Occurring Disorders Screen: ☐ Negative ☐ Positive Co-Occurring Disorders Assessment: ☐ Yes ☐ No

Co-Occurring: ☐ Yes ☐ No ☐ Unknown Opioid Maintenance Therapy: ☐ Yes ☐ No ☐ Unknown

Number of Prior Treatment Episodes: ☐ ☐ Number of Arrests in 30 days Prior to Admission: ☐ ☐

Financial Support: ☐ ☐ ☐ Health Insurance: ☐ ☐ Source of Payment: ☐ ☐

DSM-IV Diagnostic Impression and/or Diagnosis

Code: Description:

Axis I

Primary _____ _____

_____ _____

Secondary _____ _____

Axis II

_____ _____

_____ _____

Axis III _____

Axis IV

☐ None
1 ☐ Problems with primary support group
2 ☐ Problems related to social environment
3 ☐ Educational Problems
4 ☐ Occupational Problems
5 ☐ Housing Problems
6 ☐ Economic Problems
7 ☐ Problems with access to health care services
8 ☐ Problems related to interaction with legal system / crime
9 ☐ Other psychological and environmental problems

Axis V Current GAF: _____

Population Codes:

☐ A – Alcohol/Drug Using Adols.
☐ V - Women IV Drug User
☐ I – Male IV Drug Users
☐ P – Preg. Women/Women w/dep. Child. IV drug users
☐ F – Preg. Women/Women w/dep. child. alcohol or drug using
☐ D – Adols. IV Drug Users
☐ W – Alcohol/Drug Using Women
☐ N – Not Applicable or Alcohol / Drug Using Males

Goal #5 Program Compliance Monitoring
Attachment # 4

DEPARTMENT OF MENTAL HEALTH
SUBSTANCE ABUSE SERVICES DIVISION
MONITORING COMPLIANCE GUIDELINES
TITLE 45: OF THE CODE OF FEDERAL REGULATIONS PART 96 (45 CFR PART 196) - SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANTS; INTERIM FINAL RULE
2010

I. SASD POLICY

These guidelines establish reasonable and minimum rules for community substance abuse prevention and treatment organizations/agencies under contract with the Department of Mental Health (DMH). The Substance Abuse Services Division of DMH as the Single-State Authority, has the responsibility and authority to appropriately monitor treatment services and activities provided by the various contracting organizations/agencies to ensure total compliance with the language spelled out in Title 45 C.F.R., Part 96 of the Substance Abuse Prevention and Treatment Federal Block Grant (SAPTBG), as well as all binding contractual language as it is written in contracts issued annually by the SAA to purchase treatment services for SA consumers.

II. GLOSSARY OF TERMS

Block Grant: Refers to the Substance Abuse and Prevention Block Grant (SAPTBG), Title 45, Part 96 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-64.

Compliance Renewal Dates: As per the SASD current guidance, all monitoring renewal survey visits will occur within 30 days of the anniversary month of the previous monitoring survey visit. Routine monitoring visits will be scheduled at a minimum of one every five years unless otherwise warranted.

Data: Facts collected or assembled in a computer database, or a compilation of aggregate statistics or trends.

Early Intervention Services Relating to HIV:

1. Appropriate pretest counseling for the detection of HIV and AIDS;

2. Testing individuals with respect to such disease, including:
   a. Tests to confirm the presence of the disease.
   b. Tests to diagnose the extent of the deficiency in the immune system.
   c. Tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;

3. Appropriate post-test HIV and AIDS counseling and education to include:
   a. Risks of needle sharing
   b. Risks of transmission to sexual partners and infants; and
   c. Steps that can be taken to ensure that HIV transmission does not occur.

4. Provide the therapeutic measures described in (2) of this definition.

Evidence-Based: Based on empirical outcome and supported by clinical, scientific, or professional practices that are recognized by a majority of professionals in a particular field.

Financial Charge-Back: Contract dollars reimbursed to DMH for paid services that can not be validated through reliable documentation.

Interim Substance Abuse Services: Temporary services provided for an individual in need of substance abuse treatment who has been denied admission to a program of such treatment on the basis of the lack of capacity of the program to serve the individual. Interim services for pregnant women also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Monitoring Visits: Unannounced or announced visits by the staff of the DMH/SASD to ensure total provider compliance with the Federal Block Grant guidelines and State contract guidelines.

Corrective Compliance Strategy Plan: A plan detailing the action(s) that an agency/organization will take to become compliant with the Federal Block Grant and State contract requirements.

Program Compliance Monitoring Survey: The formal process complete with items to be checked, comments, and findings, used by the SASD staff to conduct State contract compliance and SAPTBG monitoring activities.

Partial Compliance Status: When an agency or entity does not meet all DMH contract and SAPTBG requirements, it may be placed in Partial Compliance Status not to exceed ninety (90) days. If the agency holds a Partial status due to compliance deficiencies following a survey, there will be an automatic one (1) year return visit scheduled.

Substance Use Disorder: The existence of a disorder that meets the criteria as described in the DSM IV-TR for the presence of a condition of "substance dependence" or "substance abuse".

Tuberculosis services:
1. Counseling and educating the individual with respect to tuberculosis; including:

2. Risks of transmission to family

3. Steps that can be taken to ensure tuberculosis transmission do not occur.

4. Testing to determine whether the individual has been infected with mycobacterium tuberculosis in order to determine the appropriate form of treatment for the individual; and

5. Providing for or referring the individual infected by mycobacterium tuberculosis appropriate medical evaluation and treatment.

III. Frequency of Compliance Review

Provider compliance monitoring of the Federal Block Grant and DMH contract will be conducted by staff from the SASD on a schedule not to exceed two (2) years. A total of twenty-five percent (25%) of all providers receiving Federal Block Grant funds will be reviewed in the first year of monitoring implementation and the remaining contract providers will be reviewed in the ensuring calendar year. Following a compliance review if a contract provider receives a two year compliance certificate, the provider only need to complete a DMH survey monkey in the off year. This alternating rotation of visits will remain in effect as part of the monitoring procedure. In addition, SASD staff will review a representative sample of the agency's client records. The review of records will include both open and closed case files with the bulk of the records being reviewed belonging to clients meeting the special populations criteria.

IV. Compliance Review

The initial monitoring review will be initiated with a telephone call notifying the executive director of the month in which the review will occur. The reviewer will then select feasible dates for the monitoring visit with input from the executive director. A *Letter of Intent* (see attached) will follow ten (10) days in advance of the survey informing the agency of the date and time of the monitoring survey. The letter will list the documents to be made available for the survey such as polices and procedures, program descriptions, clinical records, sliding fee scale information, etc. All subsequent reviews will occur in accordance with compliance renewal dates. The renewal date for future visit may be unannounced.

V. Unannounced Visits

DMH and/or its agents has the authority to periodically monitor contract providers continuing compliance with Federal Block Grant and DMH contract requirements as applicable to services and program operations.

VI. Compliance Review Reports

1. Within fifteen (15) days of the compliance visit, the "*SAPTBG Monitoring Survey Report*" will be sent to the agency's executive director or designee and, as applicable, a copy sent to the agency's Board of Directors.

2. The *SAPTBG Monitoring Survey Report* lists each Federal Block Grant requirement not met by the agency/organization and the report may also include comments

regarding quality improvement suggestions. Consistent failure to meet the Block Grant requirements may result in a financial charge-back to the agency and/or loss of the agency's funding contract.

VII. Contract Providers Corrective Compliance Strategy Plan

1. As the result of a monitoring survey the agency/organization receives a "Partial Compliance Status" or is sited for being noncompliant with a particular Block Grant requirement, then the agency must submit to the SASD a "*SAPTBG Program Compliance Monitoring Provider Response*" for issues cited in the report. The Corrective Strategy Plan must be submitted within thirty (30) days after the date of receipt of the *SAPTBG Monitoring Survey Report.*

2. In the event the agency/organization receives a Partial Compliance Status and has been found to have consistently failed to meet requirements in the Block Grant, the agency/organization is required to submit to the SASD a "*SAPTBG Program Compliance Monitoring Provider Response*" that ensures the health/safety of persons served during the pending of any contract revocation.

VIII. DMH Response to Corrective Compliance Strategy Plan

1. Action taken by the SASD when the agency's "*SAPTBG Program Compliance Monitoring Provider Response*" is received may include one or more of the following:

   a. Approve plan as written;
   b. Request additional documentation or a supplemental Corrective Strategy Plan;
   c. Provide technical assistance in deficient area(s) if requested in writing to the SASD, Director of Treatment Services;
   d. Conduct a follow-up monitoring visit within ninety (90) days following the initial visit which discovered the deficiencies.

2. If the agency/organization is found to have multiple (4 or more) findings in not meeting Block Grant and DMH Contract requirements, a follow-up visit must be scheduled within ninety (90) days from receiving the agency's Corrective Strategy Plan or a recommendation must be made to the SASD Associate Commissioner for financial charge-back to the agency/organization.

IX. Loss of Contract Funding

1. If the agency/organization does not comply with Federal Block Grant and/or DMH Contract requirements for identified special populations within a specified timeframe, or if it is found to have consistently failed to meet requirements, a recommendation for loss of contract funding is made to the DMH Commissioner by the SASD Associate Commissioner. A copy of this recommendation is sent via certified mail to the Executive Director of the agency/organization and to its Board of Directors.

2. If the Commissioner notifies an agency/organization of the intent to terminate their funding contract, it may appeal the decision 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 the request. It remains solely within the discretion of the DMH Commissioner to approve such a delay, based upon the type(s) and/or numbers of deficits not met. If approved, the Commissioner will notify the agency/organization of the period of time within which the agency/organization must totally comply with the Block Grant requirements.

3. If the agency/organization does not appeal the decision for contract termination, or does not request a delay to comply with requirements, the agency/organization will loose their funding contract on the date specified by the DMH Commissioner.

X. Appeal Procedures Within DMH

A recommendation by the SASD for loss of contract funding may be appealed within fifteen (15) working days of the agency/organization receiving the report/recommendation. The appeal by the agency/organization must specify the precise reason(s) for the appeal and provide documentation to support modification of the monitoring compliance report recommending loss of contract funding.

1. The first appeal is made to the SA Director of Community Programs. The Director of Community Programs must respond in writing to the appeal within fifteen (15) working days of receipt of the appeal, upholding or revising the initial findings of the monitoring compliance survey report. If the appeal is denied:

2. The second appeal from the agency/organization is made to the SASD Associate Commissioner within fifteen (15) working days of the agency/organization's receipt of the decision on the first appeal.

3. The SASD Associate Commissioner has fifteen (15) working days to schedule a review and respond in writing to the agency/organization either upholding the denial or revising the decision.

4. The third and final appeal by the agency/organization is made to the Commissioner of the Department of Mental Health within fifteen (15) working days of receipt of the second step appeal decision by the SASD Associate Commissioner.

XI. Service Conditions on the Use of Block Grant Funds

(45 CFR, Part 96.124 – Set Aside for Pregnant Women and Women with Dependent Children)

If the program receives Block Grant funds set aside for Specialized Women's Treatment Services for pregnant women and women with dependent children (including women attempting to regain custody of their children), they must comply with the following:

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate;

2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care;

3. The program provides or arranges for childcare while the women are receiving services; the program arranges for Therapeutic Daycare and Early Childhood Programs for children.

4. The program provides or arranges for primary pediatric care for the women's Children, including immunization;

5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sex abuse, physical abuse, and parenting;

6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment, which may among other things, address the children's developmental needs, their issues of sexual and physical abuse, as well as neglect issues;

7. The program provides or arranges for sufficient case management and transportation services to ensure that women and their children have access to the services needed during the course of treatment. Theses services include employment and training programs, education and special education programs and drug-free housing for women and their children.

Note: When pregnant women are referred to the SASD due to unavailability of treatment, the state must:

a. Refer them to programs with the capacity.
b. Ensure interim services, to include pre-natal care, are made available within 48 hours after women seek treatment.
c. Maintain a system for identifying the capacity for pregnant women who can not be admitted.
d. Develop a mechanism to match such women to treatment programs with sufficient capacity.
e. Monitor programs for compliance with these requirements:

    1. SASD will routinely retrieve data through ASIS to determine which programs currently have priority populations awaiting treatment services and if these programs are providing interim services to the client(s).

    2. This information will be compared to the *Capacity Management Notices* received by the SASD.

    3. If a priority population client is on the waiting list for services and interim services are not being provided, SASD will:

a. Determine why
b. Ensure interim services are extended by the provider, and/or provided by another provider within the geographic area
c. Document the rationale as to why services were refused by the client.

4. If a *Capacity Management Notice* was not completed and submitted to SASD, the program will be cited as a result and must immediately implement an action plan to ensure future incidents do not occur.

(45 CFR, Part 96.126 – Capacity of Treatment for Intravenous Substance Abuse)
DMH contract programs using Block Grant funds must offer priority admission, either through immediate admission or priority placement on a waiting list, to individuals for intravenous substance abuse. The program must provide interim services to individuals for intravenous substance abuse on the waiting list and also must report all services to individuals for intravenous substance abuse:

1. No later than 7 days after reaching 90% of its capacity to admit individuals, the program notifies the SASD of that fact;

2. The program admits each individual who request and is in need of treatment for IV drug use no 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.

3. When applicable, the program provides interim services that include, at a minimum, the following:
   a. Counseling and education about HIV and Tuberculosis, about the risks of needle sharing, the risk of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and Tuberculosis transmission does not occur;
   b. Referral for HIV or Tuberculosis services, if needed;
   c. Counseling on the effects of alcohol and other drug use on the fetus for pregnant women, as well as referral for prenatal care. Interim services for pregnant women may also include federally authorized methadone maintenance.

4. The program has established a formal waiting list process that includes a unique patient identifier for each injecting drug user seeking treatment, including patients receiving interim services while awaiting admission to treatment.

5. The program has a mechanism that enables it to maintain contact with individuals awaiting admission for intravenous drug treatment.

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6. Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area. The program must develop written procedures for submission of data to and utilization of the capacity management function of ASAIS to admit clients into treatment for IV drug use.

7. The program removes clients awaiting treatment for intravenous substance use off the waiting list only when:
    a. Such person cannot be located for admission into treatment when services become available;
    b. Such person refuses treatment; or
    c. Such person request to be removed from the waiting list.

8. The program ensures that outreach efforts have polices and procedures that include the following:
    a. Selecting, training, and supervising outreach workers;
    b. Contacting, communicating, and following up with high-risk substance abusers, their associates, 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;
    c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
    d. Recommending steps that can be taken to ensure that HIV transmission dose not occur;
    e. Encouraging entry into treatment.

9. All outreach services must be rendered using outreach models that are locally applicable and scientifically sound. If there are no locally applicable scientifically sound models available, contracted programs are to use one or more of the following scientifically sound outreach models:
    a. The standard intervention model as described in the NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, February 1992,
    b. The health education model as described in Rhodes, F. Humfleet, G. L., et al, Aids Intervention Program for Injection Drug Users: Intervention Manual, February 1992; and
    c. The indigenous leader model as described in Wiebel, W., Levin, L. B., The Indigenous Leader Model: Intervention Manual, February 1992.

(45 CFR, Part 96.127 – Tuberculosis Requirements)
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 DMH for the provision of tuberculosis.

1. 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 mycobacterium tuberculosis to determine the appropriate form of treatment for the individual;
    c. Providing for or referring the individual infected by mycobacterium tuberculosis appropriate medical evaluation and treatment.

2. The program has implemented infection control procedures that are consistent with standards established by the Alabama DMH to prevent the transmission of tuberculosis and that address the following:
    a. Screening patients and identification of those individuals who are at high risk of becoming infected;
    b. Meeting all State reporting requirements for individuals with active TB while adhering to Federal and State confidentiality requirements 45 CFR, Part 160 & 164, Health Insurance Portability and Accountability Act (HIPPA), including 42 CFR Part 2;
    c. Case management activities to ensure that individuals receive such services.

3. For individuals who are denied admission to treatment due to a lack of the program's capacity to serve such a population, the program refers the individual to another provider of tuberculosis services.

(45 CFR, Part 96.127 – Additional Requirements)

1. The program has developed and implemented a formal admission waiting list system.

2. The program utilizes the capacity management functions of ASAIS, as required by the SASD of the Alabama DMH, for the maintenance of an admission waiting list.
    a. Clients are enrolled in ASAIS as prescribed by SASD;
    b. Client admission records are established in ASAIS as prescribed by SASD;
    c. Referrals for admission/continued care are made to other providers through ASAIS utilizing SASD prescribed protocol;
    d. Client referral/transfer records are established in ASAIS as prescribed by SASD;
    e. Client discharge records are established in ASAIS as prescribed by SASD;
    f. Referrals received through ASAIS are managed by the program as prescribed by SASD and are either accepted into the program or denied placement on the program's waiting list;
    g. The program prioritizes individuals on the admissions waiting list as according to SASD established priority population;
    h. The program has developed and implements a formal process for maintaining contact with individuals placed on the waiting list;
    i. The program provides interim services for clients on their waiting list.

j. The Program provides treatment and related therapeutic services to individuals who are categorized indigent by the courts.
    1. The program keeps a court order declaring indigent status on file.
    2. The client's ability/inability to pay is substantiated throughout the provision of services.
    3. The waiver of fees is revoked when the client income exceeds indigent status level.
k. The program provides unimpeded access to clients by Department of Mental Health.
l. The program verifies U. S. citizenship for all clients for whom services are billed to the Alabama Department of Mental Health.
m. HIV risk education is provided to each client.
n. The program admits clients with co-occurring disorders who are appropriately stabilized on medications (Program Specific).
o. Program provides vocational assistance and housing support. (Correctional Programs)

3. The program provides continuing education for employees as according to rules established SASD.

4. The program coordinates the provisions of treatment services with the provision of other appropriate services, including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services.

5. The program has in effect a system to protect client records from inappropriate disclosure, and the system:
    a. Is in compliance with all applicable State and Federal laws and regulations 45 CFR, Parts 160 and 164, as well as 42 CFR Part 2;
    b. Includes provisions for employee education on the confidentiality requirements;
    c. The program provides for employee disciplinary action upon inappropriate disclosure of client information.

(45 CFR, Part 96.128 – HIV Services)

1. 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. Test for individuals with respect to such disease, including test to:
        1. Confirm the presence of the disease;
        2. Diagnose the extent of the deficiency in the immune system;
        3. Provide information on prevention and testing deterioration of the immune system;
        4. Provide information on appropriate therapeutic measures for preventing and treating conditions arising from the disease.

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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.

2. The program has linkage with a comprehensive 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.

3. The program follows all procedures established by the Alabama DMH, in cooperation with the Alabama Department of Public Health Communicable Disease Officer, in regard to the provisions of HIV early intervention services.

4. The program implements written polices and procedures to ensure that: HIV early intervention services will be undertaken voluntarily by, and with the informed consent of, the individual; undergoing such services will not be required as a condition of receiving treatment for a substance abuse or any other services.

(45 CRF, Part 96.131 – Treatment Services for Pregnant Women)
The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.
Further, all agencies/organizations that serve women and who receive block grant funds must provide preference in the following order:

a. To pregnant women with intravenous substance use disorders;
b. To other pregnant women with substance use disorders;
c. To all other intravenous substance use disorders;
d. Women with substance use disorders and dependent children;
e. All other individuals with substance use disorders.

Agencies/organizations receiving Block Grant funds through a DMH Contract must publicize the availability of treatment services for women and the fact that pregnant women receive preference for admission. This may be done in the following ways: street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social services agencies.

1. The program refers pregnant women to the State (SASD) when the program has insufficient capacity to provide treatment services to any such pregnant women who seek the services of the program.

2. The program makes available interim services within 48 hours to pregnant women who cannot be admitted because of the lack of capacity.

3. The program submits data and utilizes ASAIS' functionality as required to support proper working of the state's capacity management program and to ensure that pregnant women receive priority treatment and referral services as appropriate.

(45 CFR, Part 96.135 – Restriction on Expenditures)

1. 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; to provide financial assistance to any entity other than a public or nonprofit entity;
    d. To provide individuals with hypodermic needles or syringe;
    e. To provide treatment services in penal or correctional institutions of the State;
    f. To provide inpatient hospital services, except when services has been determined to be medically necessary and when it has been determined by a physician that:
        1. The primary diagnosis of the individual is substance abuse, and the physician certifies this fact;
        2. The individual cannot be safely treated in a community based, non-hospital, residential treatment program;
        3. The service can be reasonably be expected to improve an individual's condition or level of functioning;
        4. The hospital-based substance abuse program follows national standards of substance abuse professional practice.

2. In the case of an individual for whom a grant/scholarship is expected 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, non-hospital, residential programs for substance abuse.

3. When sub-contracts are issued by the SASD Contracted Agency to purchase services using SAPTBG, the condition of first priority of services will be to pregnant women, and the reporting requirements for NOMS. These requirements will be monitored by the contracting agency. Thus the agency should develop a policy to ensure that all vendors/sub-contractors comply with all the requirements.

(45 CFR Part 96.136- Independent Peer Review)

In addition to regularly scheduled site certification reviews, contracted providers must expect to receive Independent Peer Reviews as the SASD must provide for these. The Peer reviews address the quality, appropriateness, and efficacy of Block Grant funded treatment. Block Grant regulations define:

1. Quality as: the provision of treatment services that meet accepted standards and practices that will improve patient/client health and safety in the context of recovery.

2. Appropriateness as: the provision of treatment services consistent with each individual's identified clinical need and level of functioning.

To determine quality and appropriateness of treatment, reviewers must include examination of a representative sample of patient/client records. In reviewing client records, the reviewer will examine:

1. Admission criteria and intake processes
2. Assessments
3. Treatment planning
4. Documentation of the implementation of treatment strategies
5. Discharge and continuing care planning
6. Indications of treatment outcome

Independent Peer Reviewers must meet specific criteria. They must:

1. Be experts in the substance abuse field.
2. Represent various disciplines used by the program.
3. Be knowledgeable about the modality being reviewed and the underlying theoretical approach to addictions treatment.
4. Be sensitive to the cultural environmental issues that may influence quality of care.
5. Can not be providers/practitioners of the program being reviewed.
6. Can not be individuals who have oversight to make funding decisions of program under review.
7. Must review 5% of Block Grant providers each year.
8. The reviews must not be conducted in conjunction with or as a part of a certification process.

(45 CFR Part 96.137 - Payment Schedule)
The program uses the Block Grant as the "payment of last resort" for services for pregnant women and women with dependent children, TB services, and HIV services and, therefore makes every reasonable effort to do the following:

1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX; any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

2. Secure from patients or clients' payments for services in accordance with their ability to pay.

The program does not use Block Grant Funds to pay salaries of senior executives more than the level 1 on the Federal Pay Scale or $193,300 as listed in 2008.

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.

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).

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).

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.

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.			

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.	___	___	___

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;	a. Type of service rendered.	___	___	___
	b. Setting in which the service was rendered;	b. Setting in which service was rendered.	___	___	___
	c. Date and amount of time spent on delivering the service;	c. Date and time service was delivered.	___	___	___
	d. Client's involvement in the activity;	d. Client's involvement in the activity.	___	___	___
	e. Relationship of the service to the client's treatment or rehabilitation plan.	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:	a. The Problem Assessment includes the following required elements:	___	___	___
	1. Family history;	1. Family history;	___	___	___
	2. Educational history;	2. Educational history;	___	___	___
	3. Relevant medical background;	3. Relevant medical background;	___	___	___
	4. Employment/vocational history;	4. Employment/vocational history;	___	___	___
	5. Psychological/psychiatric history;	5. Psychological/psychiatric history;	___	___	___
	6. Military history;	6. Military history;	___	___	___
	7. Legal history;	7. Legal history;	___	___	___
	8. Alcohol/drug abuse history;	8. Alcohol/drug abuse history;	___	___	___
	9. Mental status examination;	9. Mental status examination.	___	___	___
	b. **Client identifying data including**:	b. Required client identifying data is on file.	___	___	___
	1. Case number;	1. Case number;	___	___	___
	2. Client name;	2. Client name;	___	___	___
	3. Date of birth;	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.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___

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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).	___	___	___

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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
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
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	___	___	___
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.	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___

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. 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.	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. 2. Supportive care services a. Supportive counseling; b. Substance abuse education (didactic group); c. Family education.	___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___

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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.	___	___	___

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.	___ ___ ___	___ ___ ___	___ ___ ___

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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 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.	d. Assays reflect required cut-offs for each substance tested. 1. Other ORT drugs used with State Methadone Authority approval.	____	____	____
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.	____	____	____

Standard		Measurement Criteria	YES	NO	N/A
7809	All direct service staff must be trained in:				
	a. CPR	a. Staff trained in CPR	___	___	___
	b. Program policies and procedures.	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.	___	___	___

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.	____	____	____

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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.	___ ___ ___ ___ ___	___ ___ ___ ___ ___	___ ___ ___ ___ ___

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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.	___	___	___

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.			

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:	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.	____	____	____
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.	____	____	____

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.	____	____	____

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.	___	___	___

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.			