I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2013

State DUNS Number

Number
929956324

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name
Alabama Department of Mental Health

Organizational Unit
Substance Abuse Services Division

Mailing Address
100 North Union Street, Suite 430

City
Montgomery

Zip Code
36130-1410

II. Contact Person for the Grantee of the Block Grant

First Name
Tammy

Last Name
Peacock, PhD., LCSW, CADP

Agency Name
Alabama Department of Mental Health

Mailing Address
100 North Union Street, Suite 420

City
Montgomery

Zip Code
36130-1410

Telephone
334-242-3642

Fax
334-242-3025

Email Address
tammy.peacock@mh.alabama.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
10/1/2009

To
9/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date
10/3/2011 8:03:08 PM

Revision Date
12/22/2011 3:29:39 PM

V. Contact Person Responsible for Application Submission

First Name
Brandon

Last Name
Folks

Telephone
334-353-7175

Fax
334-242-0759

Email Address
brandon.folks@mh.alabama.gov

Footnotes:

I: State Information

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 Costal 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.

Name	Zelia Baugh
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

Certifications

1. Certification Regarding Debarment and Suspension

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

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place 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), ?, (d), ?, and (f).

For purposes of paragraph ? 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. Certifications Regarding Lobbying

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned 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, subgrants, 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, daycare, 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 Services 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.

Name	Zelia Baugh
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

FY 2012 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

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

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

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

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

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

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. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Alabama will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS 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.

Name	Robert Bentley, MD
Title	Governor
Organization	Alabama Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

PLANNING STEPS

Step 1: Assess the strengths and needs of the service system to address the specific populations.

1. OVERVIEW OF ALABAMA'S SUBSTANCE ABUSE PREVENTION, EARLY INTERVENTION, TREATMENT, AND RECOVERY SUPPORT SYSTEM

This plan describes the Alabama Department of Mental Health's substance abuse prevention and treatment system and its priorities, goals, and strategies for utilization of Substance Abuse Block Grant funds in FY 2012 - FY 2013.

The Alabama Department of Mental Health (ADMH) was established by Alabama Acts 1965, No. 881, Section 22-50-2. A cabinet-level state government agency, ADMH has the authority to act in any prudent way to provide mental health and intellectual disability services for the people of Alabama. Act 881 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 illness, including but not limited to, alcoholism, drug addiction, or epilepsy in combination with mental illness or intellectual disability.

ADMH is comprised of three unique divisions: Administration, Developmental Disabilities, and Mental Illness and Substance Abuse Services. Each division operates under the direction and control of its own Associate Commissioner who is appointed by and reports directly to the ADMH Commissioner. The Commissioner reports directly to the Governor. A Board of Trustees, appointed by the Governor, serves in an advisory capacity to the Commissioner.

Among its designated powers, ADMH is authorized to plan, supervise, coordinate, and establish standards for all operations and activities of the State of Alabama, including the provision of services, related to intellectual disability and mental health. ADMH's two service divisions, the Intellectual Disabilities Division and the Mental Illness and Substance Abuse Services Division have primary responsibility for accomplishment of these tasks.

Historically, ADMH's responsibilities for mental illness services and substance abuse services were under the supervision of two distinct Associate Commissioners who operated two separate service divisions, respectively. In March 2011, seeking to create an organizational structure that would enable more efficient and effective service delivery for individuals who have mental illness, substance use, and co-occurring mental illness and substance use disorders, ADMH's Commissioner merged the operations of the two divisions. Now functioning under the supervision of one individual, the Associate Commissioner of Mental Illness Division and Substance Abuse Services, this newly combined division is working towards systems integration through establishment of a common vision and mission, development of unified policies and procedures, and realignment of staff roles and responsibilities. This rigorous process is likely to be a work in progress throughout FY 12 and FY 13.

ADMH is designated as the single state agency in Alabama authorized to receive and administer any and all funds available from any source to support the provision of services and other activities within the scope of its statutory authority. This responsibility includes receipt and administration of the Mental Illness and Substance Abuse Block Grants provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). ADMH's decision to submit separate SAMHSA block grant applications for mental illness and substance abuse services, respectively, for FY 12 – FY 13 allows for more realistic planning based upon currently identified needs, than does submission of a combined application that plans for a behavioral health division that is still in the early stages of conceptualization.

2. ORGANIZATION OF ALABAMA'S SUBSTANCE ABUSE SERVICE DELIVERY SYSTEM

ALABAMA DEPARTMENT OF MENTAL HEALTH

ADMH has established a formal committee structure through which service providers, service recipients, families, and advocates actively participate in the Department's planning and budgeting processes. Created in 1994, a Management Steering Committee provides for the development and oversight of a planning process for the provision of mental illness, developmental disabilities, and substance abuse services. This committee, in accordance with guidelines established by the ADMH Commissioner, is charged with the following responsibilities:

1. Develop strategic direction for the provision of developmental disabilities, mental illness, and substance abuse services;

2. Develop the Departmental legislative budget requests consistent with established priorities;

3. Develop budget allocations and major reallocations (e.g., proration, revenue changes, etc.) which impact the plan;

4. Review quarterly the progress on plan implementation;

5. Establish a conflict-resolution procedure, including criteria and guidelines under which issues shall be determined to be subject to such procedure;

The Management Steering Committee also has responsibility for establishing Coordinating Subcommittees to facilitate the development of plans for developmental disabilities, mental illness, and substance abuse services, respectively. The Coordinating Subcommittees, chaired by the Associate Commissioner for each departmental division, function to integrate local and regional planning efforts with statewide planning, consistent with the strategic directions established by the Management Steering Committee. Plans and recommendations developed by the Coordinating Subcommittees

are sent to the Management Steering Committee for review and appropriate action. Actions and recommendations of the Management Steering Committee are advisory to the Commissioner and do not circumvent or diminish ADMH's statutory authority.

Act 881 grants ADMH statutory responsibility for operation and regulation of Alabama's public substance abuse service delivery system. Specific responsibilities, as implemented through the Division of Mental Illness and Substance Abuse Services (the Division), include:

- Planning, development, coordination, and management of a comprehensive system of prevention, treatment and recovery support services for individuals adversely impacted by, or with the potential to be adversely impacted, by alcohol, tobacco, and/or other drug use;
- Resource solicitation, development, and dissemination;
- Funding solicitation, receipt, and allocation;
- Contracting for service delivery and contract compliance monitoring;
- Development of program certification regulations, and management and implementation of a regulatory review process;
- Development and dissemination of best practice guidelines for prevention, treatment, and recovery support services;
- Collaboration with state and local government and community-based organizations to support fulfillment of its statutory responsibilities;
- Protection of client rights, confidentiality, and privacy; and
- Collaboration with service recipients and advocates to support systems improvements and enhanced service outcomes.

For planning purposes, ADMH's former Substance Abuse Service Division has divided the state into four (4) regions which are defined in terms of Alabama's sixty seven (67) counties, as listed in **TABLE 1.**

TABLE 1 **ADMH Mental Health Regions**

Region 1	Region 2	Region 3	Region 4
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
De Kalb	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**	

Service Delivery

ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services. The agency has established the state's public system of services through the execution of contractual agreements with sixty four (64) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of six (6) levels of care that together, compose the state's treatment service continuum, funds to provide one or more of the six (6) primary preventions strategies, and/or funds to provide recovery support services. ADMH also certifies thirty four (34) other providers but does not have a contractual relationship with them.

The SABG provided by SAMHSA is the primary funding source for Alabama's public system of substance abuse services. State funding is provided by the Alabama State Legislature. The Alabama Medicaid Agency makes payment through ADMH to providers for services rendered through its rehabilitation services option for eligible Medicaid recipients. Providers are reimbursed by ADMH on a fee for service basis.

TREATMENT SERVICES

Treatment Eligibility Criteria

Contract providers are required to abide by the following eligibility requirements in order to bill ADMH on a fee-for-service basis for services provided:

1. The individual must 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.

    - Pregnant women (with diagnostic criteria).
    - Women with dependent children (with diagnostic criteria).
    - Injection drug users (6 month history of injection drug use and injection drug use within the last 30 days, with diagnostic criteria).
    - Psychoactive substance dependence, severe.
    - Psychoactive substance dependence, moderate.
    - Psychoactive substance dependence, mild.
    - Psychoactive substance abuse.

2. All potential clients must be screened for substance use and co-occurring disorders, as according to ADMH specified policies and procedures.

3. A need for financial assistance must be established by an individual financial assessment.

4. Efforts must be made to collect reimbursement for the costs of providing services for individuals who are entitled to insurance benefits under the Social Security Act, including programs under title XVIII, any State compensation program, and any other public assistance program for medical expenses, any grant program, any private insurance, or any other benefit program.

5. Providers may secure client payment for services in accordance with the ability to pay. However, the client's inability to pay cannot be a barrier to treatment.

Use of Placement Criteria

Alabama has established a standardized screening process and adopted the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for use in making decisions for appropriate referrals for treatment. Unable to find such an instrument after extensive search, staff of the ADMH Substance Abuse Services Division worked over a three-year period to develop a clinical placement assessment that would:

- Establish a need for immediate crisis intervention.
- Establish a DSM IV TR diagnosis or diagnostic impression indicating the existence of a substance related disorder.
- Screen for the presence for co-occurring mental disorders.
- Collect adequate information in each of the six (6) ASAM dimensions to support client placement in a level of care appropriate to his or her needs. The ASAM dimensions include (1) Acute Intoxication and/or Withdrawal Potential; (2) Biomedical Conditions and Complications; (3) Emotional/Behavioral/Cognitive Conditions and Complications; (4) Readiness to Change; (5) Relapse, Continued Use or Continued Problem Potential; and Recovery Living Environment.
- Provide for timely administration in one setting.

The resulting document, the SASD Integrated Placement Assessment, was developed in consultation with Dr. David Mee Lee, Chief Editor of the American Society of Addiction Medicine Patient Placement Criteria 2-R. The Integrated Assessment incorporates the ASAM Placement Criteria with the URICA, MINI SCREEN, and a mental status examination to provide for a comprehensive assessment of needs to support a level of care decision.

Treatment Levels of Care

ADMH, in accordance with its regulatory authority, has established standards of care in the Alabama Administrative Code that are used to certify programs as eligible to provide substance abuse treatment services. Only programs that have been surveyed by ADMH and found to be in compliance with its regulatory standards are eligible to receive funding

from the agency. ADMH treatment standards currently address the following six (6) levels of care:

1. **Crisis Residential:** A highly structured, short-term, substance abuse treatment service providing intensive therapeutic activities for the purpose of client stabilization. Services are provided within a 24-hour staff supervised residential facility.

2. **Residential Rehabilitation:** A long-term, six (6) to twelve (12) months, 24-hour staff supervised residential supportive service. Onsite therapeutic activities combine with community activities, resources, and support systems necessary for sustained recovery.

3. **Residential Detoxification Programs**: A 24-hour medically managed service that provides medical monitoring and intervention intended to aid in withdrawal from alcohol or other drugs requiring such, to promote recovery from the toxic effects of the drugs or alcohol, and to stabilize psychological, physiological, and behavioral functions.

4. **Outpatient Program:** Flexibly scheduled individual or group sessions in which addiction treatment personnel provide professionally directed evaluation and treatment for substance use disorders.

5. **Intensive Outpatient Program:** A program providing structured alcohol and drug use related clinical services for clients who have fairly stable to stable mental and/or physical health problems, as well as, supportive living arrangements. Services are provided a minimum of nine (9) hours for adults and six (6) hours for adolescents, weekly.

6. **Opiate Maintenance Therapy**: An organized ambulatory addiction treatment service for opiate addicted clients delivered by trained personnel. The nature of the services provided is determined by the individual's clinical needs, but includes case management, psychosocial treatment sessions, and daily, or other scheduled, medication visits within a structured program. Opioid maintenance therapy is provided under a defined set of policies and procedures stipulated by state and federal law and regulation.

Within Alabama's treatment service continuum, services are provided for males and females, adults and adolescents. In addition, the Division funds specialized programs for the following populations: pregnant women and women with dependent children, individuals who have co-occurring disorders, individuals participating in drug court programs, and individuals diverted from the criminal justice system. Program locations funded by ADMH are identified by region in **TABLE 2.**

TABLE 2

Adult and Adolescent Regional Service	Region	Region	Region	Region	TOTAL

Locations	1		2		3		4		
	Adult	Adoles	Adult	Adoles	Adult	Adoles	Adult	Adoles	
IOP	27	6	18	8	13	3	22	3	100
IOP/Special Women Services	1		4		3		1		9
IOP/Crisis Residential Component									0
IOP/Residential Rehabilitation Component			1		1				2
IOP/Partial Hosp Component									0
IOP/Co-occurring Component			1		1		1		3
Outpatient	10	7	7	8		3	1	4	40
Crisis Residential	5	1	4				4	1	15
Residential Rehabilitation/Special Women Services			3						3
Residential Rehabilitation	10		6		1		4		21
Residential Detoxification			2						2
Residential/Corrections	1				2				3
Residential/Co-occurring Disorders			1				1		2
Opioid Maintenance Treatment							1		1
Total	54	14	47	16	21	6	35	8	201

In addition to funding for the six (6) levels of care, ADMH also provides funding for the services identified in TABLE 3. These services may be provided within the levels of care and specialized programs described above:

TABLE 3

Services Funded to Support Levels of Care	
Case Management	Individual Counseling
Diagnostic Interview	Physician Support
Family Counseling	Bed, Board, and, and Protection
Group Counseling	Ancillary Services

Program certification regulations are nearing completion for public comment to expand the levels of care offered in Alabama's public substance abuse service delivery system. The levels of care to be established consist of a modification of the levels of care established in the ASAM PPC-2R, as indicated in **TABLE 4.** As indicated, specialty levels of care will be available for adolescents, individuals with co-occurring disorders, and pregnant women and women with dependent children, with the exception of

TABLE 4

ADMH Levels of Care	
Level 0.5: Early Intervention Services, consisting of:	
	Early Intervention Services for Adults.
	Early Intervention Services for Adolescents.
	Early Intervention Services for Pregnant Women and Women with Dependent Children.
	Early Intervention Services for Persons with Co-Occurring Substance Use and Mental Disorders.
Level I: Outpatient Treatment, consisting of:	
	Outpatient Services for Adults.
	Outpatient Services for Adolescents.

	Outpatient Services for Pregnant Women and Women with Dependent Children.
	Outpatient Services for Pregnant Women and Women with Dependent Children.
	Outpatient Services for Persons with Co-Occurring Substance Use and Mental Disorders.
	Ambulatory Detoxification Without Extended on-site Monitoring.
	Opioid Maintenance Therapy Program.
Level II: Intensive Outpatient Services/Partial Hospital Treatment, consisting of:	
	Intensive Outpatient Services for Adults.
	Intensive Outpatient Services for Adolescents.
	Intensive Outpatient Services for Pregnant Women and Women with Dependent Children.
	Intensive Outpatient Services for Persons with Co-Occurring Substance Use and Mental Disorders.
	Partial Hospital Program for Adults.
	Partial Hospital Program for Adolescents.
	Partial Hospital Program for Pregnant Women and Women with Dependent Children.
	Partial Hospital Program for Persons with Co-Occurring Substance Use and Mental Disorders.
	Ambulatory Detoxification With Extended on-site Monitoring.
Level III: Residential Treatment Services, consisting of:	
	Transitional Residential Services for Adults
	Transitional Residential Services for Adolescents.
	Clinically Managed Low Intensity Residential Programs for Adults.
	Clinically Managed Low Intensity Residential Programs for Adolescents.
	Clinically Managed Low Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed Low Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Clinically Managed Medium Intensity Residential Programs for Adults
	Clinically Managed Medium Intensity Residential Programs for Adolescents.
	Clinically Managed Medium Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed Medium Intensity Residential Programs for Persons with Co-Occurring Substance Use and Mental Disorders.
	Clinically Managed High Intensity Residential Programs for Adults.
	Clinically Managed High Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed High Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Medically Monitored Intensive Residential Programs for Adults.
	Medically Monitored Intensive Residential Programs for Pregnant Women and Women with Dependent Children.
	Medically Monitored Intensive Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Medically Monitored High-Intensity Residential Programs for Adolescents.
	Medically Monitored Residential Detoxification Program.

PREVENTION SERVICES

ADMH, in accordance with its regulatory authority, has established service delivery standards in the Alabama Administrative Code used to certify programs as eligible to provide substance abuse prevention services. Currently certification is required only of prevention programs operated by community-based organizations that receive funding from ADMH. These standards currently address the following six (6) prevention strategies:

1. **Information Dissemination**: The Division has implemented a statewide system for distributing substance abuse information through the establishment of two regional clearinghouses. Information dissemination is a way of creating awareness and knowledge about the use, abuse and addiction of alcohol and other drugs and/or services available, and is characterized by one-way communication from the source to the audience, with little or no contact between the two.

2. **Education**: This strategy involves two-way communication and is distinguished from information dissemination by the fact that it is based on an interaction between the educator and the participants. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal, and critical analysis skills. Examples of methods used are the following: classroom and small group sessions, parenting and family management classes, peer leader and peer helper programs, education programs for youth groups, and educational groups for children of substance abusers. This strategy may be used in conjunction with other strategies, practices and policies to have efficacy in communities.

3. **Alternative Programs**: Evidence does not support the use of an alternative strategy as a sole prevention strategy with the intended target population. Alternatives are most effective when used as a part of a comprehensive plan of prevention services. The goal of this strategy is to have target populations participate in activities that are alcohol, tobacco, and other drug free in nature and incorporate educational messages. Examples of methods used in this strategy are summer recreational activities, drug free dances, youth and adult leadership activities, community service centers and mentoring programs.

4. **Problem Identification and Referral**: This strategy aims at the general classification of those who have indulged in illegal or age-inappropriate use of tobacco or alcohol, and those who have indulged in the first use of illicit drugs, in order to assess whether the behavior can be reversed through education. It should be noted that this strategy does not include any function designed to determine whether a person is in need of treatment.

5. **Community-Based Process**: The Community Based Process Strategy is aimed to enhance the ability of the community to provide more effective prevention services for substance abuse issues. Activities in this strategy include organizing, planning, and enhancing efficiency and effectiveness of the services being offered. Effective organizing and planning are paramount to the success of prevention practices, policies and programs. These programs consist of activities at the community level to train volunteers, parents, community action groups, school teachers, law enforcement personnel, health workers, and other professionals on topics that impact directly or indirectly alcohol, tobacco, or other drug use.

6. **Environmental**: Environmental strategies focus on the cause and the conditions of the community environment that are:

    - Changing economic conditions (How much things cost; how available things are);

- Changing social conditions (What people think; how people live;
- Changing media conditions (what people read, watch,, hear, and see); and
- Changing political conditions (Who has power; who has influence)

Environmental strategies also focus on changing the norms and regulations that influence/control the social and physical contexts of the use of alcohol, tobacco and other drugs.

Eligibility Criteria for Prevention Services:

Prevention services may be provided to target populations as defined in the Division's Substance Abuse Prevention Planning Guidelines. Services must be based upon assessed community needs with priority given to programs that serve at risk individuals and communities. 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. All prevention services must be approved by ADMH prior to implementation.

Strategic Prevention Framework

In 2010, the Division executed a Cooperative Agreement with SAMHSA to support implementation of the Strategic Prevention Framework (SPF) as the planning process for prevention services in Alabama. A project director has been assigned responsibility for management of this State Incentive Grant and is working in conjunction with the State Prevention Advisory Board (SPAB) and the Alabama Epidemiological Outcomes Workgroup (AEOW) to fulfill its objectives.

The SPAB, originally appointed by Governor Bob Riley, consists of a multidisciplinary group of individuals who are interested in substance abuse prevention services in Alabama, and who have a range of experience (personal and professional), skills, and resources to support the successful development and implementation of the SPF. The AEOW works under the authority of the ADMH. Its membership consists of organizations and agencies that collect state specific data. The AEOW functions to support state and community efforts to prevent substance abuse, dependency, and related problem, collect, analyze, and disseminate data, and to describe the prevalence, consumption, and consequences of alcohol, tobacco, and other drug use in Alabama. The AEOW is chaired by the Division's Epidemiologist and the Prevention Services Director.

RECOVERY SUPPORT

ADMH has not traditionally funded recovery support services in its substance abuse service delivery system however we have included these services in our Medicaid State Plan Amendment and expanded service array. In preparation for development of a recovery oriented system of care, ADMH has provided funding for peer support training through one of our consumer advocacy groups. Through this funding more than seventy (70) individuals have been trained and certified in peer support. ADMH has also

established standards for these specialist as part of its newly developed regulatory requirements.

ALABAMA MEDICAID AGENCY

The Alabama Medicaid Agency is a close collaborator of the ADMH in regard to service development and funding for the state's public system of services for substance use disorders. Through its state plan Rehabilitation Option, Medicaid has approved a broad array of covered services to support rehabilitation of individuals enrolled in ADMH sanctioned treatment programs. These services, as identified **TABLE 5** below, may only be provided for an eligible Medicaid recipient, based upon medical necessity, by an appropriately credentialed provider working in an ADMH certified program. ADMH pays the Federal Financial Participation state match requirements for substance abuse treatment programs that meet the staffing, certification and reporting criteria it has established for such.

TABLE 5

Intake Evaluation	Family Counseling
Physician/Medical Assessment and Treatment	Group Counseling
Diagnostic Testing	Medication Administration
Crisis Intervention	Medication Monitoring
Individual Counseling	Mental Health Consultation
Substance Abuse Intensive Outpatient Services	Basic Living Skills
Family Support	Methadone Treatment

In calendar year 2010 the Alabama Medicaid Agency paid claims for 45,280 unduplicated recipients who had a primary alcohol, drug, or tobacco abuse or dependency diagnosis. These claims included those submitted by ADMH for rehabilitation services, as well as those submitted by providers outside of the ADMH system.

OTHER STATE AGENCIES

Although ADMH has statutory responsibility for and is the greatest contributor to the operations and development of Alabama's public substance abuse treatment system, other state agencies **(TABLE 6)** have over time created substance abuse treatment and prevention systems within their organizational structures to specifically address needs they have identified in the public sector.

TABLE 6

State Agency	Services Provided
Alabama Department of Corrections	Substance Abuse Treatment for Inmates
Alabama Department of Pardons and Parole	Substance Abuse Treatment for Parolees
Alabama Administrative Office of the Courts	DUI Early Intervention, Court Referral Services, Drug Courts
Alabama Department of Public Health	Prescription Drug Monitoring Program, Smoking Prevention and Treatment
Alabama Department of Youth Services	Substance Abuse Treatment for Youthful Offenders,

	Medicaid Rehabilitation Services
Alabama Community Corrections	Substance Abuse Treatment for Individuals Diverted from Correctional Settings
Alabama Department of Human Resources	Contractual Substance Abuse Treatment and Medicaid Rehabilitation Option Services
Alabama Department of Education	Substance Abuse Prevention
Alabama Department of Economic Affairs	Underage Drinking Initiatives

b. REGIONAL, COUNTY, AND LOCAL ENTITIES THAT PROVIDE SUBSTANCE ABUSE SERVICES OR CONTRIBUTE RESOURCES THAT ASSIST IN PROVIDING THE SERVICES.

REGIONAL, COUNTY, AND LOCAL ENTITIES

Entities participating as providers in Alabama's public system of substance abuse services are legally structured as either (a) a public not-for-profit organizations operating under the authority of Alabama Acts 1967, Act 310; or (b) private not-for-profit organizations or (c) private for profit corporations or partnerships operating under the authority of Alabama Business and Nonprofits Entities Code, Title 10a of the Code of Alabama 1975. ADMH's relationship to these organizations is described below:

Public Not-For Profit Organizations

Alabama Acts 1967, Act Number 310, Sections 22-51-1 -14 provides for the formation and operation of public corporations to contract with ADMH for constructing facilities and operating programs for mental health services. Such entities are known as "310 Boards". Comprehensive 310 Boards are authorized to directly provide planning, studies, and services, for mental illness, intellectual disability, and substance abuse populations for all counties for which they are incorporated to serve. Membership of the 310 Boards consists of appointments made by local city and county governments. The executive directors of 310 Boards are significant contributors to ADMH's planning and budgeting processes, with prominent positions on the agency's Management Steering Committee and the Substance Abuse Coordinating Subcommittee.

There are twenty-five (25) regional 310 Boards encompassing twenty-two (22) catchment areas in the state. ADMH certifies, contracts with twenty-one (21) and funds twenty (20) of these Boards for the operation of programs in the state's public system of substance abuse services. Funding is provided by ADMH to support the operations of substance abuse programs operated by the 310 Boards, with two exceptions. Jefferson-Blount- St. Clair Mental Health Authority (JBS) serves only as mechanism for pass through of funds from ADMH to ADMH selected community-based free-standing programs. The other exception is AltaPointe Health Systems. This agency receives funding from ADMH for programs it operates, as well as, serves as a conduit for pass through of funds to free-standing substance abuse prevention and treatment programs. ADMH does not assign 310 boards with any responsibility for management, funding, or monitoring other substance abuse programs within their catchment service area.

Free-Standing Private Not-For-Profit Organizations

Free-standing charitable agencies either contract directly with ADMH or through JBS or AltaPointe for funding to support the services they provide. These entities have their own Governing Boards, and have no ties to ADMH or other governmental agencies except on a contractual basis. The mission, operational policies and procedures, and scope of services provided by these agencies are established by the entity's Board of Directors. Representatives from free-standing organizations participate in ADMH's planning processes by invitation only or as a citizen participant in an open public meeting.

Private For-Profit Organizations

Private for profit organization are free standing programs that operate as a for profit business entity. Privately owned, these entities contract with ADMH are Medicaid service providers. Participate in ADMH's planning processes is by invitation or as a citizen participant in an open public meeting.

Provider Participation Requirements

Each entity contracting with ADMH must meet all certification, reporting, and data submission requirements as specified by the state. All claims for services provided, regardless of whether the payment source is SABG funding, state funding, or Medicaid reimbursement, must be submitted to ADMH through its Alabama Substance Abuse Management Information System (ASAIS). Provider contacts incorporate all SABG requirements and assurances.

c. How these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Beyond contractual requirements for compliance with applicable federal and state laws relative to equal opportunity and discrimination, establishment of procedures for service recipients to access advocates as needed, and promulgation of program certification standards relative to client rights, ADMH has not directed its contract or certified providers to engage in specific activities to address the diverse needs of racial, ethnic and sexual gender minorities. In addition, it has not come to the attention of the agency through its program certification application and review processes, contract monitoring procedures, or through the provision of onsite technical assistance, of any current initiatives in the state's public substance service delivery system which have a specific racial, ethnic, or sexual gender minority population as the target of focus.

As indicated in **TABLE 7**, there has been little change in the demographics of the state's treatment population during the last four years, although data in regard to gender minorities has not been maintained. On the other hand, the system's contract prevention providers are currently required to develop annual prevention plans. ADMH requires a data driven assessment of the provider's service area needs, analysis of community data gathered during the assessment process, and prevention service planning and delivery based upon the risks and protective factors identified. This process has frequently

resulted in the identification of at risk populations for service delivery, which historically have been African American children and youth.

TABLE 7

ADMH TREATMENT POPULATION	2005	2006	2009	2010
TOTAL	**20,081**	**20,845**	**22,346**	**22,755**
Sex				
Male	67.2	69.4	70.4	68.4
Female	38.2	30.6	29.6	31.6
Age at Admission				
0-11	0.0	0.0	0.1	0.0
12-17	9.7	9.7	7.3	7.5
18-20	7.3	6.9	6.2	4.8
21-25	16.6	15.1	15.6	14.9
26-30	15.3	15.4	16.5	16.6
31-35	12.9	12.1	12.2	13.3
36-40	11.8	10.9	10.8	10.4
41-45	11.2	11.2	9.9	9.4
46-50	8.1	7.8	8.9	8.4
51-55	3.6	3.9	5.3	5.8
56-60	1.3	1.6	2.3	2.3
61-65	0.6	0.6	0.8	0.8
66+	0.3	0.3	0.3	0.4
Unknown	1.4	4.6	3.7	5.5
Race				
White	59.3	58.2	56.7	57.1
African American	39.4	40.9	36.9	35.6
American Indian or Alaska Native		0.1	0.4	0.3
Asian or Native Hawaiian or Other Pacific Islander	0.1	0.2	0.1	0.1
Other	0.3	0.4	0.4	0.6
Unknown	0.9	0.3	5.6	6.3
Ethnicity				
Hispanic or Latino	0.4	1.6	0.9	0.7
Not Hispanic or Latino	24.5	98.4	82.9	86.3
Unknown	75.1	0.0	16.2	13.0

d. Strengths and Weaknesses of the System

Numerous strengths support the operations of Alabama's public substance abuse service delivery system, including:

- **Collaborative Relationships**: ADMH has a history of collaboration with other agencies: which supports effective and efficient use of state resources.
- **Relationship with Medicaid**: ADMH's partnership with the Alabama Medicaid agency has allowed for efficient use of state dollars to expand access to care.
- T**he Substance Abuse Services Integrated Placement Assessment**: SASD has developed extensive training material for implementation of the SASD Integrated Placement Assessment, established a cadre of trainers who were trained by Dr. Mee Lee and others, and provides all of its training material on the DMH web site. In

addition, SASD has developed criteria to guide placement in each ASAM level of care, along with operational standards for each level of care.

- **Stable Provider Base:** The vast majority of the division's providers have been its providers for over thirty years.
- **Office of Deaf Services:** ADMH operation of the Office of Deaf Services gives the state a unique opportunity to address an issue that is too often ignored within the substance abuse service delivery system. The director of this office provides training for behavioral health professionals all over the world.
- **ASAIS:** Developed as the substance abuse division's management information system, ASAIS is allows for client level service reporting, supports service utilization reviews, as well as directly interfaces with the Alabama Medicaid Agency's MIS. The system is built on a platform that is capable of data sharing with the state's Health Information Exchange.
- **Substance Abuse Staff Qualifications and Diversity:** The **s**taff of the Division has a wealth of experience, education, and training to move the Division forward in the new world of services that reforms in the country's health care delivery system will require. The staff, also, reflects the diversity of Alabama's population.
- **Political Constituency:** There is currently a strong political voice for individuals who have substance use disorders in Alabama through the Governor's office and the Chief Justice.

In addition to the unmet needs and gaps identified in this planning document, the state's system faces many challenges, including:

- **Data Underutilization:** Throughout the years, there has been very little utilization of data to ADMH for substance abuse service planning purposes.
- **Service Locations:** There is no organized plan for a development of a continuum of care within the state's planning regions. Services, basically, exist in locations that were decided upon by the program's owner or governing body in accordance with the funding available to operate the program.
- **Provider Performance Standards:** At the present time, ADMH makes no request of it's providers to meet performance standards; however there are plans to implement elements of performance based funding in the near future.
- **Service Need:** ADMH serves less than 10% of the estimated need for substance abuse treatment in Alabama.
- **Systems Change:** There has been little change in the state's service delivery system in nearly twenty years. Despite advances in knowledge about addiction and its prevention and treatment, evidence-based practices in that regard, innovations in technology, and changes health care delivery, few adaptations have been made within ADMH's provider base.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Alabama Department of Mental Health Services Proposed for Alabama's Good and Modern Substance Abuse Service Delivery System	
H2032	**ACTIVITY THERAPY** Structured, object-oriented recreational, social, or therapeutic activities conducted by a qualified substance abuse professional to assist a client in developing or enhancing psychosocial competencies. (
H0003	**ALCOHOL AND/OR DRUG SCREENING** Professional laboratory analysis of specimens for the presence of alcohol and/or drugs.
H0048	**ALCOHOL AND/OR DRUG TESTING: COLLECTION AND HANDLING** Specimen collection, other than blood, including hair, saliva, or urine for the purpose of analysis for the presence of alcohol and/or other drugs. Does not include the laboratory analysis of such specimens.
H0001	**ASSESSMENT SERVICE** A structured interview process that takes place after intake, admission, and implementation of a client's initial treatment plan by a trained clinician. This service functions to evaluate presenting problems, establish additional or modify existing diagnoses, establish additional or modify new treatment goals, and/or to evaluate progress and need for continued care.
H2014	**BASIC LIVING SKILLS** The provision of scheduled interventions by a qualified substance abuse professional to train and assist a client in reestablishing the ability to perform and manage fundamental tasks required for daily living.
H0002	**BEHAVIORAL HEALTH SCREENING** A structured interview process conducted by a trained clinician, utilizing the DMH uniform assessment tool, for the purpose of identifying an individual's presenting needs and establishing a corresponding recommendation for placement in an appropriate level of care.
H0050	**BRIEF INTERVENTION** A brief, face-to-face, motivational encounter conducted immediately after establishment of a positive alcohol/drug screen. During this brief encounter, a trained clinician provides feedback on the individual's alcohol and/or drug use patterns, expresses concerns about the pattern of use, provides advice in regard to strategies to eliminate or cut-back in regard to destructive alcohol/drug use patterns, assists in development of an action plan, and initiates referrals, as appropriate. This service shall be provided for individuals receiving services in primary medical care or other community–based settings. This service may not be provided in addictions treatment programs.
H0006	**CASE MANAGEMENT** Activities provided, brokered, and monitored by a trained case manager to assist individuals in gaining access to and engaging in needed medical, social, educational, and other services essential to addressing basic human needs and supportive of holistic care for substance use and co-occurring substance use and mental disorders.
T1009	**CHILD SITTING SERVICES** Care provided for children of clients in treatment during the same time period as the specific occurrence of the parent's treatment.
H2011	**CRISIS INTERVENTION** An immediate response by a trained interventionist to address and stabilize the needs of individuals who are experiencing abrupt and substantial changes in behavior that result in severe impairment of functioning or a marked increase in personal distress.
H2037	**DEVELOPMENTAL DELAY, PREVENTION ACTIVITIES, DEPENDENT CHILD** Structured services provided by an appropriately credentialed professional for children of clients in treatment, during the same time period as the specific occurrence of the parent's treatment. These services function to foster healthy psychological, emotional, social, and intellectual development of the child.
90801	**DIAGNOSTIC INTERVIEW EXAMINATION (Intake Evaluation)** An extensive clinical and functional evaluation of an individual's substance use disorder and related issues by a trained professional resulting in a diagnosis or diagnostic impression and an initial service plan.
96103	**DIAGNOSTIC TESTING: COMPUTER** Administration of a computerized standardized objective and/or projective test for

	psycho-diagnostic assessment of emotionality, intellectual abilities, or psychopathology with interpretation of test results by a qualified health care professional.
96101	**DIAGNOSTIC TESTING: PSYCHOLOGIST** Administration of a standardized objective and/or projective test for psycho-diagnostic assessment of emotionality, intellectual abilities, or psychopathology by a licensed psychologist. Includes face-to-face time with client, interpretation of test results, and preparation of findings.
96102	**DIAGNOSTIC TESTING: TECHNICIAN** Administration of a standardized objective and/or projective test for psycho-diagnostic assessment of emotionality, intellectual abilities, or psychopathology by a trained technician psychopathology with interpretation of test results by a qualified health care professional..
H2025	**EMPLOYMENT MAINTENANCE SUPPORT** Structured activities provided by an appropriately trained professional to assist clients in preparing for successful employment outcomes. These activities include development of job search skills and techniques, application completion exercises, interview skill development, resume writing skill development, strategic planning to address criminal record issues relative to employment, and activities to assist in development and maintenance of positive work related skills, behaviors, and attitudes.
90849	**FAMILY COUNSELING-MULTIPLE FAMILY GROUP** Therapeutic sessions provided by a qualified substance abuse professional for multiple families of unrelated clients enrolled in specified levels of care. These group sessions address psychosocial problems within the family which may have resulted from or were exacerbated by substance use or co-occurring substance use and mental illness disorders.
90847	**FAMILY COUNSELING-WITH CLIENT PRESENT** Therapeutic sessions provided by a qualified substance abuse professional for a client, along with the client's family /significant others, to address psychosocial problems within the family which may have resulted from or were exacerbated by substance use or co-occurring substance use and mental illness disorders.
90846	**FAMILY COUNSELING-WITHOUT CLIENT PRESENT** Therapeutic sessions provided by a qualified substance abuse professional for family members/significant others of a client enrolled in a specific level of care to address psychosocial problems within the family which may have resulted from or were exacerbated by substance use or co-occurring substance use and mental illness disorders.
T1027	**FAMILY TRAINING AND COUNSELING FOR CHILD DEVELOPMENT** The provision of child-focused interventions for parents/significant others by qualified children's services professionals. Interventions address the assessed developmental, biopsychosocial, and emotional needs of infants, toddlers, and children through age eighteen, and provide guidance and age appropriate strategies to support healthy development and functioning of this population.
H0005	**GROUP COUNSELING** The utilization of professional skills by a trained clinician to assist two or more unrelated individuals in a group setting in achieving specific objectives of treatment or care for a substance use or co-occurring substance use and mental health disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to substance use and utilization of the shared experiences of the group's members to assist in restoration of the individual to a level of functioning capable of supporting and sustaining recovery
96150	**HEALTH AND BEHAVIOR ASSESSMENT** A health focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires, or other assessment procedures conducted to identify alcohol and/or drug use, psychological, behavioral, emotional, cognitive, or social factors as they relate to the prevention, treatment, or management of conditions affecting the recipient's physical health. This assessment may result in service plan additions or modifications that include specific health and behavioral interventions to address identified problems.
96151	**HEALTH AND BEHAVIOR REASSESSMENT** A health focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires, or other assessment procedures conducted, after an initial assessment and clinical interventions, to identify continued or additional

	alcohol and/or drug use, psychological, behavioral, emotional, cognitive, or social factors as they relate to the prevention, treatment, or management of conditions affecting the recipient's physical health. This assessment may result in service plan additions or modifications that include specific health and behavioral interventions to address identified problems.
96152	**HEALTH AND BEHAVIOR INTERVENTION** A service prescribed to modify assessed alcohol and/or drug use, cognitive, behavioral, emotional, social, and/or psycho-physiological factors relevant to and affecting the recipient's physical health problems. This service is provided for individuals who have established illnesses or symptoms, and may be at risk for, but have not been diagnosed with a mental or substance use disorder. The intervention utilized shall be designed specifically for the individual recipient based upon a separately reported assessment.
96153	**HEALTH AND BEHAVIOR INTERVENTION: GROUP** Services provided for two (2) or more recipients, simultaneously, as described in 96152.
96154	**HEALTH AND BEHAVIOR INTERVENTION/ FAMILY WITH THE RECIPIENT PRESENT** A service provided, with the recipient and his/her family present, to address family dynamics related to alcohol and/or drug use, cognitive, behavioral, emotional, social, and/or psycho-physiological factors that are exacerbating the health issues of the recipient, or could otherwise impact the outcome of care for the recipient's identified health problem.
96155	**HEALTH AND BEHAVIOR INTERVENTION/ WITHOUT THE RECIPIENT PRESENT** A service provided for the family of a recipient, who is not present for the encounter, to address family dynamics related to alcohol and/or drug use, cognitive, behavioral, emotional, social, and/or psycho-physiological factors that are exacerbating the health issues of the recipient, or could otherwise impact the outcome of care for the recipient's identified health problem.
H0004	**INDIVIDUAL BEHAVIORAL HEALTH COUNSELING AND THERAPY** The utilization of professional skills by a trained clinician to assist an individual, in a face-to-face, one-to-one encounter in achieving specific objectives of treatment or care for a substance use or co-occurring substance use and mental health disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to substance use, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery.
99214	**MEDICAL ASSESSMENT - AMBULATORY CARE** The provision of a detailed history and medical examination, and related medical treatment services for clients enrolled in an ambulatory level of care by an authorized, by a licensed medical professional. (30 minutes)
99252	**MEDICAL ASSESSMENT – RESIDENTIAL CARE** The provision of a detailed history and medical examination, and related medical treatment services for clients enrolled in a residential level of care by an authorized, licensed medical professional. (30 minutes)
H0016	**MEDICAL/SOMATIC SERVICES** Procedures utilized by qualified medical or allied medical personnel, other than physicians and nurses, to observe, assess, monitor, and provide appropriate care for the physical needs of individuals enrolled in a non-residential level of care.
96372	**MEDICATION ADMINISTRATION (INJECTABLE MEDS)** Injection of prescribed medication, under the direct supervision of a physician, as according to assessed needs stipulated in a client's service plan.
H0033	**MEDICATION ADMINISTRATION (ORAL MEDS)** The direct administration of prescribed medication, as according to assessed needs stipulated in a client's service plan, and observation of the client's intake of the medication by mouth.
H0034	**MEDICATION MONITORING** Face-to-face contact between a qualified medical professional, other than a physician, and a client for the purpose of reviewing medication efficacy, monitoring compliance with dosage instructions, educating the client and family/significant others of the expected effect of specified medication, identifying needed changes in the medication regimen.
H0046	**MENTAL HEALTH CONSULTATION**

	Procedures to assist collaborating agency providers or independent practitioners in providing appropriate services to an identified Medicaid recipient by providing clinical consultation. Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing identified rehabilitation services needs of an individual recipient, as well as services to support continuation of care for the recipient in another setting.
J2315	**NALTREXONE INJECTION** Administration of Naltrexone by authorized, trained medical personnel in accordance with a client's service plan.
T1002	**NURSING SERVICES** Procedures utilized by Registered Nurses to observe, assess, monitor, and provide appropriate care for the physical needs of individuals enrolled in a specified level of care, and provide related information for their families/significant others.
T1003	**NURSING SERVICES** Procedures utilized by Licensed Practical Nurse to observe, monitor, and provide appropriate care for the physical needs of individuals enrolled in a specified level of care and provide related information for their families/significant others.
T1004	**NURSING SERVICES** Procedures utilized by a Nursing Assistant to observe, monitor, and provide appropriate services for the physical needs of individuals enrolled in a specified level of care.
H0020	**OPIOID THERAPY** The administration of Opioid replacement medication to individuals enrolled in an authorized Opioid maintenance therapy program for the purpose of detoxification or maintenance to support restoration of adequate functioning in major life areas. Includes medication administration and related medical and case management services. Assessment and counseling services are excluded.
H0023	**OUTREACH SERVICE** An organized process established to reach a specified target population within their environment. This service shall seek to engage and inform individuals about substance use disorders and to motivate and assist them in the process of obtaining appropriate treatment or care.
S9444	**PARENTING SKILLS DEVELOPMENT** A structured face-to-face encounter facilitated by a trained clinician for the purpose of enhancing the parenting competency of individuals who are parents of dependent children, and who have a substance use disorder. This service may include interactive activities involving the parents' children.
H0038	**PEER COUNSELING** The provision of scheduled interventions by a certified peer counselor, who is in recovery from a substance use or co-occurring substance use and mental illness disorder, to assist a client in the acquisition and exercise of skills needed to support recovery. Services may include activities that assist clients in accessing and/or engaging in treatment and in symptom management, promote socialization, recovery, and self-advocacy, and provide guidance in the development of natural community supports and basic daily living skills.
90862	**PHARMACOTHERAPY MANAGEMENT** A direct pharmacotherapy service provided by a licensed professional with prescriptive authority to assess and evaluate a client's presenting conditions and symptoms, medical status, medication needs, and/or substance abuse status, including assessing the need for pharmacotherapy and prescribing such as needed.
H2027	**PSYCHO-EDUCATIONAL SERVICES** Structured, topic specific educational sessions provided by qualified substance abuse professionals to assist clients and their families/significant others in understanding and managing issues relative to substance abuse and addiction.
H0049	**SCREENING** A face-to-face encounter in which a brief, valid, questionnaire is administered by a trained authorized clinician to examine the context, frequency, and amount of alcohol or other drugs used by an individual. This process seeks to identify individuals who have an alcohol or drug use problem or are at risk for development of such. Includes, feedback on the screening results, and referral for additional services, if indicated.
T1007	**SERVICE PLAN DEVELOPMENT/MODIFICATION** A procedure implemented by a qualified substance abuse professional working

	collaboratively with a client to develop service goals and strategies relative to participation in a specific level of care, to formalize these goals and strategies into a written document, and to modify this document as the client's needs change.
T1013	**SIGN LANGUAGE OR ORAL INTERPRETER** The provision of sign language or interpreter services for clients enrolled in a specified level of care by appropriately credentialed professionals.
S9453	**SMOKING CESSATION** A structured, face-to-face encounter provided by trained personnel to assist individuals enrolled in a specific level of care in efforts to stop smoking.
A0100	**TRANSPORTATION** Non-emergency taxi services utilized to transport a client to and from treatment or care, and to and from community-based organizations and activities during the course of treatment or care, as identified in the individual's service plan.
A0110	**TRANSPORTATION** Non-emergency bus services utilized to transport a client to and from treatment or care, and to and from community-based organizations and activities during the course of treatment or care, as identified in the individual's service plan.
A0130	**TRANSPORTATION** Non-emergency wheel-chair van services utilized to transport a client to and from treatment or care, and to and from community-based organizations and activities during the course of treatment or care, as identified in the individual's service plan.
A0160	**TRANSPORTATION** Agency provided non-emergency services utilized to transport a client to and from treatment or care, and to and from community-based organizations and activities during the course of treatment or care, as identified in the individual's service plan.(per mile)
A0170	**TRANSPORTATION ANCILLARY** Ancillary services provided in conjunction with agency sponsored transportation services. Examples include parking fees, tolls,
903	**BEHAVIORAL HEALTH PLAY THERAPY**
H2012	**BEHAVIORAL HEALTH DAY TREATMENT** **Alabama ASAM Level 2.2**
H2034	**ALCOHOL AND/OR DRUG ABUSE HALFWAY HOUSE SERVICES – PER DAY** **Alabama ASAM Level 3.1**
H2036	**ALCOHOL AND/OR DRUG TREATMENT PROGRAM** **Alabama ASAM Level 3.01**
H0019	**BEHAVIORAL HEALTH LONG TERM RESIDENTIAL TREATMENT PROGRAM (30+) (RR)** **Alabama ASAM Level 3.3 Adult & 3.5 Adolescent**
H0018	**BEHAVIORAL HEALTH SHORT-TERM RESIDENTIAL TREATMENT PROGRAM (≤30)(CR)** **Alabama ASAM Level 3.5 Adult & 3.7 Adolescent**
H0013	**ACUTE DETOXIFICATION** Face-to-face interactions with an individual for the purpose of medically managing and monitoring moderate to severe withdrawal symptoms from alcohol and/or other drugs in an ambulatory program with extensive on-site monitoring by trained medical professionals. **Alabama ASAM Level 2.4**
H0011	**ACUTE RESIDENTIAL DETOXIFICATION** Face-to-face interactions with an individual for the purpose of medically managing and monitoring severe withdrawal symptoms from alcohol and/or other drugs in a twenty-four hour medically staffed program setting. **Alabama ASAM Level 3.7D**
H2019	**THERAPEUTIC BEHAVIORAL SERVICES (IN-HOME INTERVENTION)**

1002	**Behavioral Health Accommodation (Chemical Depend)**
1004	**Behavioral Health Accommodation (Halfway House)**
1003	**Behavioral Health Accommodation (Supervised Living)**

Step 2: Identify the unmet service needs and critical gaps within the current system.

ASSESSMENT OF NEEDS AND IDENTIFICATION OF GAPS IN ALABAMA'S PUBLIC SUBSTANCE ABUSE SERVICE DELIVERY SYSTEM

1. **Identify the data sources used to identify the needs and gaps of the populations, relevant to the SA Block Grant, within the State's behavioral health care system, especially for those required populations described in the planning document and other populations identified by the State as a priority.**

ADMH has not conducted a formal needs assessment since 1999 when it received funding from SAMHSA through its State Needs Assessment Initiative to conduct a student survey, a social indicator study, and a community resource assessment study. Since that time, ADMH has utilized data from these studies, which were published in 2003, to aid in assessing the public's need for treatment and prevention services. ADMH's establishment of the Alabama Epidemiological Workgroup (AEOW) in May 2006, and subsequent employment of an epidemiologist has greatly enhanced the availability of relevant information to assist ADMH in system's planning for individuals who are adversely impacted by or have the potential to be adversely impacted by the use of alcohol, tobacco, or other drugs in Alabama.

The current economic and political environment, nationwide changes in the health care delivery system, and the proliferation of evidence-based practices for prevention and treatment of substance use disorders has challenged ADMH to make better use of available data to support its service planning and resource allocation decisions. Data generated through the work of the AEOW clearly illustrates the extent of alcohol and drug use in Alabama, the consequences of this use, and the need for an integrated system of services to address these consequences.

In June, 2011, ADMH released a Request for Proposals to seek a vendor to conduct a comprehensive behavioral health needs assessment in Alabama. This process will seek to determine the need for both mental health and substance abuse services for diverse populations. Proposals have been received and a contract is expected to be awarded no later than December 1, 2011.

UNMET SERVICE NEEDS AND GAPS

The following issues encompass the unmet service needs and critical gaps that exist within Alabama's public substance abuse service delivery system, and establish the basis for SABG priorities to be addressed during FY 12 – FY 13 by ADMH. These needs and gaps were identified through consensus of the MISA's substance abuse team after an environmental scan that included review and analysis of data and other information retrieved from the AEOW, ASAIS, federal, state, and local agency reports, professional journals and other specialized publications, and MISA program monitoring reports.

1. Compliance with SABG Statutory Requirements

The Alabama Department of Mental Health faces ongoing threats of a reduction in state funding in FY 12 and has already reduced the number of employees by with 25 %. The Substance Abuse

Block Grant, which provides funding for nearly 40 % of the treatment services and 100% of the prevention services provided by agencies under contract with ADMH, is now of even greater importance to sustainability of Alabama's public system of substance abuse services. The SABG's maintenance of effort requirements provide a degree of protection for state funding allocated to ADMH for substance abuse services. Funding provided by the block grant enables the continued existence of the public system's core service components. It is critical that we assure continued compliance with SABG regulatory requirements, including the provision of services to priority populations as specified below:

Injection Drug Users

Injection drug users (IDUs) face multiple health risks, including exposure to HIV and Hepatitis B and C. Drug overdose is also a major cause of death among IDUs. In 2009, 7.3% of admissions to the state's public substance abuse treatment system reported current injection drug use. This represents a 4% increase from 2000 for Alabama, while the national average has increased less than 1% (**Table 1**). Reported use increased from 5.4% to 8.6% for women and from 3.2% to 6.8% for men admitted to treatment during this same period. **(1)** The increase in IDU in Alabama corresponds with the state's increased use of Opiates and Methamphetamine. The number of meth lab seizure incidents in Alabama increased from 2007 to 2009 by 199% **(2).**

TABLE 1

% IUD Treatment Admissions	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Alabama	3.3	3.7	3.8	4.7	5.6	6.5	6.9	6.5	5.7	7.3
United States	13.7	13.7	13.6	13.0	13.1	13.5	13.8	13.4	13.7	14.5

Unmet Need/Gap: Although substance abuse treatment for IDU supports efforts to prevent the spread of blood borne infections, there has been very little outreach to IDUs by programs in the state's public substance abuse service delivery system. SABG compliance monitoring data indicates a significant gap in the provision of outreach services in programs serving IDU's. With Alabama's IDU admission rate at nearly 50% less than the national rate, strategies to improve access to care for this population are needed.

Pregnant Women & Women with Dependent Children

All programs under contract with ADMH are required to give priority admission to pregnant women and to publicize the fact that priority admission is available. According to data reported in **TABLE 2**, there has been little change in the percentage of pregnant women participating in the state's treatment system throughout the years. In addition, Alabama lags behind the nation in such admissions

TABLE 2

% Women Pregnant at Admission to Treatment	2002	2005	2009
Alabama	**2.9**	**3.4**	**3.3**
United States	**3.8**	**4.1**	**3.9**

According to the 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) Surveillance Report conducted by the Alabama Department of Public Health, 15.8 % of Alabama mothers

reported they continued smoking during pregnancy. In addition 13.2 percent of Alabama mothers reported drinking alcoholic beverages on a weekly basis during the last three months of pregnancy**. (4)** The Division's admission data indicates 11.9 % of the pregnant women admitted to treatment in 2009 identified as IUDs **(5).**

Access to care has been consistently identified as a barrier for women seeking substance abuse treatment. Services for pregnant women are not easily accessible in Alabama. Treatment programs that serve the public are not available in every Alabama County. Treatment programs with gender responsive services are even more limited as indicated in **Table 3.**

TABLE3

Adult and Adolescent Regional Service Locations	Region 1		Region 2		Region 3		Region 4		TOTAL
	Adult	Adoles	Adult	Adoles	Adult	Adoles	Adult	Adoles	
IOP	27	6	18	8	13	3	22	3	100
IOP/Special Women Services	1		4		3		1		9
IOP/Crisis Residential Component									0
IOP/Residential Rehabilitation Component			1		1				2
IOP/Partial Hosp Component									0
IOP/Co-occurring Component			1		1		1		3
Outpatient	10	7	7	8		3	1	4	40
Crisis Residential	5	1	4				4	1	15
Residential Rehabilitation/Special Women Services			3						3
Residential Rehabilitation	10		6		1		4		21
Residential Detoxification			2						2
Residential/Corrections	1				2				3
Residential/Co-occurring Disorders			1				1		2
Opioid Maintenance Treatment							1		1
Total	54	14	47	16	21	6	35	8	201

45 CFR 96.131 establishes minimum requirements for pregnant and parenting women receiving services funded by the SABG. These requirements include the provision of therapeutic interventions for women which may address relationships, sexual and physical abuse, as well as parenting. ADMH assures compliance with this regulation through its contractual and program compliance monitoring processes. In light of recent research findings on the long term impact of adverse childhood events, along with efforts of ADMH to promote and provide an integrated system of services for prevention and treatment of substance use disorders, the need exists for the expansion of interventions that address relationships, sexual and physical abuse, and parenting to programs that also serve males.

More than eight million children in the United States live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year **(7).** Living under such conditions can have long term consequences on a child's wellbeing. One study reports that children of parents with substance use disorders are nearly three times more likely to be abused, and more than four times more likely to be neglected than children of parents who do not abuse substances

(8) . In FY 10, Alabama's Child Protection Agency removed 882 children from their homes as a result of child/parent alcohol or drug abuse. **(9)** Children of parents who have substance use disorders and who are also in the child welfare system are more likely to experience emotional, physical, intellectual, and social problems than children whose parents do not have substance use disorders. Parental substance abuse and related stressors, as domestic violence, have been identified as factors that increase a child's risk of developing mental, emotional, and behavioral disorders **(10).**

Unmet Need / Gap: In 2009 there were 62,476 live births in Alabama **(6)**. In order to combat both the potential health related consequences of drug use and pregnancy, the need exists to develop and implement strategies to strongly promote the efficacy and availability of treatment, and to improve service accessibility. These efforts will also support closure in the gap between Alabama's rate of service for pregnant women and women with dependent children and that of the country as a whole.

Tuberculosis Services

Requirements regarding Tuberculosis (TB) as outlined in 45 CFR 96.127, the Division ensures that TB services are available and provided to individuals receiving substance abuse treatment. ADMH contractual providers are required to implement written policies and procedures for the provision of TB services. Directly or through arrangements with other public or nonprofit private entities, providers must make available TB services to include:

- A screening process for identification of high risk individuals;
- Referral for testing, medical evaluation and treatment, if indicated by the screening process;
- Case management, as indicated, and
- A reporting process to appropriate state agencies as required by law.

Initial screening for identification of high risk individuals is accomplished through a uniform screen contained within then integrated placement assessment used by all contractual providers. Utilization of a uniform screening enables the Division to identify the number of individuals served that are at high risk for TB. Through established relationships and cooperative agreements with community health providers, Substance abuse treatment providers are able to ensure TB services are available and provided when the screening process is indicative of the need. TB services are monitored through the Program Compliance Monitoring Survey (PCMS) process conducted by the Division's Office of Substance Abuse Treatment Services.

The Alabama Department of Public Health (ADPH), Division of Tuberculosis Control endeavors to eliminate TB in Alabama. In 2010, the ADPH reported 146 new TB cases which was a decline from the 168 cases in 2009. There has been a continual decline of new TB cases since 2007. Alabama's TB infection rate of 3.1 cases per 100,000 persons is less than the U.S. rate of 3.8 per 100,000 **(12).**

ADMH will continue to ensure TB services are available and provided to individuals receiving substance abuse treatment. The PCMS process will be utilized to identify providers who are in need of technical assistance to enhance compliance with provision of TB services.

Unmet Need/Gap: Effective June 1, 2011, the Alabama Department of Public Health informed the Division it would no longer routinely provide TST to specific entities due to budget constraints. The ADPH oversees county health departments throughout the state. These health departments have traditionally been the primary provider of TST when a TB screening has indicated an individual is in need of further assessment for TB. The loss of this service through the health departments presents a critical gap for TB services with greatest impact potentially affecting providers in rural communities. An additional need has been identified through the SABG monitoring process. It has been noted that several provider agencies need to formally establish agreements that support the TB services that have been informally provided through public and/or nonprofit entities. More specifically, it has been recommended this be established thorough a memorandum of understanding that clearly articulates the requirements outlined in 45 CFR 96.127.

HIV/AIDS Prevention and Early Intervention

Alabama is not currently a SAMHSA HIV Designated State that requires the provision of HIV early intervention services. However, HIV/AIDS continues as a major health problem in the state. As indicated in **TABLE 4,** several counties in Alabama have consistently reported HIV/AIDS incidence rates that exceed the state average since 2007.

TABLE 4

Alabama HIV/AIDS Incidence Rates	2007		2008		2009		2010	
	State Average	County Average	State Average	County Average	State Average	County Average	State Average	County Average
	19.75		**18.68**		**16.35**		**16.04**	
ADMH Region 1								
None								
ADMH Region 2								
Jefferson		30.89		32.90		31.24		30.48
ADMH Region 3								
Bullock		27.14		37.08		18.53		27.79
Chambers		31.02		23.24		31.95		26.14
Hale		21.84		33.07		22.04		38.58
Lowndes		53.53		23.73		31.64		47.45
Macon		35.07		31.40		40.38		44.86
Montgomery		52.79		54.71		41.81		40.92
Russell		40.55		37.62		19.80		29.70
ADMH Region 4								
Dale		26.67		49.70		39.34		22.78

Mobile		39.11		26.83		29.04		26.09

The state's most recently reported AIDS incidence rate is 8.7 per 100,000 people. In 2008, Alabama ranked 22nd highest among the 50 states in cumulative AIDS cases **(13)**. As of June 30, 2011 a cumulative total of 17,674 cases of HIV/AID had been reported for the state. Of that number, nearly 15.8% are injection drug users and men who have sex with men and inject drugs **(14).**

Unmet Need / Gap: Although the AIDS prevalence rate has dropped in Alabama, the number of individuals living with the disease in the state is increasing, requiring more and more of scarce community resources. In several locations within the state the incidence of HIV/AIDS has consistently remained significantly above the state level. The need continues in Alabama to assure that the Division's providers develop and implement strategies to reach and provide HIV education, counseling, and referral services as required by the Block Grant for pregnant women and IDUs.

2. Diversification of Service Populations

Despite changes in state demographics and the availability of alarming statistics which identify the needs of underserved populations, there has been little change in the population served by Alabama's substance abuse service delivery system. In addition there are significant differences in regard to access to care in rural areas of the state in comparison to access in urban areas. Guided by changes in the country's health care delivery system, ADMH's plans to establish a recovery oriented system of care, the increasing demands from the community for more services, a need exists for ADMH to plan for diversification of it service population.

Rural Populations

Alabama's rural population has higher rates of mortality, chronic disease, and disability than urban residents. Special challenges that impair the health status of rural residents include lower socioeconomic status, higher average age, lower literacy, and more limited access than urban households to affordable, nearby, high-quality health care **(15).** Of the 67 counties in Alabama, 55 are designated as rural **(16).**

Living and working in rural Alabama presents a variety of distinct stresses and strains .Major depression rates in some areas significantly exceed those in urban areas. Teens and older adults in rural areas have significantly higher suicide rates than their urban counterparts. Additionally, stress is associated with increased mental health disorders. People in rural areas may experience stress with cyclical farm crises, natural disasters, and social isolation **(17)**. In many rural communities, substance abuse treatment services are simply not available. Given the scarcity of services in rural areas, it is no wonder that the distance to such services, along with a lack of public transportation create significant barriers to needed care.

Table 5

ADMH Clients Served by County FY10							
County	**Distinct Case No Count**	**% of Clients**	**County Popula**	**County**	**Distinct Case No Count**	**% of Clients**	**County Popula**
Jefferson	6180	23.44%	656700	Escambia	154	0.58%	37849
Mobile	2039	7.73%	404157	Colbert	149	0.57%	54766
Montgomery	1724	6.54%	404157	Coffee	147	0.56%	46027
Madison	1280	4.85%	304307	Pike	142	0.54%	29620
Tuscaloosa	1204	4.57%	171159	Lamar	129	0.49%	14548
Houston	982	3.72%	95660	Winston	124	0.47%	24634
Shelby	596	2.26%	178182	Pickens	124	0.47%	20133
Dekalb	592	2.25%	68014	Cherokee	115	0.44%	24863
Marshall	568	2.15%	87185	Randolph	107	0.41%	22673
Morgan	516	1.96%	115237	Franklin	104	0.39%	30847
Calhoun	513	1.95%	112903	Marengo	103	0.39%	21842
Baldwin	508	1.93%	169162	Out Of State	99	0.38%	
Etowah	508	1.93%	103362	Tallapoosa	97	0.37%	41010
Lee	506	1.92%	125781	Butler	96	0.36%	20520
Talladega	485	1.84%	80271	Clarke	85	0.32%	27248
Jackson	462	1.75%	53745	Henry	80	0.30%	16706
Walker	457	1.73%	70034	Lawrence	79	0.30%	34312
Cullman	449	1.70%	80187	Monroe	74	0.28%	23342

Elmore	411	1.56%	75688	Macon	69	0.26%	22594
Lauderdale	386	1.46%	87891	Clay	66	0.25%	13829
Dallas	302	1.15%	43945	Crenshaw	66	0.25%	13719
St. Clair	286	1.08%	75232	Hale	58	0.22%	18236
Dale	281	1.07%	48392	Lowndes	58	0.22%	12759
Autauga	259	0.98%	49730	Cleburne	47	0.18%	14700
Blount	237	0.90%	56436	Conecuh	47	0.18%	13403
Chambers	225	0.85%	35176	Wilcox	41	0.16%	12911
Limestone	221	0.84%	72446	Bullock	40	0.15%	10906
Fayette	218	0.83%	18005	Coosa	39	0.15%	11044
Russell	207	0.79%	50085	Washington	36	0.14%	17651
Covington	193	0.73%	37234	Sumter	36	0.14%	13606
Marion	191	0.72%	30165	Choctaw	31	0.12%	14656
Chilton	181	0.69%	41953	Greene	30	0.11%	9374
Barbour	176	0.67%	28171	Perry	23	0.09%	11186
Geneva	164	0.62%	25868	UK/NR	8	0.03%	
Bibb	157	0.60%	21482				4779616

But even when the care is available nearby, still other barriers exist. The social stigma attached to substance use disorders may loom larger in rural area. A general lack of anonymity in many small communities often leads people to forego treatment. As indicated in **Table 5**, the majority of clients entering treatment in the public service delivery system reside in urban areas of the state.

Unmet Need / Gap: Based on available data, Alabama is 23rd in population among the 50 states with over four million residents. Almost half of this population is deemed to be rural **(18)**. While the Division has made attempts to ensure that each of the state's 67 counties have some service availability, these services are not fully inclusive of each level of care and priority population. Thus unmet service needs exist across these counties. Critical gaps existence within specific provider agencies with barriers existing related to transportation for the prospective client and the provider agency, as well as, limited expansion of service provision beyond the traditional office setting. Furthermore, the ability for available providers to fully address the needs of these clients from a culturally competent framework within a rural community is another area of concern.

Veterans

More than 2 million men and women have been deployed to serve in Operation Iraqi Freedom or Operation Enduring Freedom (Afghanistan), and more than 40 percent of them have served at least two tours. Nearly 300,000 troops have served three, four or more tours. More than half of those currently at war are at least on their second tour **.** In 2005, the Veterans Administration reported that 18% of Afghanistan veterans and 20% of Iraq vets suffer from some type of service connected psychological disorder. A 2009 report of Army troops in Afghanistan found that the rate of psychological problems rose significantly with the number of deployments: 31 % for three tours, more than double the rate of those with just one. In Iraq, the survey found that nearly 15 % of Army troops who served two tours suffered from depression, anxiety or traumatic stress, more than double that of a single tour **(19)**. In addition,

- 50% of troops report having a friend wounded or killed
- 45% troops witnessed an accident resulting in death or serious injury.
- 19% troops experience PTSD or depression (higher rates among Army/Marines, Reservists, Women, Hispanics)
- 20% of suicides in the U.S. are among veterans although vets only compose 7.6% of population (mental illness & substance abuse affect 90% of those who die as a result of suicide)
- 50% of veterans needing help, seek help
- 30-50% of homeless veterans report co-occurring disorders and substance abuse
- 75% of combat veterans with lifetime PTSD met criteria for alcohol abuse / dependence (Alcohol is the primary substance of abuse among veterans)
- More than 700,000 have experienced one or more parental military deployments.
- A growing body of research continues to show the adverse impact of prolonged deployment on the families of military personnel **(20).**

Combined data from SAMHSA's 2004 and 2006 National Survey on Drug Use and Health (NSDUH) indicate that an annual average of 7.1 percent of veterans aged 18 or older (an estimated 1.8 million persons) met the criteria for a substance use disorder (SUD) in the past year (Figure 1). One quarter of veterans aged 18 to 25 met the criteria for SUD in the past year compared with 11.3 percent of veterans aged 26 to 54 and 4.4 percent of veterans aged 55 or older (Figure 2). There was no difference in SUD between male and female veterans (7.2 vs. 5.8 percent) **(21).**

The Veteran's Administration (VA) has taken steps to combat these issues, including hiring more than 900 mental health care professional in the past 2 years, establishing the 24 hour Suicide Prevention Lifeline, 1-800-273-TALK (8255), providing anonymous chat opportunities with VA counselors and dedicating 400 people solely to suicide prevention research and counseling in the VA. Although theses are positive steps, additional help is needed from the communities in which veterans live **(22).**

As of September 10, 2010, as described in **TABLE 6,** there were 405,600 Veterans living in Alabama .

TABLE 6

Alabama Veteran Population	
Wartime Vets	302,800
Gulf War	114,500
Vietnam Era	137,000
Korean Conflict	42,500
World War II	28,900
Peacetime	102,800
Female	35,500
Male	370,100
Total	**405,600**

The State of Alabama has generously contributed to military deployments since 2001. In 2007, Alabama's Army National Guard had the nation's third-highest number of deployments to Iraq and Afghanistan since September 11, 2001. At the end of 2009, the number of Alabama Army

and Air National Guard members who had been mobilized in the country's global war on terror totaled nearly 16,000 members **(23).** On February 8, 2010, the Alabama National Guard had 515 soldiers deployed overseas **(24)**. In 2010 the Alabama National Guard reported three (3) completed suicides **(25).**

Jefferson County, the largest county in the state of Alabama, is home to approximately 50, 000 veterans. While the Birmingham Veterans Administration Medical Center is not the only VA Center in the state, it is one of the largest. The Center provides substance abuse treatment services to returning veterans but the care given at the VA is limited in that the center is only equipped to provide outpatient treatment services. This is somewhat problematic as there are veterans identified as needing residential treatment with limited community resources available to provide this care. In 2010, the Birmingham VA reported the following information:

- The Birmingham VA Medical Center Substance Use Program is an Intensive Outpatient Program comprised of 75% homeless veterans with no resources available to them except the Veterans Administration.
- The Alabama VA Services Network (VISN) has only two (2) residential/domiciliary programs: The Tuscaloosa VA Medical Center and the Tuskegee Medical Center. Both of these programs have extensive waiting lists. In fact, the Birmingham Veterans Administration Medical Center (BVAMC) has stopped making referrals to the Tuscaloosa Center because of the length of the waiting list.

Unmet Need / Gap: In 2009, Alabama's public substance abuse service delivery system admitted only 860 veterans. Providers in the system have not strategically targeted veterans or their families for services despite their growing behavioral health needs. Although ADMH participated in a 2010 SAMHSA sponsored policy academy to promote strategic development of behavioral health services for returning military personnel, veterans, and their families, there has been little promotion of this cause. The exponential growth of behavioral health problems of this population establishes a need for ADMH to implement strategies to improve access to care for returning service members, veterans, and their families.

LGBTQ Individuals

According to the 2010 U.S. Census, 11,259 same sex couples self-identified as residents of Alabama. Nearly 60% of the same-sex relationships consist of two females and 40% consist of two males **(26)**. This data, although helpful, does not provide an accurate estimate of the number of LGBTQ individuals in the state. The Census does not report whether the couples consist of lesbian, gay, bisexual, transgender, or questioning individuals. In addition, it does not provide an estimate of the number of LGBTQ individuals who are not involved in a relationship, or the number of adolescents who identify as such. As is commonly the case, ADMH does not require its contract providers to report the sexual or gender orientation of clients served in the system. Thus, the agency does not currently have information on this population's participation in Alabama's public substance abuse services delivery system.

It is well documented, however, that substance abuse impacts all populations. According to ***Healthy People 2010: Lesbian, Gay, Bisexual, and Transgender Health***,

> Although no national data are available, a recent review of the literature based on smaller population studies suggests that lesbians and gay men may be still be at heightened risk for substance abuse. Much less is known about bisexual or transgender women and men, but these groups also may be at increased risk for substance abuse, in addition to being discriminated against by many heterosexuals. Like the general population of the United States, substance abuse in the LGBT community is associated with a myriad of public health challenges, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases (STDs), violence (of particular concern, acts committed by and against the LGBT community), and chronic disease conditions, such as cirrhosis of the liver **(27)**.

Unmet Need/Gap: Services for LGBTQ individuals have not been a topic of focus for ADMH's planning processes. Although several organizations exist throughout Alabama that provide advocacy and support for LGBTQ individuals, as well as, address health disparities, ADMH has not engaged in collaborative planning activities to address the impact of mental health and substance abuse disorders on this population. The public health challenges associated with substance abuse, as reported by ***Healthy People 2010***, indicate a need for ADMH to develop strategies to improve access to prevention, treatment, and recovery support services for LGBTQ individuals.

3. Health Care Reform

The United Health Foundation currently ranks Alabama 49th in the nation in terms of overall health outcomes. This ranking is based upon analysis of the following four health determinants: (a) personal health behaviors; (b) community and environmental factors that are indicative of the reality of daily living conditions; (c) public and health policies indicative of the availability of resources to encourage and maintain health, as well as, the extent that public and health programs reach into the general population; and (d) the quality, appropriateness and cost of the clinical care received at doctors' offices, clinics and hospitals.

Alabama's 2010 health determinant analysis resulted in a ranking of 49th in the nation for premature deaths and cardiovascular deaths; 48th for infant mortality; and 44th for cancer deaths. The state placed 49th for the prevalence of strokes and diabetes; 48th for high blood pressure, poor physical health days, preterm deliveries, and low birthweight babies; 47th in poor mental health days; and 44th in smoking **(28).**

Alcohol and other drug use have been linked to poor health outcomes as those experienced in the Alabama. Excessive alcohol consumption is associated with approximately 75,000 deaths per year **(29)**. Drug use contributes directly and indirectly to the HIV epidemic, and alcohol and drug use contribute markedly to infant morbidity and mortality. Long-term alcohol use is associated with liver disease, cancer, cardiovascular disease, and neurological damage as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder. Of the fifteen (15)

leading causes of death in Alabama in 2009, Chronic Lower Respiratory Disease was ranked at number three and Chronic Liver Disease & Cirrhosis was ranked at twelve **(30)**. Both diseases are associated with alcohol, tobacco, and other drug use.

The data above illustrates the importance of access to health care in Alabama. However, many disparities prominently block access to health care in this state. In 2008, 19% of the state's population, in comparison to 11.8% for the United States, lived in Health Professional Shortage Areas. At the same time 41.6% of the state's population, in comparison to 18.7% for the United States, lived in Mental Health Professional Shortage Areas **(31)**. In 2010, 16.8% of the state's residents reported that they could not see a doctor because of cost **(32)**. Medicaid eligibility criteria in this state incorporate one of the lowest maximum income limits in the country. The National Survey of Drug Use and Health estimates that 320,000 people in Alabama needed treatment for alcohol and drug use in 2006-2007, but did not receive it. This number is up from the 2003-2004 estimate of 301,000 individuals **(33)**. The National Center on Addiction and Substance Abuse estimates Alabama spends over $300 million dollars annually on health care related to untreated substance abuse and addiction **(34)**. This estimate excludes costs associated with specialty treatment.

Unmet Need / Gap: Health care reform brings many opportunities for improvements in access and quality of primary and behavioral health care in Alabama. The state's public substance abuse service delivery has historically functioned as a specialty treatment system with very little interaction with primary care, and very little emphasis on prevention. Services have historically been addiction focused and program driven, with little emphasis on quality, performance or outcomes. Since the early 1990's the system has experienced limited growth and service diversity, despite increased knowledge of evidence based practices and unmet community needs. In consideration of the fact that alcohol and other drug use disorders are preventable, the state must employ new strategies to mitigate the impact of substance abuse on health care costs, as well as the health outcomes of Alabamians. The need exists for ADMH to provide leadership, guidance, and support for the state's public funded substance abuse service providers in this change process.

4. Adolescent/Young Adult Services

It has been clearly demonstrated that substance use disorders begin their manifestation during adolescence. In Alabama, as indicated in **TABLE 3**, adolescent services are limited in scope and availability. In addition the current system serves, primarily, a juvenile justice population. Whereas prevention services funded by ADMH, as well as Drug Free Community Programs and other independent community coalitions attempt to address the needs of children and adolescents, the availability of early interventions services is very limited. Significant service delivery gaps exist for adolescents in Alabama.

Young adults are at high risk for mental and substance use disorders. Substance abuse services addressing the needs of young adults in today's society requires nontraditional approaches to service delivery. The need exists to establish meaningful strategies for engaging young adults and enhancing efforts to both prevent the onset and treat substance use disorders.

Underage Drinking

Alcohol use by Alabama youth under the age of 21 years of age is a major health problem. As reflected in the United States, Alcohol is one of the most commonly used and abused drugs, more than tobacco and illegal drugs among Alabama youth. Consequences of underage drinking by Alabama youth will more than likely include:

- School problems, such as higher absence and poor or failing grades;
- Social problems, such as fighting and lack of participation in youth activities;
- Change in brain development that may have life-long effects;
- Legal problems, such as arrest for driving or physically hurting someone while drunk;
- Abuse of other drugs;
- Physical problems such as hangovers or illnesses;
- Memory problems;
- Unwanted, unplanned, and unprotected sexual activity;
- Alcohol-related car crashes and other unintentional injuries, such as burns, falls and drowning;
- Disruption of normal growth and sexual development;
- Higher risk for suicide and homicide; and
- Physical and sexual assault.

Individuals ages 12 to 20 years drink 11% of alcohol consumed in the United States. This statistic is comparatively slightly lower for the state of Alabama. More than 90% of alcohol is consumed in the form of binge drinking. Alabama youth who drink alcohol consume more drinks per occasion than their adult counterparts. Each year in the U.S. approximately 5,000 young people die under the age of 21 as a result of underage drinking. About 1,900 of these deaths are the result of motor vehicle crashes, 1,600 as a result of homicides, and hundreds from other injuries such as falls, burns and drowning. Monitoring The Future (MTF) reports that more than two-thirds of 10^{th} graders, and about two in every five 8^{th} graders have consumed alcohol **(35).** When Alabama youth and others drink, they tend to drink more intensely, often four or five drinks at a time. The cultural implications of the acceptance and or denial of underage drinking are complex and dynamic in nature.

In 2009, 22.8% of youth in Alabama reported alcohol use prior to age 13, with more males (26.2%) reporting early use than females (19.0%). A significant gender difference for alcohol use prior to age 13 has been apparent for the last ten years. In Alabama it has also shown to be evident that excessive alcohol intake among youth also increases with grade level in school. The percent of youth in 9^{th}-12^{th} 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 23.1% in 2009, which is comparable to estimates from previous years.

More males (25.3%) reported binge drinking than females (20.7% in 2009 and this gender difference in the prevalence of binge drinking among youth was statistically significant for the past five years. Culturally in the state, alcohol represents a “right of passage” for young males into manhood. Additionally, many social and cultural events in the state are focused, inundated and often sponsored by the alcohol industry. One of the traditional values in the state of Alabama

centers on the passion for sports, particularly football. During various times of the year family members and fans use alcohol to heighten a sense of pride and collegial spirit. Underage drinking is a very serious issue in the state of Alabama, especially, in the context of the value of sports. Fan allegiance and identification can lead to dangerous situations involving alcohol and other drugs. The public's mobilization efforts for tail-gating, celebrations, before/after parties can result in harmful consequences.

Alabama attributes underage alcohol use being associated with risky behaviors such as drinking and driving. In 2009, 12.3% of 12th grade students in Alabama drove a car or other vehicle after drinking at least once in the past 30 days. More males (14.1%) reported drinking and driving than females (10.1%). This statistic exemplifies the potential threat of drivers, pedestrians and passengers face in the state for injury and death. In addition, it is speculated by law enforcement that youth alcohol-related crimes are under-reported and are another possible consequence of excessive alcohol consumption that may lead to violent crimes, forcible rape, robbery and aggravated assault **(36).**

Unmet Need / Gap: The Alabama Epidemiological Outcomes Workgroup has worked diligently on state Epidemiological profiles for the past four (4) years. The Department of Education has facilitated the PRIDE survey for the past six years in grades 6-12. The self-reported data shows clearly Alabama youth are experiencing the consequences of drinking alcohol at too early ages. Each year, young people die as a result of underage drinking; this includes deaths from motor vehicle crashes, homicides, and suicides and well as other injuries such as falls, burns and drowning. The widespread use of alcohol among adolescents continues to be problematic for communities in Alabama. Often the consequences are hidden and adults are not privy to the overall implications of use and misuse of alcohol in our communities. When youth drink, they tend to drink more intensely, often consuming four to five drinks at a time. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 grams percent or above. To compare this to the adult population, men would consume five (5) or more drinks and four (4) or more for women in a two hour time span.

In Alabama, epidemiological data shows that the average age of first use for Alabama youth is nine years of age. Individuals who start to drink before the age of 15 are four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. New research shows that serious drinking problems typically associated with middle age actually begin to appear much earlier, during young adulthood and even during the adolescence years. Those who start to drink at an early age are more than likely to start engaging in risky behaviors, including other drugs and negative behaviors.

Multiple risk factors exist within Alabama communities that present challenges and compelling barriers to decrease the prevalence of consequences for underage drinking. The risk factors are predominately in the domains of Individual/Peer, Family and the Community domain, as indicated in **TABLE 8.**

TABLE 8

RISK/PROTECTIVE FACTOR CHART		
DOMAIN	**RISK FACTOR**	**PROTECTIVE FACTOR**
Individual	• Rebelliousness	• Opportunities for pro-social

	• Friends who engage in the problem behavior • Favorable attitudes about the problem behavior • Early initiation of the problem behavior • Negative relationships with adults • Risk-taking propensity/impulsivity	involvement • Rewards/recognition for pro-social involvement • Healthy beliefs and clear standards for behavior • Positive sense of self • Negative attitudes about drugs • Positive relationships with adults
Peer	• Association with delinquent peers who use or value dangerous substances • Association with peers who reject mainstream activities and pursuits • Susceptibility to negative peer pressure • Easily influenced by peers	• Association with peers who are involved in school, recreation, service, religion, or other organized activities • Resistance to peer pressure, especially negative • Not easily influenced by peers
Family	• Family history of high-risk behavior • Family management problems • Family conflict • Parental attitudes and involvement in the problem behavior	• Bonding (positive attachments) • Healthy beliefs and clear standards for behavior • High parental expectations • A sense of basic trust • Positive family dynamics
School	• Early and persistent antisocial behavior • Academic failure beginning in elementary school • Low commitment to school	• Opportunities for pro-social involvement • Rewards/recognition for pro-social involvement • Healthy beliefs and clear standards for behavior • Caring and support from teachers and staff • Positive instructional climate
Community	• Availability of drugs • Community laws, norms favorable toward drug use • Extreme economic and social deprivation • Transition and mobility • Low neighborhood attachment and community disorganization	• Opportunities for participation as active members of the community • Decreasing substance accessibility • Cultural norms that set high expectations for youth • Social networks and support systems within the community
Society	• Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug-use messages in the media	• Media literacy (resistance to pro-use messages) • Decreased accessibility • Increased pricing through taxation • Raised purchasing age and enforcement • Stricter driving-while-under-the-influence laws

Evidence-Based Practices.

Many ADMH adolescent service providers are beginning to infuse evidence based practices/ best practices (EBP/BP) into service delivery. More specifically, providers have infused Motivational Interviewing, Motivational Enhancement Therapy, Moral Reconation Therapy, Cognitive Behavioral Therapy, Cannabis Youth Treatment, and the Seven Challenges to name a

few. Current ADMH certification standards have not required the use of EBP/BP; however, new requirements around EBP/BP are forthcoming.

Unmet Need/Gap: While many adolescent service providers are beginning to infuse EBP/BP into service delivery, the ADMH does not have a formal means for identifying the EBP/BP being utilized. Further there is no means to analyze the effectiveness of the EBP/BP being utilized. Lastly, there is no mechanism to incentivize providers who utilize EBP/BP and have successful outcomes.

Linguistic and Culturally Competent Services

Alabama is a state with a documented history of racism tension and segregation. The state has above average poverty, unemployment, disease, death, and incarceration of males and females. During the last ten years, it has experienced a decline in population of the majority race and increases in all minority races living within its borders. The state's Hispanic or Latino population grew by 129%. Alabama's African American population significantly exceeds the national average (**TABLE 9**). Nearly 5 % of the state's population report they speak a language other than English at home **(44)**. These and other social, economic, biological, and cultural factors impact the belief systems of the state's residents, including, their daily conversations, the communities in which they live, who they chose as friends, and who they trust. These are all examples of the need for cultural and linguistic competence in the delivery of health care services, including substance abuse prevention, treatment, and recovery support services. Client centered, cultural and linguistic competent care takes into consideration the significance of historical and socioeconomic factors that influence the norms and values of the people to be served, as well as, their response to the reality of life in their communities. It drives help-seeking behaviors and impacts service outcomes.

TABLE 9

Alabama Population Percentages	2000	2010
Male	48.3	48.5
Female	51.7	51.5
White	71.1	68.5
Black or African American	26.0	26.2
American Indian/Alaska Native	0.5	0.6
Asian	0.7	1.1
Native Hawaiian and Other Pacific Islander	0	0.1
Some other Race	0.7	2.0
Two or More Races	1.0	1.5
Hispanic or Latino (of any race)	1.7	3.9

Race, ethnicity, and religion are generally perceived as the predominant elements of culture in Alabama's public substance abuse services delivery system. Although some of the system's providers incorporate program activities that minimally attend to these issues, organizational behavior, practices, and policies which are representative of a cultural and linguistic system of care do not currently exist system-wide.

Alabama's minority race population increases are noteworthy relative to limitations within ADMH substance abuse service delivery system to serve a growing non-white community whose primary language is something other than English. While a critical gap is evident in multilingual services for Hispanic or Latino and Asian citizens; similar concerns are evident for "African Americans who come from a different cultural environment that may use words and phrases not entirely understandable by the therapist" **(45)**. Alabama's predominant use of Standard English in its "health care delivery may unfairly discriminate against those from a bilingual or lower socioeconomic background and result in devastating consequences" **(46).** Such inequities have been underscored by the federal government as a form of discrimination. Alabama has a lack of multilingual therapists and individuals within the system of care which inadvertently contributes to "inferior and damaging services to linguistic minorities" **(47).** This gap presents a cultural barrier that can lend itself to ineffective service delivery and contribute to a significant number of individuals not being served or not receiving culturally competent services.

Deaf and hard of hearing people also encounter barriers to participation in Alabama's public substance abuse service delivery system. Although there are no well-controlled, methodologically sound community estimates of substance use or substance abuse among deaf and hard of hearing people, there are also no studies which show that deaf and hard of hearing people are any less likely to have substance abuse problems. There are estimates of use that are based on deduction or from small, restricted, or non-representative samples.

If it can be assumed that at least one out of 10 hearing people are in need of substance abuse treatment, it can be assumed that at least at least 860 deaf and 4,000 hard of hearing people are in need of such treatment in Alabama, based upon ADHM's Office of Deaf Services estimate of 8,600 deaf and 411,000 hard of hearing people in the state. Last year it was reported by ADMH providers that 63 deaf and 783 hard of hearing people were in treatment. However, interpreter billing does not indicate that deaf people had accessible treatment. There are no substance abuse treatment programs in Alabama and (currently about 3 nationally) that have:

- Deaf (or hearing signing) counselors fluent in sign language
- Staff knowledgeable about communication and culture
- Materials are adapted for use with deaf and hard of hearing (e.g., videos in ASL, fewer written materials, use of role play and drawing)
- Accessibility devices-VP's, video conferencing, flashing lights, etc.

Guthmann (2008), using GAIN (Global Appraisal of Individual Needs) data, found that hard of hearing youth who took the GAIN when entering treatment showed those with a hearing loss may enter treatment more severe than their hearing peers**.** Titus (2009) found

- Youths with hearing loss reported a higher overall rate of victimization and significantly greater rates of physical abuse and attacks than their hearing peers.
- Victimization among the hearing loss group was more severe than that observed in the hearing group. Youths with hearing loss were more likely to report multiple forms of abuse and their elevated scores indicate a more severe victimization history.
- Trauma-inducing attributes of abuse that distinguished the hearing and hearing loss groups include higher rates of abuse by a trusted person and abuse that the victim believes is life threatening.

- No differences between the groups were observed in reports of sexual or emotional abuse, abuse that occurs over time or by more than one person simultaneously, abuse resulting in sex, abuse which others did not believe, or future concerns about abuse **(48)**.

Best practices include:
- Meeting the communication needs of clients;
- Deaf and hard of hearing therapist or hearing therapist with knowledge of deaf culture and sign language;
- Programs adapted for deaf and hard of hearing;
- Ongoing deaf and hard of hearing support network and continuing care
- Assessments normed on the population; and
- Materials (videos, workbooks, etc.) that are deaf and hard of hearing-focused.

Unmet Need/Gap: ADMH's movement to a recovery oriented system of care for its substance abuse service delivery system requires establishment of a respectful, responsive approach to diversity that that extends beyond race, ethnicity, and religion. Cultural and linguistic competent services must also incorporate policies, procedures, and practices firmly embedded in each provider's organizational structure to address language, gender, socioeconomic, regional, and other differences that reflect the unique values, norms, and needs of clients and communities served.

Suicide Prevention

For ten (10) years ADMH has worked collaboratively with other agencies to develop and implement strategies to prevent suicide in Alabama. Yet, suicide continues as a significant public health problem that impacts hundreds of families in this state each year. The Alabama Center for Health Statistics reports that suicide in the state has climbed steadily since 2005 and now exceeds the national average. There were 14.2 suicides per 100,000 people in Alabama in 2009, totaling 665. This exceeds the national rate of 11.9 for the same period.

TABLE 9

2009 # Suicides in Alabama Race and Age	Male		Female		Total
	White	Black	White	Black	
Under 1	0	0	0	0	0
1-4	0	0	0	0	0
5-9	0	0	0	0	0
10-14	4	2	0	0	6
15-19	15	6	3	0	24
20-14	31	8	6	1	46
25-29	26	5	4	1	38
30-34	31	6	12	1	50
35-39	35	2	12	0	49
40-44	49	5	15	1	70
45-49	49	1	17	1	66
50-54	51	3	15	1	70
55-59	48	3	9	2	62
60-64	45	7	11	1	64
65-69	26	2	2	1	31
70-74	22	0	5	0	27

75-79	22	3	1	1	27
80-84	13	1	3	0	17
85+	16	0	2	0	18
TOTAL	483	54	117	11	665

Suicides in Alabama exceeded homicides in 2009. The rate climb coincides with Hurricanes Ivan, Katrina, and Rita which struck the state within a twelve (12) month period. Alabama has experienced two category 1 disasters within the last six years, Hurricane Katrina in 2005 and the tornadoes which flattened parts of the state in April, 2011, killing 240 people and leaving thousands of others injured and homeless. In 2010, the Gulf Coast oil spill left many people without jobs **(49)**.

The American Foundation for Suicide Prevention **(50)** has identified risk and protective factors for suicide prevention as listed **TABLE 10.**

TABLE 10

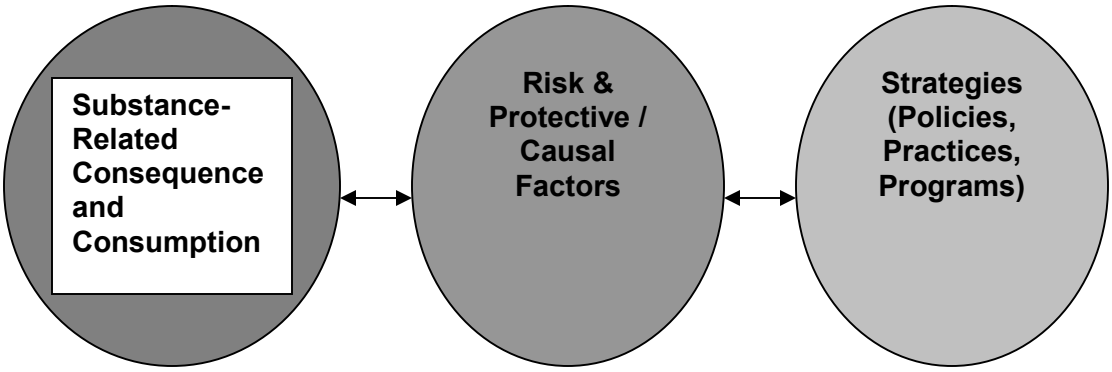
Suicide Risk and Protective Factors	
Risk Factors	**Protective Factors**
Alcohol or Drug Abuse	Network of family and friends (social support)
History of attempted suicide or the suicide of a family member	Religious convictions that condemn suicide and provide social support
Impulsivity	Marital Status – married individuals make fewer attempts
Psychiatric disorders, including depression, anorexia nervosa, bulimia, and post traumatic stress disorder	Restricted access to lethal means
Geography – Rural areas have higher rates of suicide because of lack of economic and social opportunities, lack of mental health services	
Access to lethal means, such as having a firearm or prescription drugs available	
Social isolation	

Unmet Need/Gap: ADMH does not have an internal plan to address suicide in Alabama. Both risk and protective factors for suicide present opportunities for this agency to develop strategies to mitigate the continued growth of this public health problem.

5. Community Populations for Environmental Prevention Activities

The Alabama Epidemiological Outcomes Workgroup (AEOW) produced two Epidemiological Profiles that summarize and characterize the nature, magnitude, and distribution of substance use and related consequences in the State and communities. Understanding the nature and extent of the array of substance use and related consequences in the State and communities is critical as a first step for determining prevention priorities. The work of the AEOW is framed by an outcomes-based prevention model (Figure1) that grounds prevention in a solid understanding of ATOD use and related consequences. Following the outcomes-based prevention model, once priorities are established, prevention planners then identify the factors influencing the prioritized use patterns and consequences to align relevant and effective strategies to address them.

Figure 1. Outcomes-based Prevention Model



The Division will continue the work of the AEOW to set state priorities to reflect a process by which there is a predominant focus on Environmental strategies based upon substance-related consumption and consequences, in conjunction with implementation of an outcomes-based approach. The following is a brief overview of recent findings of youth with the PRIDE Survey depicting the overall consumption patterns of Alcohol and Tobacco.

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, 24.43% reported consuming alcohol during the past month and 15.01% reported binge drinking.
- Among persons 12 years and older in Alabama, 6.07% abuse or are dependent on alcohol and 5.69% 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, 28.44% reported smoking cigarettes during the past month and 34.35% 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 **(51).**

Consumption is defined as the use and high-risk use of ATOD. Consumption includes patterns of use of ATOD, including initiation of use, regular or typical use, and high-risk use. Substance-related consequences are defined as adverse social, health, and safety consequences associated with ATOD use. Consequences include mortality, and morbidity, and other undesired events for which ATOD clearly and consistently are involved. Although a specific substance may not be the single cause of the consequence, scientific evidence must support a link to ATOD as contributing factor to the consequence.

The Department of Public Safety, a member of the AEOW recently reported at a meeting in 2011 that Alabama's predominant rural highways experience more traffic fatalities on state and county highways. An example of the Department of Public Safety working collaboratively with the Department of Transportation's efforts to "change the environment" on roadsides is by periodically removing trees. The majority of rural fatalities are those individuals hitting trees on the wayside after leaving the highway. This contextual example led to intense discussion of the need to change community practices, policies and norms (Environmental strategies) that allow underage drinkers and underage tobacco users to have less access and increased safety parameters around consumption (binge drinking, underage drinking, tobacco access and smoking while pregnant).

Unmet Need/Gap: Prevention strategies that focus solely on only one feature of a particular problem or that address factors only weakly associated with substance use and its consequences offer little promise to eliminate or reduce population based level problems. This paradigm shift in thinking is a major change for communities across Alabama. It is often human nature to "isolate" and label a problem with one specific cause or personal characteristic flaw(s). By doing so, we enable the problem to become compartmentalized and less stressful to conceptualize.

Community problems are systemic in nature and often rely upon multiple attributes in the community to be persistent and monumental. Changing conditions in the environment, as opposed to changing an individual, leads to increased sustainable change that supports and strengthens community buy-in.

6. Workforce Development

At no time in Alabama's history has workforce development been more important. Changes in the nation's healthcare delivery system are bringing forth new challenges for individuals who work in substance abuse treatment and prevention programs. With plans for an additional 500,000 individuals in Alabama to gain Medicaid and health insurance coverage in 2014, and terms such as Health Home, Managed Care, and Accountable Care Organizations becoming more and more common each day, the landscape among the substance abuse professional is likely to change.

With the current workforce aging out, there is already a serious shortage of behavioral health professionals in Alabama. At the same time, ADMH's new program certification regulations will support a higher degree of professionalism in community programs. To add to the dilemma, the implementation of evidence-based practices requires competent professions and consistent clinical supervision. State and federal budget issues present an additional concern for a public service delivery system that's already under-funded and having difficulty maintaining qualified professionals because salaries are not competitive with the private sector.

Unmet Need/Gap: Recruitment and retention remain challenges for the publicly supported system in Alabama, particularly in rural areas. There is a very serious need to develop a strategy to nurture and sustain our workforce.

7. Information Technology

Unmet Need/Gap: Currently, the systems that the Alabama Department of Mental Health, Mental Illness and Substance Abuse Services Division use to monitor and collect information from its providers are compartmentalized and difficult to reconcile or use to assess needs and improve quality. ADMH does not have a strong plan to develop a more cohesive system infrastructure between MI and SA data, at the provider, client and service level. While each independent data system has a wealth of information, the ability to cross-tabulate that information in a meaningful and timely way could be greatly expanded.

The Alabama Substance Abuse Information System (ASAIS) collects data on the 25,000 clients served each year by the Division's service providers. It collects the client level information as well as the service provision data for all funding sources through the Department of Mental Health, including Medicaid. The Alabama Community Services Information System (ACSIS) collects client level data for the 100,000 clients served by our mental health service providers. It collects the client level information and the service provision data for all funding sources through the Department of Mental Health, except Medicaid. The Alabama Medicaid Agency collects client level service data for all Medicaid-eligible clients served in our service delivery system. These disparate systems each have value alone, but bringing the information together in a meaningful way is key to improving our service provision across the state.

The Alabama Department of Mental Health, Mental Illness and Substance Abuse Services Division, also recognizes deficiencies in its ability to assist service providers in implementing new technologies that would improve care and outcomes for the people we serve. The Division currently lacks capacity in identifying and disseminating information on new technologies. When technologies are identified, as often occurs, it is often done by individual providers and the successes/failures are not given voice to the rest of our system. The need exists, in recognition of these deficiencies, to work now to begin to build the capacity currently lacking.

8. Implementation of a Good and Modern Service System

There have been no significant changes in Alabama's public substance abuse treatment system since the early 1990's when ADMH shifted its priority to funding Intensive Outpatient Programs (IOP) from more costly Residential Programs. In 2005, ADMH funded prevention programs were required to develop need-based prevention plans, and in 2007 ADMH reallocated 50 % of its prevention funding to support implementation of environmental strategies.

Although ADMH has provided funding to enhance access to treatment for specific populations, as drug court participants, individuals with co-occurring disorders, and individuals diverted from the criminal justice system, the services received by these participants are not significantly different from those received by others who are routinely admitted to the programs. Requirements specifying the use of best practices, responding to specific community needs, and demonstrating quality service delivery have not been made.

Prevention services have moved faster in Alabama towards embracing needs based planning and implementation of evidence-based service delivery. As knowledge comes forth in regard to the

significance of adverse childhood experiences in later life onset of mental and substance use disorders, prevention's role in the state's substance abuse service delivery system must become more prominent.

Health care reform and the current knowledge base of what works in substance abuse prevention and treatment creates an urgent need for changes in the state's system of care to a good and modern service delivery system that addresses the unique needs of the people of Alabama.

SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a highly effective strategy used to provide early detection of an alcohol or drug use problem, before the problem escalates to the level of abuse or dependency. SBIRT is typically implemented in locations where individuals routinely receive other health care services, such as doctors' offices, medical clinics and emergency rooms. This approach significantly expands access to care for individuals who are not likely to seek help at a substance abuse treatment facility.

During FY 09, the Division worked with the Alabama Medicaid Agency to provide SBIRT services to pregnant women participating in the Medicaid Maternity Waiver program. This population previously would not likely access these services through the traditional substance abuse provider network, where the vast majority of clients served are alcohol and/or drug dependent.

In FY 10, this process began implementation as the Alabama Medicaid Agency began coverage of procedure codes H0049 screening for substance use and H0050 brief intervention and referral to treatment for pregnant women in conjunction with ante partum care provided by physicians, physician-employed nurse practitioners, nurse midwives, physician-employed physician assistants and federally qualified health centers. Prior to offering these services, providers are required to successfully complete an online tutorial developed by ADMH in FY 10 and hosted on its Web site. This tutorial prepares health care professionals to screen and refer Medicaid recipients to treatment for substance use disorders if needed.

To date, 18 medical providers within the state utilize SBIRT. ADMH endeavors to expand the number of providers utilizing SBIRT as it has been shown to be an effective way to reduce drinking and substance abuse problems. Equally important is the relationship SBIRT provides for collaborating closely with the medical community and more specifically with FQHC's. ADMH will promote awareness of SBIRT through continued advertisement on the agency's website and inclusion in workshop/training/conference venues. ADMH has already begun implementation of one of these strategies by including the topic of SBIRT in the 8th Annual Child and Adolescent Psychiatric Institute slated for September 30 – October 2, 2011. The Institute's primary target audience is physicians.

Unmet Need/Gap: Since beginning its SBIRT initiative, Alabama has 18 medical providers utilizing SBIRT. These providers represent only 9 of the 67 counties within the state. This is an obvious gap which leaves a very big hole in identification of need for prospective services. Further, the current SBIRT providers have been slow to utilize SBIRT, billing the Medicaid agency less than $7,000 to date.

Enhancement of Substance Abuse Service Array

ADMH's current fee-for service substance abuse treatment system provides limited reimbursable options. Developed in the early 1990's, the service array has had few modifications through the years. In some cases payment is made for a bundled level of care service, as IOP, and in others for services that can be provided within a level of care, as, individual counseling. For the last three years, efforts have been made to develop a menu of treatment and recovery support services to provide greater flexibility and more options in meeting the specific needs of each specific client. This effort to enhance the service strongly supports the Division's efforts to move towards implementation of a Recovery Oriented System of Care.

Utilizing CPT codebooks as a guide, along with the ASAM PPC 2 criteria, a list of services, as attached, is now available, with planned implementation in 2012. However, preparation is needed. Adding new services to the system does not guarantee utilization. For example, the Alabama Medicaid agency currently offers a number of billable services through its Medicaid Rehabilitation Option which are accessible to Medicaid approved providers. Providers utilize only a few of these codes, however. This limited use of Medicaid services is indicative of a culture change that will need to take place within the Division's substance abuse service provider community in order to establish a system that embraces client centered care.

Unmet Need/Gap: Client centered care is essential. Access to an enhanced service array establishes more options for providing client centered care. The need exists for ADMH to identify barriers which impede provider utilization of an expanded service array, and develop and implement strategies to address the identified barriers prior to rolling out the new service array.

Implementation of a Recovery Oriented System of Care

There are a number of identified needs and gaps in the current service delivery system in Alabama that facilitates the need to development a "Recovery Oriented System of Care".

Defining recovery as a process of change through which an individual achieves abstinence and improved health, wellness and quality of life is synonymous with the Prevention of substance abuse. Healthy and safe community environments are influenced by the physical locality in which Alabamians work, play, learn and live in our sixty-seven (67) counties. The National Prevention Strategy (June 2011) states that other factors such as clear air, water, affordable and secure housing, sustainable economic attributes, efficient transportation, competent education systems, violence free communities and adequate access to health and mental health care are essential to promote a recovery oriented system of care. Alabama is no different from the U.S. in the following areas of concerns. 1) Disproportionately health related deficiencies are found in low income housing areas, 2) Exposure to environmental and occupational hazards before and during pregnancy can increase the risk of health problems for children, birth defects, developmental disabilities and childhood cancer, 3) Children are more prone to vulnerable environments because of their developmental stage, 4) Alabama asthma rates are higher in low income children, and 5) Perceptions of the threat of violence in surroundings influence whether an individual will decide to exercise/walk in their prospective communities.

Research has shown the connection between unsafe environments and the frequency of substance abuse usage. Census figures show Alabama's poverty rate increased by more than 17 percent from 2007-08 to 2009-10 and more state residents are without medical insurance coverage. The Affordable Care Act recognizes that prevention, early intervention and when necessary, treatment of mental and substance use disorders are integral parts of improving and maintaining overall health. The Affordable Care Act will open doors for these individuals to acquire health care, however physical living conditions will more than likely remain the same. The poverty rate jumped from 14.4 percent to 16.9 percent during this time span. A 17.4 percent increase has occurred within the last two years. The national poverty rate in 2009-10 was 14.7 percent. According to the Census Bureau, there were 672,000 people in poverty in Alabama in 2000 and 713,000 in 2008, the latest year for which statistics are available. This information will undoubtedly affect how the state plans to integrate services that are already challenged by virtue of the existing demographics**.**

Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. It is evidence in prevention that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavior change and therefore, an effective tool in recognizing and addressing mental health and substance use issues.

Environmental prevention strategies work toward changing community norms and practices through environmental change. Changing community ordinances, laws, and practices changes the overall dynamics of safe communities to foster safe recovery activities. All activities are interrelated and linked together to design and promote safe living conditions. Each domain (community, work-place, individual, school) have different influences over whether a community has and maintains the capacity to sustain health.

The vision of the Alabama Department of Mental Health is to truly build a system of care where there is no wrong door for consumers to enter at anytime and access prevention, substance use treatment, as well as mental health treatment. The vision is also to promote optimal individual health, prevention, screening & early intervention, treatment, recovery support, and productivity.

Recovery Oriented System of Care (ROSC) is a person-centered and a self-directed approach to care that builds on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and/or other drugs. Recovery is an on-going process in which an individual accesses a variety of formal and informal resources, across his/her lifespan, in the service of attaining and maintaining a healthy and productive lifestyle. Alabama's current system of care for substance use conditions is focused on formal treatment resources, with insufficient attention being given to ensuring the presence of and access to wrap-around recovery support services which are critical to sustaining recovery.

Current treatment for someone in Alabama with a substance use disorder is usually not a successful one-time effort, but one of multiple treatment episodes. By making a paradigm shift to a ROSC model, clients will have access to continuing recovery support services in the

community that are client-centered and ongoing. The system of care in place recognizes that recovery is a process with many pathways.

The expectation in the ROSC is that contact with the consumer will continue after the initial stage of treatment is completed and that recovery support services are extended to family members and to people who may not have completed the initial stage of treatment. Recovery support services may be in the form of follow-up phone calls, face-to-face meetings, emails, transportation, employment services, housing assistance, life skills, child care, peer services, education, faith-based support, or linkage to recovery communities. All of these identified services are flexible and can be provided prior to, during, and after treatment. In the Alabama ROSC these services may be delivered by peers, faith-based community, advocacy groups and professionals.

The transformation of the Alabama Department of Mental Health service delivery system of care to a ROSC is an ongoing process that requires improving coordination and collaboration among departments/agencies that provide services to individuals with substance use conditions to increase the likelihood of attaining and sustaining recovery.

Unmet Need/Gap:

- Improvement in consumer screening, assessment, evaluation, and placement at all points and for all populations in the system.
- Disconnect between completing initial phase of treatment and hand off to next level of care.
- Not enough co-occurring services for MI/SA consumers.
- Lack of recovery support services.
- Shortage of professionals currently practicing in the field who are sufficiently trained and skilled in working with the variety of disorders presented by individuals seeking services in Alabama.
- .It takes too much time to access services at all levels of care.
- Transportation remains a barrier to access prevention and treatment

Goals for prevention, treatment for substance use and mental disorders, and recovery support services must be aligned to enhance collaboration for implementation of a recovery oriented system of care. ADMH knows there is evidence that substance abuse prevention, treatment, and recovery support services work and work well.

Trauma Informed Services

Trauma is considered to be a near universal experience for individuals with behavioral health problems. The Adverse Childhood Experiences Study (ACE) identified eight (8) traumatic conditions in the household that, if experienced prior to age 18, create the risk of negative outcomes later in life. These conditions are recurrent physical abuse; recurrent emotional abuse; contact sexual abuse; an alcohol and/or drug abuser in the household; an incarcerated household member; someone who is chronically depressed, mentally ill, institutionalized, or suicidal; mother is treated violently; one or no parents; emotional or physical neglect. Negative outcomes include alcohol abuse, alcoholism, depression, illicit drug use, risk for intimate partner violence, sexually transmitted diseases, suicide attempts, and unintended pregnancies **(53).**

Conditions supporting creation of adverse childhood experiences are quite evident in Alabama. The state has the second highest rate in the country for men murdering women **(54**). Of the 18,239 violent offenses reported in Alabama in 2010, domestic violence was indicated in 2,193 offenses reported, in 36 homicides, 187 rapes, 52 robberies, and in 1,918 aggravated assaults. In addition, 27,470 domestic violence simple assaults were recorded **(55).** Directors of programs providing treatment services for women and their children in Alabama consistently report that the vast majority of these women have histories of domestic violence and abuse. In 2010, there were over 20,000 reports of neglect and abuse by Alabama's child welfare agency that involved over 37,000 children **(56).** Alabama prison system is vastly overcrowded with the state having the 5th highest incarceration rate in the country . Alabama's imprisonment rate for women is, also, one of the highest rates in the county. Sixty seven percent of referrals to Alabama's public substance abuse treatment system are made by criminal justice entities **(57).**

Unmet Need/Gap: The ACE Study revealed that the economic cost of untreated trauma related substance abuse in 2000 was $161 billion. The provision of services to address trauma in Alabama's public service delivery system is limited to some of the women's treatment programs funded by the SABG set-aside. Data supports system-wide implementation of trauma informed care.

Mental Health Promotion and Wellness

The National Prevention Strategy (June 2011) states that positive and emotional well being is dependent on many factors. These factors mimic strong prevention science that quality relationships in a positive workplace and community and the ability to access mental health services is key to positive outcomes. The World Health Organization (WHO) estimates that 450 million individuals suffer from mental health disorders. One (1) in four (4) will be affected by mental health disorders at some stage in their lives. It is estimated that by year 2020, depression will become the second leading cause of disease burden (Murray & Lopez 1996). Preventing mental disorders and promoting mental health interests among researchers and policy makers is a growing and lively debate. At the forefront of this concept is the need to stabilize spiraling health costs and discontinue the reactionary effort to manage disease after the problem occurs. Science offers clear evidence of individual risk and protective factors that give credence to the overall stability of health and wellness early on as a precursor to managing individual mental health and wellness.

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community. Mental health promotion values one's mental health and improves the coping capacities of individuals, rather than foster the amelioration of symptoms and deficits. The promotion of mental health and wellness mirrors the tenets of sound Prevention science. Although prevention strategies are usually directed against risk factors, hence the need to implement and gauge the type and strength of a prevention practice, before the onset of a disorder to be effective, it is necessary to broaden the definition of Mental Health Promotion and how it overlaps and complements Prevention services.

Alabama has adopted SAMHSA's National Summit's working definition of "Recovery". The guiding principles that were created during this conference incorporated developing core measures, promising approaches and evidenced based practices that support recovery-oriented elements. These elements are interrelated to the overall mental health promotion and wellness of any given community. The risk benefit is a new term being used to gauge when a disorder has developed, and how we can look at the possibility to reduce the severity of the disorder by reducing the course of treatment and the associated disability by taking other preventive measures. Another point of view to glean risk benefit is to look at another way to conceptualize prevention and promotion strategies. One could view disease/disorder by assessing the risk of an individual getting a disease against the cost, risk and discomfort of the actual preventive strategy. Prevention cost benefits are now coming to the forefront of the government to weigh the costs of programs and services. Concrete outcomes must be exemplified in the outcome for behavior change and healthier lifestyles.

Unmet Need/Gap: Limited and decreasing budgets in Alabama challenge our systems to combine strategies and goals. Mental Illness and Substance Abuse Prevention have an opportunity to forge some practices together to enable some components of the overall system to change in the future. If both areas want to prevent mental disorders in the long term, several short term goals may be achieved via improving the quality of life in the following areas: Health improvements are linked to the overall socio-economic development of any given population. A community climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health. The need exists to develop strategies for mainstreaming mental health promotion into policies and programs in Alabama government, business sectors, education as well as both private and public health sectors.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:
2012

End Year:
2013

Number	State Priority Title	State Priority Detailed Description
1	Injection Drug Users (IDUs)	Enhance access to services and service delivery for injection drug users in Alabama as according to 45 CFR 96.126
2	Pregnant and Parenting Women	Ensure priority access to substance abuse treatment for pregnant women and women with dependent children that incorporates (a) evidence-based practices; (b) prenatal care; (c) HIV/AIDS prevention education, counseling, and referral for related services; (d) services for dependent children; and (e) other gender responsive services needed to minimize barriers to treatment, support recovery, and strengthen the family.
3	Tuberculosis Services for Substance Abuse Treatment Program Participants	Ensure resource availability and the establishment of formal agreements for the provision of TB services as outlined in 45 CFR 96.127 for all substance abuse treatment programs funded by ADMH.
4	Rural Populations	Increase access to culturally competent substance abuse prevention and treatment services in rural Alabama communities.
5	Veterans	Improve access to trauma informed care and increase service delivery for veterans and their families at programs funded by ADMH
6	LGBTQ Individuals	Alabama will increase outreach and training opportunities to serve LGBTQ individuals.
7	Health Care Reform	Enhance Alabama's public substance abuse services delivery system readiness for changes in health care delivery.

8	Underage Drinking	Facilitate implementation of a strength-based approach to addressing underage drinking in Alabama.
9	Linguistic and Culturally Competent Services	Improve the state's substance abuse prevention, treatment, and recovery support service system so that it is more responsive to the needs of a culturally and linguistically diverse client population.
10	Suicide Prevention	Actively participate in efforts to combat the state's increase of deaths by suicide and promote suicide prevention in Alabama.
11	Community Populations for Environmental Prevention Activities	Enhance efforts throughout the state to address the health and social well-being of the community at large through implementation of environmental change processes.
12	Workforce Development	Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state.
13	Behavioral Health Information Technology	Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system.
14	Implementation of a Good and Modern Services System	Alabama will enhance the available substance abuse service array. Alabama will actively promote implementation of a Recovery Oriented System of Care. Alabama will integrate Mental Health Promotion and Wellness (MHPW) into community prevention services. Alabama will increase access to Trauma Informed Services.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:
2012

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Injection Drug Users (IDUs)	Enhance access to services and service delivery for injection drug users in Alabama as according to 45 CFR 96.126.	1. Work in conjunction with community partners to review evidence-based outreach models and identify at least three models for use in conjunction with or by treatment programs. 2. Incorporate the requirements of 45 CFR 96.126 into ADMH protocols. 3.Monitor implementation of outreach activities as according to 45 CFR 96.126.	1. IDU admissions to ADMH funded treatment programs will increase by 10% from 1,813 admissions in FY 2011 to 1,995 by September 30, 2013. 2. By 2013 there will be a 50% increase in program compliance with 45 CFR 96.126 over the established 2012 baseline	Staff assigned to manage this Priority will: 1. Establish the baseline number of programs in compliance with the outreach and service requirements of 45 CFR 96.126 by September 30, 2012. 2. Obtain quarterly reports of IDU admissions from ASAIS, the ADMH management information system.
		1. Identify and implement strategies to more effectively publicize the availability of treatment for pregnant women		

Pregnant and Parenting Women	Ensure priority access to substance abuse treatment for pregnant women and women with dependent children that incorporates (a) evidence-based practices; (b) prenatal care; (c) HIV/AIDS prevention education, counseling, and referral for related services; (	and women with dependent children. 2. Develop and implement strategies to promote the use of Screening Brief Intervention and Referral to Treatment in the Alabama Medicaid Maternity Care Network. 3. Survey programs serving pregnant women and women with dependent children to establish baseline data on utilization of evidence-based practices; access to prenatal care; HIV/AIDS prevention education, counseling, and referral for related services; services for dependent children; and other gender responsive services. On the basis of the survey's results, develop and implement strategies to increase use. 4. Modify the ADMH substance abuse services contract billing manual and contract language to comply with 45 CFR 96.121, 96.126, and 96.131. 5. Provide provider training and make available technical	From October 1, 2011 thru September 30, 2012, data collection and analysis will establish a baseline level of performance by ADMH contract substance abuse treatment providers that establishes:	Treatment Services staff assigned to manage this Priority will: 1. Obtain quarterly reports of the number of admissions of pregnant women and women with dependent children to ADMH funded treatment programs and provide a report of such to the Executive Staff and the Division's Associate Commissioner. 2. Modify program monitoring reports to capture information on the use of evidence-base practices, access to prenatal care, the provision of HIV/AIDS prevention education, counseling, and referral services, services provided for children, gender responsive services, and the development of program policies to enhance access to care for pregnant women and women with dependent children. 3. Develop quarterly reports of progress toward attainment of the stated objectives and report findings to the Executive Staff and Associate Commissioner.

		assistance to support compliance with contract requirements. 6. Monitor provider compliance with contract requirements.		
Tuberculosis Services for Substance Abuse Treatment Program Participants	Ensure resource availability and the establishment of formal agreements for the provision of TB services as outlined in 45 CFR 96.127 for all substance abuse treatment programs funded by ADMH.	1. The Substance Abuse Office of Treatment Services will identify how recent ADPH TST changes are affecting providers. 2. The Substance Abuse Office of Treatment Services will develop a sample template as an example for providers to use for the provision of TB services. 3. The Substance Abuse Office of Treatment Services will monitor the provision of TB services through its SAPT Block Grant monitoring process.	1. By September 30, 2012, at least 25% of the 50 contractual SA treatment providers will report to the SA Office of Treatment Services on the existence of gaps in the provision of TB services as the result of ADPH TST changes.	Treatment Services staff assigned to manage this Priority will: 1. A document listing the providers affected by the ADPH TST changes along with the proposed plan to ensure TST resources are available will be developed by the Substance Abuse Office of Treatment Services. 2. The Substance Abuse Office of Treatment Services will conduct SAPTBG monitoring compliance visits on a scheduled rotation, that will yield evidence of compliance specific to 45 CFR 96.127, tracked on the SAPTBG Program Compliance Monitoring Survey. This survey will yield evidence of compliance, no evidence of compliance, or partial evidence of compliance.
		1. Identify opportunities for medical providers in rural communities to participate in SBIRT. 2. Establish a process wherein existing rural		Staff assigned to manage this goal will collect the following data, develop quarterly reports

Rural Populations	Increase access to culturally competent substance abuse prevention and treatment services in rural Alabama communities.	community providers, especially FQHCs, and current/ prospective SA service providers collaborate for the delivery of integrated substance abuse treatment and primary care services. 3. Explore grant opportunities through the Alabama Office of Rural Health. 4. Expand opportunities for telehealth.	By September 30, 2012, establish a baseline to determine the number integrated service activities implemented that engage medical providers, existing rural community providers, and current/prospective SA providers.	of this information, and submit these reports, along with recommendations for goal and/or strategy modifications to the Executive Staff and Associate Commissioner: 1. Documentation of activities that engaged medical providers, existing rural community providers, and current/prospective SA providers. 2. The number of new SBIRT enrollee's. 3. Utilization rates of SBIRT billing code. 4. The number of grants and/or RFP's applied for / published. 5.The number of new service providers and / or levels of care within rural communities.
Veterans	Improve access to trauma informed care and increase service delivery for veterans and their families at programs funded by ADMH.	1. Identify, initiate contact, and establish collaborative relationships with veteran serving organizations throughout the state. 2. Research, develop, and implement effective outreach and engagement strategies for veterans and their families. 3. Develop opportunities for community providers to obtain trauma training for all staff, including administrative and support personnel. 4. Collaborate with federal, state, and community partners	1. The number veterans receiving services from ADMH funded substance abuse treatment programs will increase by 10% from 1044 individuals in FY 2011 to 1148 individuals in FY 2013.	Staff assigned to manage this Priority will collect the following data, develop quarterly reports of this information, and submit these reports, along with recommendations for goal and/or strategy modifications to the SA Executive Staff and Associate Commissioner: (a) The number of trauma specific training events in which staff from ADMH contract agencies participated organizations in FY 2012. (b) The number of veterans receiving services in ADMH funded substance abuse treatment programs.

		to develop resources to support access to trauma specific services.		
LGBTQ Individuals	Alabama will increase outreach and training opportunities to serve LGBTQ individuals.	1. Identify speakers to provide LGBTQ content sessions at the Alabama School of Alcohol and Other Drug Studies and at the Council of Community Health Center Annual Conference 2. Initiate invitations for qualified organizations to formally serve on appropriate ADMH planning bodies.	1. ADMH will partner with the Alabama School of Alcohol and Other Drug Studies to provide a course titled Gay, Lesbian, Bisexual, Transgender (GLBT) and Behavioral Health Issues at the conference in March 2012.	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts to engage LGBTG individuals and organizations in ADMH planning efforts, and to make quarterly reports of such to the Associate Commissioner and to the MISA Executive Staff Committee.
Health Care Reform	Enhance Alabama's public substance abuse services delivery system readiness	1. Provide opportunities for providers' self assessment of readiness to adapt to changes in the country's health care delivery system. 2. Establish and implement a process for routine dissemination of information on health care reform related funding opportunities. 3. Collaborate with state agency partners in development of the behavioral health benefit options to be provided through the	1. By September 30, 2013, self-assessments will be completed by at least 50% of ADMH sixty (60)	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and to make written quarterly reports of such, along with recommendations

	for changes in health care delivery.	Alabama Health Insurance Exchange. 4. Collaborate with state agency partners to maximize opportunities for individuals with substance use disorders to benefit from Alabama's Health Insurance Exchange. 5. Provide technical assistance and education activities for ADMH staff and for providers to support implementation and compliance with the Affordable Care Act and related changes in the health care.	substance contract treatment providers.	relative to progress toward attainment of benchmarks, to the Associate Commissioner and to the MISA Executive Staff Committee
		1. Identify underage drinking as a priority for prevention efforts across the CSAP strategies; 2. Apply principles of didactic learning, adult learning skills to facilitate effective underage drinking awareness and education to promote community buy in and		

Underage Drinking	Facilitate implementation of a strength-based approach to addressing underage drinking in Alabama.	community collaboration; 3. Demonstrate sound application of data to inform where and how to provide applicable services to those whom experience underage drinking. 4. Initiate consistent statewide underage drinking public education efforts 5. Collaborate with community partners to identify and develop key practical solutions that demonstrate sound Prevention practice that would build on existing strengths of communities and individuals.	1. By Sept. 30, 2012 the prevention plan template for FY2013 will reflect underage drinking as a priority.	1. Documentation of underage drinking as a priority in prevention plan template for FY2013. 2. Documentation of efforts to raise awareness of underage drinking. 3. Documentation of data will identify areas of incidences of underage drinking. 4. Documentation of media outlets addressing underage drinking for FY13. 5. Documentation of resources and collaborative efforts being utilized throughout the state.
		1. Gather community -based information on needs and concerns of cultural groups regarding substance abuse services. 2. Assess the staff and service capacity of the public substance abuse system to serve the identified groups. 3. Assess the policies and procedures provider organizations to address the needs of cultural groups. 4. Develop reporting processes which will		

Linguistic and Culturally Competent Services	Improve the state's substance abuse prevention, treatment, and recovery support service system so that it is more responsive to the needs of a culturally and linguistically diverse client population.	allow the Division to determine with precision the numbers of people who are limited English proficient (including people are who are deaf and use American Sign Language) and what language assistance is provided to them per Executive Order 13166, which includes: (a) Revision of data fields in the ADMH management information system, ASAIS, to capture language of preference and hearing status in reportable form; and (b) Revision of service reporting procedures for providers to capture expenditures for language assistance. 5. Conduct trainings to improve competence skill sets for the public workforce to address a culturally and linguistically diverse client population.	By September 30, 2013, participation of cultural and linguistic minorities within Alabama's public substance abuse service delivery system will increase by 10% over baseline figures established September, 30 2012.	Report number and language preference of any consumer who is LEP. Report number of hours of free language assistance provided. Description of Collecting and Measuring Changes in Performance Indicator 1. Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and submit an end of the year report listing the findings as they relate to the stated indicators to the Associate Commissioner. 2. Office of Deaf Services will offer at least two training events on identifying people with hearing loss and at least two training events on cross-linguistic service delivery. 3. Bi-monthly performance reports developed by assigned ADMH personnel and disseminated to the cultural competence advisory committee and Associate Commissioner.
		1. Actively collaborate with federal, state, and local agencies in the development and implementation of a		

Suicide Prevention	Actively participate in efforts to combat the state's increase of deaths by suicide and promote suicide prevention in Alabama.	statewide plan to prevent suicide. 2. Develop strategies to implement the DMH-components of the statewide suicide prevention plan, but clarifies ADMH's role in relation to other agencies addressing this problem and identifies specific internal strategies, policies and procedures to be implemented on a continuous basis. 3. Examine the feasibility of implementation and promotion of Mental Health First Aid in Alabama as an adjunct to ADMH's suicide prevention plan.	1. By September 30, 2013 ADMH will document active participation in at least four (4) sustainable activities with state and local partners that support suicide prevention for individuals who have substance use and co-occurring substance use and mental dis	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and to make written quarterly reports of such, along with recommendations relative to progress toward attainment of benchmarks, to the Associate Commissioner and to the MISA Executive Staff Committee.
	Enhance efforts throughout the	1. Identify Environmental as a CSAP strategy priority for prevention efforts; 2. Demonstrate the use of Environmental as a CSAP strategy priority for prevention efforts; 3. Align funding to support Environmental as a CSAP strategy priority for prevention efforts;		1. Documentation of Environmental as a CSAP strategy priority in prevention plan template for FY2013. 2. Documentation of Environmental as a CSAP strategy priority in

Community Populations for Environmental Prevention Activities	state to address the health and social well-being of the community at large through implementation of environmental change processes.	4. Individualize what “capacity building” means to communities before an attempt is made to ensure prevention activities and outcomes are finalized based solely on funding. 5. Establish Campus-Community Collaborative Partnerships to strengthen community mobilization efforts 6. Assist with a community approach to sustaining training, support, and supervision	1. By Sept. 30, 2012 the prevention plan template for FY2013 will reflect Environmental as a priority.	proposed prevention plans for FY2013. 3. Documentation of Environmental as a CSAP strategy priority in proposed prevention rates for FY2013. 4. Documentation of community providers and services offered will be indicated in prevention plans by FY2014. 5. Documentation of Campus-Community Partnership collaborative efforts by FY14. 6. Documentation of sustainability in Alabama communities
Workforce Development	Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state.	1. Increase cooperative relationships with universities whereby students complete the internship/practicum portion of their degrees within mental health disciplines. 2. Advocate for changes in the licensing law for psychiatrists to observe reciprocity with other state licensing bodies. 3. Expand use of telemedicine.	By September 30, 2012, the SA Office of Treatment Services will disseminate the SA Provider directory to 100% of the educational institutions within the state that have master’s level counseling programs to foster opportunities for students to complete	1. The Substance Abuse Office of Treatment Services will query providers about the # of internship/practicum students hired and/or retained post degree attainment on an annual basis through use of a survey administered by FY2013. 2. The ADMH’s documentation of communication with ABME. 3. Increas the number of opportunities pursued by the ADMH to expand use of telemedicine.
				1. Analysis of current information system

Behavioral Health Information Technology	Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system.	1. Analyze ADMH's current information system infrastructure to identify gaps and determine ways to be more efficient in collection and access to data from the service delivery system.	Description of Collecting and Measuring Changes in Performance Indicator	infrastructure completed. The Department will complete a comprehensive analysis of current information system infrastructure and identify goals and strategies that will need to be implemented to create a cohesive structure for all data the department maintains. 2. Development of an ongoing process involving user groups in identifying new technologies and engaging the service delivery system in their use. We will establish and help to facilitate at least five groups on various types of technology where there is identified interest. These groups will each have team leaders and be assisted by staff from the division, but be composed of providers who have an interest in that particular technology. All meetings will be available to all, whether by teleconference or in-person and the groups will report out to relevant bodies as appropriate.
Implementation of a Good and Modern Services System	Alabama will actively promote implementation of a Recovery Oriented System of Care.	1. Collaborate and enhance program planning to promote recovery oriented system of care via expanding and increasing access to Prevention awareness and information technology to promote cross-discipline information exchange-treatment-mental illness-prevention; 2. Maximize choice and control for consumers and families to self-direct care and treatment with a focus on recovery and support. 3. Promote	1. By September 30, 2012, data collection and analysis will establish a baseline level of performance by ADHM contract substance abuse treatment providers that specifies the number:	1. The number of consumers and families who report that they were present and involved in their individual service plan. 2. Number of service plans reviewed that reflect that services and support are consistent with individual need and preference. 3. Review of recovery support services and early intervention services submitted for payment.

		evidence-based practices and co-occurring training at the state level.		
Implementation of a Good and Modern Services System	Alabama will enhance the available substance abuse service array.	1. Incorporate CPT service codes previously identified and defined for use in ADMH funded programs into the agency's contract billing manual and management information system. 2. Develop guidelines and related training to assist providers in moving to an environment of billing for services rather than levels of care. 3. Provide technical assistance as needed to address issues of over and/or under service utilization. 4. Develop process for evaluation of utility and provider satisfaction with expanded service array.	By September 30, 2013, there will be at least sixty (60) authorized billable service options available for providers to use in providing treatment services for individuals who have substance use disorders, a 93% increase from the thirty one (31) billable	Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and report quarterly findings as they relate to each identified indicator.
		1. Develop opportunities for community providers to obtain trauma training for all staff,		

Implementation of a Good and Modern Services System	Alabama will increase access to Trauma Informed Services	including administrative and support personnel. 2. Establish a process for provider self-assessment to determine if internal policies and procedures are supportive of the needs of trauma survivors. 3. Collaborate with state and community partners to develop resources to support access to trauma specific services.	From October 1, 2011 thru September 30, 2012, data collection and analysis will establish a baseline level of performance (number) of ADHM contract substance abuse treatment providers that integrate trauma informed care into their treatment protocol.	Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and report quarterly findings as they relate to the stated indicator to the Associate Commissioner and to the MISA Executive Staff Committee.
Implementation of a Good and Modern Services System	Alabama will integrate Mental Health Promotion and Wellness (MHPW) into community prevention services.	1. Explore how MHPW can be embedded into the prevention discipline. 2. Embed MHPW into the prevention goals. 3. Work toward the intersection of Prevention with Mental Health promotion messages that are consistent and clear to improve how individuals receive information dissemination to problem solve with difficult situations. 4. Explore mental health impact of vulnerable populations. 5.T arget metal health promotional activities that target vulnerable	1. By Sept. 30, 2013, prevention staff will attend at least 1 educational effort (conference, webinar, conference call, etc.) specific to MHWP.	1. Documentation of educational efforts specific to MHWP. 2. Documentation that MHPW is a part of the prevention goals. 3. Documentation of MHPW information will be disseminated statewide. 4. Epidemiological documentation of data relative to potential mental health effects in relation to a specific population and/or geographical area. 5. Documentation of activities specific to mental health promotion.

	groups/populations.

Footnotes:

Two additional performance indicators for Pregnant Women & Women with Dependent Children:
Conduct structured activities to identify barriers which inhibit or prevent access to substance abuse treatment and recovery support services by individuals with custody of underage children. Develop and implement strategies in response to barrier assessment.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy	Other
Encounter based reimbursement	Assessment Clinically Managed High Intensity Residential Clinically Managed Low Intensity Intensive Outpatient Program Medically Managed Residential Detox Opioid Maintenance Treatment Outpatient Treatment Individual Counseling (HIV) Group Counseling (HIV) Laboratory Testing (HIV) Physician Services (HIV)	
Grant/contract reimbursement	Intensive Outpatient Program (Special Women) Clinically Managed High Intensity Residential (Special Women) Clinically Managed Low Intensity Residential (Special Women)	

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	<10% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	10-25% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	26-50% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		N/A 6
Other		N/A 6

Footnotes:

FY2013
Healthcare Home/Physical Health <10%
Engagement Services 10-25%
Outpatient Services <10%
Medication Services <10%
Community Support (Rehabilitative) 10-25%
Recovery Supports <10%
Other Supports (Habilitative) <10%
Intensive Support Services 10-25%
Out-of-Home Residential Services 10-25%
Acute Intensive Services <10%
Prevention (including Promotion) 10-25%

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$200,000	$	$233,520	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$200,000	$	$233,520	$	$
Education	Universal	$1,232,661	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$1,232,661	$	$	$	$
Alternatives	Universal	$683,553	$	$200,000	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$683,553	$	$200,000	$	$
Problem Identification and Referral	Universal	$72,431	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$72,431	$	$	$	$
Community-Based Process	Universal	$763,553	$	$	$	$

Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$763,553	$	$	$	$
Environmental	Universal	$1,781,623	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$1,781,623	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$1,650,487	$201,090	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$1,650,487	$201,090	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$17,751,828	$6,751,738	$300,000	$25,911,956	$	$5,072,916
2. Primary Prevention	$4,733,821	$	$1,650,487	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$1,183,455	$	$291,262	$2,041,406	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$23,669,104	$6,751,738	$2,241,749	$27,953,362	$	$5,072,916
10. Subtotal (Rows 5, 6, 7, and 8)	$1,183,455	$	$291,262	$2,041,406	$	$
11. Total	$23,669,104	$6,751,738	$2,241,749	$27,953,362	$	$5,072,916

Please indicate the expenditures are actual or estimated.

( ) Actual ( ) Estimated

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year: 2012

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		$ 0		$ 0	$	$0
2. Quality Assurance		$ 0		$ 0	$	$0
3. Training (Post-Employment)		$ 0		$ 0	$	$0
4. Education (Pre-Employment)		$ 0		$ 0	$	$0
5. Program Development		$ 0		$ 0	$	$0
6. Research and Evaluation		$ 0		$ 0	$	$0
7. Information Systems		$ 0		$ 0	$	$0
8. Total	$	$0	$	$0	$	$0

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Section IV: Narrative Plan D. Activities that Support Individuals in Directing the Services

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

ADMH does not currently have formally established programs or processes established for individuals with substance use disorders to self direct their care. The agency has historically allocated funding for substance abuse services to agencies for their utilization to establish the services they believe to best for meeting the needs of their clientele. While individuals and their support systems are able to access services and supports, they are limited in their ability to self-direct these services and supports because they do not have control of the funding needed to purchase those services.

At the present time, initial service access routinely occurs by individuals and/or their support system contacting the Division's office through its toll-free number. Individuals are provided the contact information for service providers within the closest geographic area and/or area of their request. If the individual chooses to make contact with a provider and it is deemed an assessment is necessary, an assessment appointment is offered to the individual. If an assessment determines services are recommended, those recommendations are provided to the individual, to include service provider recommendations from which the individual can make a choice. The individual has the right to decline services and provider recommendations. Furthermore, the individual may communicate their provider of choice and the level of care they

prefer. If the level of care is different from that which is recommended this is documented on the assessment, as well as, the reason for the difference.

The Division's Provider Directory lists of all certified substance abuse service providers within the state and categorizes providers by available service (level of care), geographic area, and funding. This directory is accessible to all individuals with internet access and a hard copy can also be accessed at any provider location. While this directory provides the aforementioned content, it does not readily provide access to information regarding the quality of the programs. The Division realizes this is not truly a process of self-directed care, but does provide the individual some choice in the selection of service providers, with additional choices made available during the service planning process after treatment admission.

DMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, DMH has engaged in the following: Updated the DMH Administrative Code for SA Program Standards that incorporates person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing will be integrated in every level. It is believed that newly revised programmatic standards and needs based funding will further contribute to a paradigm shift towards person centered planning that includes self-directed care.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Section IV: Narrative Plan E. Data and Information Technology

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
    - Provider characteristics
    - Client enrollment, demographics, and characteristics
    - Admission, assessment, and discharge
    - Services provided, including type, amount, and individual service provider
    - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
    - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
    - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
    - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
    - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
    - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
    - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
    - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
    - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
    - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
    - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

Alabama Substance Abuse Information System (ASAIS)

The Alabama Substance Abuse Information System (ASAIS) went live in June of 2008. It captures information on all of the clients who receive substance abuse services from the 64 DMH-contracted providers of substance abuse prevention and treatment services in the state of Alabama. This system captures provider characteristics, including levels of care and services delivered, addresses, points of contact, etc. It also collects client enrollments, demographics and characteristics. The Treatment Episode Data Set (TEDS) information is collected at time of assessment, admission and discharge. This is done by some providers through direct entry into the web-based system and some through a secure web-based upload.

We collect data on services provided, including type and amount, through a standard 837 that can be submitted at anytime during the fiscal year by our service providers into the ASAIS system. The system serves as the "middle man" between Medicaid-certified substance abuse providers and Medicaid, as well as the payment system for state and block grant funded services. All claims are submitted to the system then validated against the system edits to determine Medicaid eligibility. If the provider, client and service are all eligible for Medicaid payment, ASAIS sends that claim automatically to Alabama Medicaid's MMIS system. If the claim is denied by Medicaid for a reason that would still allow for payment from other sources, than the claims automatically roll to the state or block grant funds upon receipt of the Medicaid determination.

QUESTION	ANSWER
For provider information, are providers required to obtain NPI (national provider identifiers) and does the system collect and record these identifiers?	Yes, both ASAIS and the Medicaid MMIS system use NPI as the primary identifier for provider payment.
Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?	Yes, the state financial system requires a separate vendor ID to be able to track payments by provider.
Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?	Yes, each client is assigned a unique ID at the time of screening that follows them through the system regardless of provider.
Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?	Yes, we capture all encounters including all of the elements listed, except individual provider.
Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?	Yes, the system complies with Federal data standards and we are currently testing the new 5010 requirements and planning for ICD-10 changes to the system.
Do provider and client identifiers in the	Yes, ASAIS serves as the first point of

behavioral health IT system allow for linkage with Medicaid provider identifiers that provide the ability to aggregate Medicaid and non-Medicaid provider information?	submission for all rehab option Medicaid and non-Medicaid claims for substance abuse services.
Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?	Yes, we routinely run reports that include Medicaid and non-Medicaid data.

ADMH IT participates in quarterly meetings with Medicaid and other state agencies including Public Health, to address issues with system interoperability, Federal IT requirements, and Medicaid billing issues.

The State of Alabama has a grant to create a state wide health information exchange. The initiative, OneHealthRecord, has recently issued a contract to a vendor to begin development of the HIE. ADMH has been at the table with the state Medicaid agency from the beginning of the grant process and actively participated in the development of the grant and state health information plan SMHP at all levels – legal, policy, governance, IT structure and marketing. ADMH will be included in the state agency hub on the HIE and is actively participating in the design phase of the HIE with the vendor. The implementation of electronic health records in ADMH state hospitals is included in the SMHP as it pertains to increasing the capacity within the state for health information exchange. Data from ADMH facility electronic health records and community mental health data will become part of the data warehouse planned for state agency date as part of the state agency hub on the HIE. We have been included in all discussions around the Medicaid system upgrade to accomplish these objectives as well.

As pointed out above, many of the substance abuse providers already have electronic health records. They have formed user associations among themselves to obtain favorable prices on licenses and maintenance rates from several different vendors and are actually ahead of ADMH in utilization of the electronic health record. We encourage discussion about electronic health records during meetings with IT directors and administrative managers, as well as in other training forums.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

IV: Narrative Plan F. Quality Improvement Reporting

SAMHSA expects states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addictions systems. These measures should be based on valid and reliable data. CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The state's CQI process should also tract programmatic improvements; and garner and use stakeholder input to include individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's CQI plan.

In May of 2011 the Alabama Department of Mental Health (ADMH) began to integrate its Performance Improvement program to include both the Division of Mental Illness and the Division of Substance Use Disorders. The combined system will identify and assess processes and outcomes, to improve the quality of services provided, and to improve client and family satisfaction with services provided.

The authority and responsibility for the MI/SA performance improvement program is vested in the Commissioner of the ADMH and the Associate Commissioner for MI/SA who have delegated the authority for conducting the PI program to the MI/SA Director of Performance Improvement. It is the responsibility of the PI Director to administer and coordinate the functions of the program and to report on PI measures and PI activities on a scheduled basis to the MI/SA Associate Commissioner and the PI committee. It should be noted that with the merger of the two divisions (MI/SA) the PI Plan is currently being revised to include the reconfiguration of the PI committee in order for co-occurring consumers (MI/SA) and SA consumers to share in an equal voice on the committee.

Guided by the mission, vision and values of the ADMH, the purpose of the Performance Improvement (PI) Plan is to provide a framework for treatment and prevention providers to report identified performance indicators. This plan is applicable to the community programs operated/contracted and/or certified by the ADMH and is based on the ADMH's commitment to provide a recovery oriented system of care that is client-centered, evidence-based, recovery-focused, outcome-oriented and easily accessible to all clients in need of treatment or prevention services. The MI/SA Performance Improvement program is designed to measure the success of selected processes and outcomes of the Division services in facilitating achievement of ADMH objectives and values. Because the majority of CQI activities have been related to individuals committed to the state hospitals there will be significant modifications to appropriately capture the relevant measure with individuals receiving substance abuse services.

Alabama currently uses a combination of process, and outcome measures, including NOMS, to evaluate and monitor the quality of care and progress on state initiatives at the local and state level. The agency has the capability through our information system (ASAIS) to collect a wide range of client level data. We are in the process of developing performance-based quality improvement strategies to measure outcomes in our serve delivery system.

All certified Community MI/SA providers, under the direction of the organization's Executive Director, must develop, implement, and maintain a performance improvement system that is based on a consumer/family-driven system that fosters continuous quality improvement in all aspects of 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 individual advocates. Client and family satisfaction surveys shall be used to obtain information which impacts the care and treatment they received while actively enrolled in the service delivery and outcomes. The PI system should include a timely and appropriate review of incidents and/or critical incidents data by the agency/organization's governing body, along with its executive and clinical leadership staff.

The incident management system of the PI program addresses the following process:

- **Identification and Reporting of Incidents and /or Critical Incidents**

  A. Neglect, sexual abuse, physical or verbal abuse, mistreatment, breach of patient confidentiality, illness, elopement (adolescent), criminal activity, media events, medication error, sexual contact (non-consensual), suicide attempt, death, and other adverse events.

- **When to Report an Incident and/or Critical Incident and Reporting Procedures**

  A. Critical incidents which occur on a certified/contract provider's premises;

  B. Any setting, location, or event in which care or services are provided by a certified/contract provider;

  C. Critical incident reports must be submitted to the ADMH;
  (1). Within 24 hours of the occurrence of each incident.

  D. The details of each 24 hour reportable incident shall be recorded on form # 101;
  (1). Medication errors shall be recorded on form # 401,
  (2). Deaths shall be recorded on form # 301 and,
  (3). Follow-up information shall be recorded on form # 201,
  a. Submitted within 14 days of the death of a client or other participant,
  b. Submitted within 30 days of the occurrence of each 24 hour reportable event, other than the death of a client.
  (4). Monthly Incident Summary Reports shall recorded on form # 501,
  a. Submitted within 10 days of the month following the month of an incident occurrence.

❖ **Notification to DMH Advocacy Office**

A. The Performance Improvement Director or designee will notify the DMH Advocacy office of all reportable incidents as follows:
(1). 24 hour reportable incidents received by PI shall be forwarded to the Advocacy office within 24 hours of its receipt,
(2). Monthly summary critical incident reports received by PI shall be submitted to the Advocacy office no later than the twentieth day of the month following the month of incident occurrence.

❖ **Review of Incident Data**

A. The PI office will maintain a data base of all incident reports and have them available for distribution;
B. A quarterly incident report will be complied and submitted to the MI/SA Associate Commissioner.

❖ **Reporting of Complaints and Grievances**

A. All complaints and grievances currently go through the Associate Commissioner's office and then are forwarded to the Director of Treatment Services for Investigation. This process may change based on the reconfiguration of the PI program;
B. All complaints and/or grievances are handled either by phone, letter, face-to-face, or a combination of the three types of contact;
C. The outcome of all complaints and grievances are documented and a copy sent to the Associate Commissioner and Advocacy office;
D. The decision on all complaints and grievances can be appealed to the Associate Commissioner of MI/SA Services and to the Commissioner of ADMH.

The Substance Abuse Service Division, prior to its merger with the Mental Illness Division, did not have an independent CQI Plan, but as previously stated a combined plan is currently under development. The PI office has already developed a single set of procedures and forms for service providers to report incidents and/or critical incidents. The goal is to have the revised CQI committee in place by the first of the year. The PI office is also working on a web-based reporting system. This will allow service providers to upload the information into ASAIS.

See attachment for the MI Performance Improvement Plan.

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL ILLNESS
PERFORMANCE IMPROVEMENT PLAN

I. INTRODUCTION

Guided by the mission, vision and values of the Alabama Department of Mental Health (ADMH), the purpose of this plan is to provide a framework for operation of the Mental Illness (MI) Division Performance Improvement (PI) Program. This plan is applicable to the state facilities and community programs operated/contracted and/or certified by the ADMH and is based on the Department's commitment to provide a system of care and support that is consumer-driven, evidence-based, recovery-focused, outcome-oriented and easily accessible, with a life in the community for everyone. The MI PI program is designed to measure the success of selected processes and outcomes of the MI Division services and supports in facilitating achievement of the department's objectives and values. Community and inpatient services and supports should encompass and reflect the ADMH's values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, accessibility, choice and compassion. Performance measure data should provide information that can be utilized by stakeholders to make informed decisions about care, resources, safety and performance improvement initiatives. Each MI facility and certified or contracted program shall have a site specific Performance Improvement Plan and program based on the ADMH's commitment to a consumer/family-driven system that fosters continuous quality improvement in all aspects of services provided.

II. MISSION

The Mission of the ADMH is to lift life's possibilities for Alabamians' with mental illness through the provision of a system of care and support that is consumer-driven, evidence-based, recovery-focused, outcome-oriented and easily accessible to individuals with serious mental illnesses and severely

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emotionally disturbed children/adolescents. The outcome desired by the ADMH is "a life in the community for everyone". Services and supports should be designed to contribute in a positive way to achieving this goal.

III. GOALS AND OBJECTIVES OF THE MI PI PROGRAM

The primary goal of the MI PI Program and MI PI Committee is to measure the improvement of selected key functions and processes designed to achieve ADMH outcomes, while continuing to facilitate problem identification and resolution when desired outcomes are not met. Specific objectives and responsibilities include the following:

1. To ensure there is an ongoing process to provide meaningful opportunity for input on operation and improvement of the ADMH MI PI systems from consumers, family members, providers, consumer groups, advocacy organizations and advocates.

2. To assist in the identification and/or development of performance indicators that measure accomplishment or positive contribution to selected aspects of the ADMH's mission and values for the MI Division.

3. To assess the MI Division's success in providing a system of care and support that is consumer-driven, evidence-based, recovery-focused, outcome-oriented and easily accessible and contributes to the achievement of a life in the community for everyone.

4. To assess the MI Division's success in providing services and supports that uphold the ADMH values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, accessibility, choice and compassion.

5. To assess the MI Division's success in providing services and supports in a culture that fosters safety as a priority for everyone. This includes effective mechanisms for evaluating the culture of safety and quality on an ongoing basis and requirements for identifying, reporting, investigating, reviewing, and preventing special incidents involving consumers.

6. To assess the MI Division's success in complying with applicable standards for accreditation and certification.

7. To track performance of selected performance measures over time to assess sustained improvements and/or to identify opportunities for improvement.

8. To seek comparison data from national databases, national reporting, the literature and other similar organizations to gauge and benchmark the performance of ADMH services as compared within the state, regionally and nationally as applicable.

9. Provide a mechanism for sharing of ideas and information relative to Performance Improvement strategies and "best practices".

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10. To utilize feedback from consumers, families, practitioners, employees, payers, the community, accrediting agencies and other organizations to trigger assessments aimed at improving services.

11. To facilitate the development of recommendations and actions including, but not limited to, changes in policies and procedures and standards of practice, when trends, problems or opportunities to improve care are identified.

12. To proactively assess and facilitate the identification and implementation of strategies to enhance the quality of services and supports, to enhance consumer safety, and to reduce risk to consumers and staff members in community and inpatient facilities.

13. To disseminate information to the appropriate committee(s), department(s), discipline(s) and/or state facility or community provider stakeholder(s) in response to PI recommendations and/or regarding follow-up actions/improvement strategies taken in response to identified performance improvement opportunities.

14. To seek ongoing involvement and periodic evaluation of the PI Program from stakeholders, the Governing Body, Facility Directors, Community Program Executive Directors, Medical/Clinical Committee and the Division's PI Committee.

15. To encourage participation and commitment of all levels of leadership and all levels of facility and community program staff in performance improvement initiatives in the MI Division.

16. To provide a mechanism for the development of joint inpatient and community activities designed to improve services for consumers at different levels of care.

17. To provide information, consultation and training at the provider and division/state level regarding performance improvement topics, issues, methods and requirements.

18. To develop and approve a PI Plan that outlines the responsibilities and activities of the MI PI Program as described above.

IV. STATEMENT OF AUTHORITY

The authority and responsibility for the MI Division PI Program is vested by the Commissioner of ADMH and the Associate Commissioner for MI who have delegated the authority for conducting the program to the MI Director of Performance Improvement. It is the responsibility of the Director of Performance Improvement to administer and coordinate the functions of the program and to report on PI Measures and PI activities on a regular basis to the Division Performance Improvement Committee. In accordance with the Governing Body Bylaws, the Associate Commissioner for Mental Illness has delegated to each of the facility directors the responsibility to establish and maintain effective performance improvement programs in addition to participation in the Division Performance Improvement Program. The facility performance improvement programs shall be organized and managed by the leadership of each facility, primarily through committee functions. The Facility

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Performance Improvement Directors will submit periodic reports to the Office of Performance Improvement via system level indicators and reporting. PI data and activities affecting the state facilities will also be reported to the Medical/Clinical Committee, Directors' Committee and the MI Governing Body.

Community providers, under the direction of the Executive Director, shall develop, implement, and maintain a Performance Improvement System as specified in the *Alabama Department of Mental Health, Mental Illness Community Programs Administrative Code* (Chapter 580-2-9-.07) require that each " provider shall operate and maintain a Performance Improvement (PI) System that is designed to assess important processes and outcomes, to correct and follow-up on problems, to improve the quality of services provided, and to improve consumer and family satisfaction with services provided." Section (i) further specifies that ".. the agency will participate in all required performance indicators and quality improvement reporting requirements as specified by the ADMH Mental Illness Performance Improvement Committee." The community provider PI designee will submit periodic reports to the Office of Performance Improvement for identified system level indicators and pursuant to published special incident and quality indicator reporting procedures.

V. COMMITTEE STRUCTURE

Composition of PI Committee:

The MI PI Committee members are appointed by the Commissioner and the MI Associate Commissioner and include representatives from the various provider and stakeholder groups. The voting membership is designed to reflect the equal partnership between consumer/family stakeholders and provider stakeholders in achieving the objectives of the Committee. Committee membership will consist of the following providers and stakeholder representatives: (Ex-Officio Members will not vote unless otherwise specified).

- 3-NAMI representatives
- 3-Consumer representatives
- 1-MHA representative
- 3-Council of Community Mental Health Boards representatives
- 1-"hands on" clinician from a community program
- 1-"hands on" clinician from an inpatient facility
- 1-Facility Director representative
- 6-Facility PI Directors/designees (ex-officio) –one shall be a voting member
- 1-Advocacy representative (ex-officio)
- 1-ADMH representative (ex-officio)
- 1-Alabama Family Ties (ex-officio)
- Director of MI Performance Improvement (ex-officio) * Chairperson
- Director of Community Programs (ex-officio)
- Director of Consumer Relations (ex-officio)
- ADAP representative (ex-officio)

* *Chairperson will vote in tie situations only*

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The Director of MI Performance Improvement, the Director of Advocacy, the Director of Consumer Relations and the Director of Community Services will serve as permanent ex-officio members of the PI Committee. The term of office for members shall be two years. Terms of service will generally begin in February. All members are eligible for reappointment.

Inpatient Performance Improvement Subcommittee
A permanent Subcommittee of the MI Division's Performance Improvement Committee, comprised of the MI Performance Improvement Directors from the MI facilities, is responsible for small group work related to development and refinement of indicators. The Subcommittee shall meet on an as needed basis and may be requested to work on additional PI related activities by the PI Committee and/or the MI Director of Performance Improvement.

Additional subcommittees or workgroups of the MI Division's Performance Improvement Committee may be appointed on either a permanent or temporary basis at the discretion of the MI Division Performance Improvement Director. In general, subcommittees/workgroups may be appointed to study and provide recommendations to the MI Division's Performance Improvement Committee concerning broad areas of divisional function that affect patient care or clinical practice and may include individuals outside of the MI Division's Performance Improvement Committee who have particular expertise/experience in the area(s) under study.

VI. ORGANIZATION AND REPORTING OF THE MI DIVISION LEVEL PERFORMANCE IMPROVEMENT ACTIVITIES

The MI Division Level Performance Improvement functions shall be performed by the MI Performance Improvement Office that is within the Office of the Associate Commissioner of the Mental Illness Division. The MI Performance Improvement Office will be responsible for developing division wide reports for the committee's review. The PI Committee will meet at least quarterly and review system findings for opportunities for improvement. Final committee reports and recommendations will be submitted to the MI Associate Commissioner through the PI Committee's report to the MI Governing Body and related committees. Findings relevant to community data will be shared with pertinent stakeholders as outlined in item (# 4) in the below section:

1. **The MI Division Performance Improvement Committee**

The MI PI Committee is a Division level advisory committee to the Associate Commissioner for Mental Illness, the MI Governing Body, Directors' Committee and the Med/Clin Committee on matters related to improvement of patient services and patient outcomes. The MI Division's Performance Improvement Committee meets on a quarterly basis to review performance and a quorum is defined as the presence of seven members exclusive of the Chairperson. Any business brought before the committee may be passed by a simple majority of the members present. The Chairperson shall vote only in the event of a tie. The Chairperson shall be responsible for developing the meetings' agenda and distributing it to the Committee Members prior to any scheduled meeting. The PI Office shall be responsible for sending data items to committee members in advance of the meeting.

Recommendations for new and/or revised MI Division indicators may be made by the MI Division Performance Improvement Committee, the MI Performance Improvement Subcommittees/workgroups,

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the Directors' Committee, the Medical/Clinical Committee or Certified Community Providers. Recommendations from any interested stakeholders are also considered. After new and/or revised indicators are developed/refined by a relevant subcommittee/workgroup, they are submitted to the MI Division's Performance Improvement Committee for approval. With the exception of measures mandated by The Joint Commission (TJC) or Centers for Medicaid and Medicare Services (CMS), proposals for new indicators or to discontinue current indicators for state facilities must also have the approval of the MI Directors' Committee. The MI PI Plan shall include an updated listing of all active inpatient and community indicators (see Appendixes A and B).

Significant findings include, but are not limited to, any indicators that present as Division Issues (defined as 3 or more facilities/programs falling below the identified target performance level) and any indicator presenting a significant/performance trend/issue for one or more facilities/programs. The MI Division's Performance Improvement Committee reviews the report and may make actions and recommendations. In particular, the MI Division's Performance Improvement Committee examines and makes recommendations to the Medical/Clinical Committee, the Directors' Committee, the Governing Body, and/or directly to the MI Associate Commissioner regarding patterns and trends in order to improve processes, and thus outcomes of care. The Medical/Clinical Committee examines and makes recommendations to the MI Division Performance Improvement Committee, the Directors' Committee, and the Governing Body on matters related to the care and treatment of individuals in the MI facilities. Med/Clin reviews activities relating to patient care to ensure that policies and procedures are consistent with policies of the ADMH, TJC, and other applicable standards.

The Director of PI is responsible for ensuring that any PI related recommendations to or from the PI Committee are communicated to the appropriate stakeholder committees including the MI Directors' Committee, Med/Clin Committee, Governing Body and/or relevant Community Provider Stakeholder Committees.

2. **Directors' Committee**

The Directors' Committee is comprised of each of the MI Facility Directors, a consumer representative, a family representative, the Director of MI Facilities, and the Associate Commissioner for Mental Illness. The MI Division Director of Performance Improvement, the Director of the Office of Consumer Relations, an Office of Advocacy Services representative, the Executive Assistant to the Associate Commissioner for MI, and the Director of the Office of Deaf Services serve as ex-officio members of the Directors' Committee. This committee reviews and approves the specific measurement activities for state facilities as recommended by the MI Division Performance Improvement Committee.

3. **Medical/Clinical Committee**

The Medical/Clinical Committee is a MI Division level advisory committee to the Governing Body, the Directors' Committee, and the MI Division's Performance Improvement Committee on matters related to state facility patient care. The committee is comprised of the Medical Director for ADMH, the Clinical Directors of each facility operated by the MI Division, a facility directors' representative, a consumer representative, an Advocacy Services representative and the chairperson of each Medical/Clinical Professional staff subcommittee to include pharmacy, psychology, social work, nursing, psychiatry, medical physician, infection control, rehabilitation services, and health

information management. The MI Division Director of Performance Improvement or designee and Director of Consumer Relations serve as ex-officio members. The MI Division Director of Performance Improvement or designee shall provide the Medical/Clinical Committee regular reports from the MI Division Performance Improvement activities. In the review of these reports, the Medical/Clinical Committee may provide recommendations to correct problems and/or improve care and services. These recommendations shall be communicated to the MI Division's Performance Improvement Committee by the MI Division Performance Improvement Director or designee. The PI Director shall then communicate recommendations to the Directors' Committee and, as appropriate, by the Governing Body for approval and/or action.

4. **Community Stakeholder Committees**

Recommendations regarding the community programs shall be made directly to the Associate Commissioner for MI and/or to relevant committees such as the Council of Community Mental Health Boards Executive Directors and Clinical Directors Committees, Regional Boards of Supervisors, the Office of Community Services, the Office of MI Certification, the ADMH Nurse Delegation Office, the ADMH Internal Advocacy and the ADMH Medical Director. With the exception of indicators mandated by the ADMH Commissioner or other regulatory/statutory requirements (i.e. *Alabama Department of Mental Health, Mental Illness Community Programs Administrative Code)*, the MI PI Committee should approve the addition of any new indicators or the removal of any current indicators that affect community providers.

VII. COMMUNICATION

The Associate Commissioner for Mental Illness shall be kept aware of the activities of the MI Division Performance Improvement Program through committee meetings, meetings with and reports from the Director of Performance Improvement, and MI Division reports from Performance Improvement activities. The Commissioner of Mental Health and other members of the Governing Body shall be kept informed of significant Performance Improvement activities through reports provided by the MI Division Director of Performance Improvement and/or his designee in Governing Body meetings and other communications as indicated.

VIII. CONFIDENTIALITY OF QUALITY ASSURANCE DATA (HIPAA)

In order to participate, any individual appointed to the PI Committee as a full committee member, alternate member and/or a permanent or ad hoc workgroup subcommittee member shall sign the MI Confidentiality Statement(s) as applicable (see Appendix C). Confidential quality assurance data including any information defined by HIPAA as Protected Health Information (PHI) shall not be disclosed by members in a manner that violates applicable law (including HIPAA) or violates the requirements for confidentiality as outlined in the PI Committee Confidentiality Statement. Failure to comply with confidentiality requirements may result in removal from the committee. Members of committees and stakeholder groups reviewing reports from the MI PI Committee as specified in Section VI shall also be required to sign the Confidentiality Statement.

IX. PROGRAM EVALUATION

The MI Division Performance Improvement Director shall conduct a periodic evaluation of the MI Division Performance Improvement Program relative to the Plan objectives with the assistance of the

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Division Performance Improvement Committees. This evaluation will include feedback (as applicable) from the Division Performance Improvement Committee, the Directors' Committee, the Medical/Clinical Committee, the Governing Body and relevant Community Provider Stakeholders. The results of the evaluation will be shared with the above committees/stakeholders and shall be utilized to make continuing improvements in the program. The MI PI Plan will be revised and updated periodically and approved by the MI PI Committee.

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APPENDIX A
CURRENT ACTIVE INPATIENT INDICATORS & SOURCE OF DEFINITION*

*Key for source of definition : **AMDH IMP**: Alabama DMH Incident Management Plan : **TJC**: The Joint Commission
NRI: National Association of State Mental Health Program Directors Research Institute

ADMISSION SCREENING: ASSESSMENT OF RISK, SUBSTANCE USE, TRAUMA & PATIENT STRENGTHS COMPLETED-CORE MEASURE: Indicator measures the rate of patients admitted to a hospital-based inpatient psychiatric setting who are screened by the third day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history and patient strengths. (NRI)

ALLEGATIONS OF ABUSE/NEGLECT: Indicator measures the number of reported and the number of substantiated allegations of abuse/neglect. **Abuse** – An employee/agent acts, or incites another to act, in a manner that willfully, intentionally, or recklessly causes or may cause pain, physical, or emotional injury. Abuse categories include physical, verbal, sexual, and mistreatment. **Neglect** – The failure to carry out a duty through carelessness, inattention, or disregard of duty whereby the client is exposed to harm or risk of harm. Reportable Abuse/Neglect categories include physical abuse, verbal abuse, sexual abuse, mistreatment , exploitation and neglect. (ADMH IMP)

ANTI-TESTOSTERONE USE IN MALE PATIENTS: Indicator measures compliance with the Clinical Protocols developed by the Medical Clinical Committee for the Administration of Anti-Testosterone medications to include criteria for the Initial Review, Follow-up Review and Consent for Administration of Anti-Testosterone Drugs (Depo-Provera, Lupron, or Oral Provera) in Male Patients.

CONTRACT INPATIENT PROVIDER MEASURES: Measures that apply to the contracted inpatient adolescent unit. These include sentinel events, deaths, suicide attempts, medication errors, major injuries, suspected or alleged non-consensual sexual contact, suspected or alleged abuse/neglect allegations, elopements, transfers out, unplanned evacuation, outside law enforcement involvement, unplanned media involvement, seclusions, restraints, injuries during seclusion/restraint, and 30 day readmissions. Measures defined per contract reporting procedures.

DEATH: Indicator measures the number of deaths reported. **Expected Death:** A death which, based on the recipient's medical history, was predictable and was consistent with the course of death from natural causes. **Unexpected Death:** A death which, based on the recipient's medical history, was not predictable. (ADMH IMP)

DEFICIENCIES ACCREDITATION, LICENSURE OR CERTIFICATION: **Deficiencies** – Requirements (Joint Commission standards/elements of performance and/or CMS Conditions of Participation and/or standards) that, if not met, are likely to create an immediate threat or a threat over time that could increase the risk of safety and quality of patient care. **Accreditation** – The organization is in compliance with all standards at the time of an on-site survey or has successfully addressed all Requirements for Improvement of The Joint Commission or is in compliance with all standards at the time of an on-site survey or has successfully addressed "tags" from CMS. **Licensure** – A legal right that is granted by a government agency in compliance with a

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statute governing an occupation or the operation of an activity. **Certification** – Determined by The Joint Commission or CMS that an eligible program or service complies with applicable requirements.

ELOPEMENT: Indicator measures the number of elopements per inpatient day. An elopement is the absence from a location defined by the client's leave or legal status. A client should be considered to have eloped if the client has not been accounted for when expected to be present. (NRI)

HOURS OF SECLUSION USE: Indicator measures the total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. (NRI)

HOURS OF RESTRAINT USE: Indicator measures the total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. (NRI)

INFORMED CONSENT: Indicator measures compliance with ADMH Policy 430-20 (Informed Consent for Psychiatric Medications) regarding obtaining and documenting informed consent procedures for clients who receive certain Psychiatric Medications.

INJURY RATE: Indicator measures the number of client injury events with a severity level of more than minor first aid per inpatient day. (NRI)

MEDICAL ADMISSION CRITERIA: Indicator measures compliance with medical stability criteria and documentation requirements developed by the Medical Clinical Committee for patients who are being transferred to The Alabama Department of Mental Health inpatient facilities from acute care hospitals. The criteria specifies that individuals with medically unstable conditions should be stabilized prior to admission to The Alabama Department of Mental Health inpatient facilities.

MEDICATION ERROR RATE: Indicator measures the ratio of the number of medication errors reported to the duplicated count of clients served during the reporting period. A medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. (NRI)

NON-CONSENSUAL SEXUAL CONTACT: Indicator measures the number of reported incidents of non-consensual contact. Non-consensual sexual contact involves sexual contact between recipients involving a recipient who is coerced, is under sixteen (16) years of age, or does not otherwise have the capacity to consent (Capacity may be either mental or physical, or the individual may be mentally incapacitated). (ADMH IMP)

NPSG 1: IMPROVE THE ACCURACY OF INPATIENT IDENTIFICATION: Indicator measures the compliance with the use of at least two patient identifiers when providing care, treatment, and services. (TJC)

NPSG 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS: Indicator measures the compliance with identifying and reporting critical results of tests and diagnostic procedures on a timely basis. (TJC)

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NPSG 3: IMPROVE THE SAFETY OF USING MEDICATIONS: Indicator measures the compliance with standards for safe medication administration to label all medications, medication container, and other solutions on and off the sterile field in peri-operative and other procedural settings. (TJC)

NPSG 7: REDUCE THE RISK OF HEALTH CARE ASSOCIATED INFECTIONS: Indicator measures the compliance with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines. (TJC)

NPSG 8: ACCURATELY & COMPLETELY RECONCILE MEDICATIONS ACROSS THE CONTINUUM OF CARE: Indicator measures the compliance with the requirement to have a process for comparing the patient's current medications with those ordered for the patient while under the care of the hospital. (TJC)

NPSG 15A: THE ORGANIZATION IDENTIFIES PATIENTS AT RISK FOR SUICIDE: Indicator measures the compliance with measures to identify patients at risk for suicide. (TJC)

PATIENTS DISCHARGED ON MULTIPLE ANTIPSYCHOTIC MEDICATIONS: Indicator measures the rate of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications. (NRI)

PATIENTS DISCHARGED ON MULTIPLE ANTIPSYCHOTIC MEDICATIONS WITH APPROPRIATE JUSTIFICATION: Indicator measures the rate of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. (NRI)

PERCENT OF CLIENTS SECLUDED: Indicator measures percent of clients secluded at least once during reporting period. Seclusion is the involuntary confinement of a client alone in a room or an area where the client is physically prevented from leaving. (NRI)

PERCENT OF CLIENTS RESTRAINED: Indicator measures percent of clients restrained at least once during reporting period. Restraint is any manual or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely. (NRI)

PERCEPTION OF CARE (ICS): Indicator measures the percent of clients at discharge or annual review of who respond positively to the following domains :Outcome of Care, Dignity, Rights, Participation in Treatment, Facility Environment. (NRI)

POST DISCHARGE CONTINUING CARE PLAN CREATED: Indicator measures the rate of patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created that contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications, and next level of care recommendations. (NRI)

POST DISCHARGE CONTINUING CARE PLAN TRANSMITTED TO NEXT LEVEL OF CARE PROVIDER UPON DISCHARGE: Indicator measures the rate of patients discharged from a hospital-based inpatient psychiatric setting with a complete continuing care plan provided to the next level of care clinical or entity by the 5th day post discharge. (NRI)

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REFERRAL FOR ECT- Indicator measures compliance with ADMH Policy 430-25 - Electroconvulsive Therapy (ECT) Referral Procedure regarding the components of Physician Peer Review, Timeliness, Consent, Notifications and documentation of Outcome.

30-DAY READMISSION RATE: Indicator measures the rate of readmissions to an inpatient facility that occur within 30 days of a previous discharge from the same facility. (NRI)

SENTINEL EVENT: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. (TJC)

SUICIDE ATTEMPTS: Indicator measures the number of reported attempts to kill oneself.(ADMH IMP)

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APPENDIX B
CURRENT ACTIVE COMMUNITY INDICATORS

ADULT FAMILY SATISFACTION: Indicator measures the results of the annual Adult Family Satisfaction Survey conducted by the MI Community programs. This survey instrument consists of 26 questions. It was developed through NAMI Alabama.

ALLEGATIONS OF ABUSE/NEGLECT: Indicator measures the number of reported and substantiated allegations of abuse/neglect involving staff members of the provider regardless of where the abuse/neglect was alleged to have occurred. **Abuse** – An employee/agent acts, or incites another to act, in a manner that willfully, intentionally, or recklessly causes or may cause pain, physical, or emotional injury. Abuse categories include physical, verbal, sexual, and mistreatment. **Neglect** – The failure to carry out a duty through carelessness, inattention, or disregard of duty whereby the client is exposed to harm or risk of harm. Reportable abuse/neglect categories include physical abuse, verbal abuse, sexual abuse, mistreatment, exploitation and neglect.

CERTIFICATION: Indicator reports of the results of reviews performed by The Office of Certification Services for all covered entities to assure that they comply with standards of operation and treatment.

CLIENT DEATH: Indicator measures the number of client deaths reported (from known or unknown causes) in 24- hour care settings, on the provider's premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager.

CONSUMER SATISFACTION ADULT (MHSIP): Indicator measures the results of the annual Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey conducted by the MI Community programs. Using the nationally recommended tool, the MHSIP Adult Consumer Survey consists of 36 questions. The tool assesses consumer perception of care in the following seven domains: Access to Treatment/Service, Quality/Appropriateness of Care/Services, Participation in Treatment Planning, Outcomes of Care, General Satisfaction as well as the Social Connectedness and Functioning Domains – which were added in 2006.

CONSUMER SATISFACTION YOUTH: Indicator measures the results of the annual Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey (YSS) conducted by the MI Community programs. Using the nationally recommended MHSIP tool, the YSS consists of 21 questions. This survey is administered to youth 13 and older. The tool assesses consumer perception of care in the following five domains: Access to Services, Satisfaction with Services, Participation in Treatment Planning, Outcomes of Services and Cultural Sensitivity.

CONSUMER SATISFACTION YOUTH FAMILY (MHSIP): Indicator measures the results of the annual Mental Health Statistics Improvement Program (MHSIP) Youth Family Satisfaction Services (YSSF) Survey conducted by the MI Community programs. Using the nationally recommended tool, the Youth Family Survey consists of 26 questions. The tool assesses consumer perception of care in the following seven domains: Access to Services, Satisfaction with Services, Participation in Treatment Planning, Outcomes of Services, Cultural Sensitivity as well as the Social Connectedness and Functioning Domains – which were added in 2006.

Effective: 02-27-02
Revised: 07-15-04
Revised: 11-07-07
Revised: 03-17-09
Revised: 02-11-11

DEPO-PROVERAL USE IN MALE PATIENTS: Indicator monitors use of Depo-Provera in male consumers in certified community residential programs. Community Mental Health Centers must adhere to the *Clinical Guidelines for Use of Depo-Provera in Male Patients* developed by the ADMH Medical Clinical Committee and report quarterly, using approved indicator forms, to Office of Performance Improvement, MI Division.

ELOPEMENT OF CONSUMERS FROM RESIDENTIAL PROGRAMS UNDER A COMMITMENT ORDER/ON A TEMP VISIT/LOCKED UNIT: Indicator measures the number of adult elopements reported for clients from a locked residential program, for clients under an inpatient commitment order to a residential program or for clients in a residential program on a temporary visit from a state facility.

ELOPEMENT OF A CHILD/ADOLESCENT: Indicator measures the number of elopements for any child/adolescent client.

HOSPITALIZATION OF A CLIENT FROM LOCKED RESIDENTIAL UNIT/PROGRAM: Indicator measures the number of hospitalizations for medical and/or psychiatric reasons reported for clients on crisis units, child/adolescent programs and other locked units/program.

MAJOR CLIENT INJURY: Indicator measures the number of reported major client injuries in 24- hour care settings, on the provider's premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager. A major client injury is an injury that is rated at a severity level of 4 or greater on the ADMH Severity of Injury Criteria Scale and/or on the NRI Injury Severity Scale.

MEDICATION ERRORS: Indicator measures the number of medication errors reported in 24- hour care settings, on the provider's premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager. A medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. Additionally, a medication error occurs when the medication is not given for the right purpose or if there a documentation error. Therefore, both the failure to administer a drug ("missed dose"), the administration of a drug on a schedule other than intended, medication not given for the right purpose, and incorrect or missing documentation, constitute medication errors. (DMH Nurse Delegation Program)

NON-CONSENSUAL SEXUAL CONTACT: Indicator measures the number of reports of non-consensual sexual contact in 24- hour care settings, on the provider's premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager. Non-consensual sexual contact involves a client(s) who is forced or coerced, is under sixteen (16) years of age, or does not otherwise have the capacity to consent (Capacity may be either mental or physical, or the individual may be mentally incapacitated).

QUALITY OF LIFE: Indicator measures the results of the annual Life Satisfaction Questionnaire conducted by the MI Community programs. The survey instrument consists of 24 questions. The survey addresses satisfaction with living situation, finances, leisure, family relationships, social relationships/connectedness, and physical health.

Effective: 02-27-02
Revised: 07-15-04
Revised: 11-07-07
Revised: 03-17-09
Revised: 02-11-11

REGIONAL MEASURES: Measures that apply to the community transitioning projects in Region 2 and Region 4. These include Advocacy/ADAP Consumer Monitoring Visits, Returns from temporary visit/readmission within 6 months of discharge, discharge planning conferences, consumer satisfaction. Measures have been defined by the Regional Boards of Supervisors.

SUICIDE ATTEMPTS: Indicator measures the number of reported suicide attempts in 24- hour care settings, on the provider's premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager. A client suicide attempt may or may not be associated with an injury.

SUICIDE OF CLIENT IN A PROVIDER'S NON-RESIDENTIAL CASELOAD: Indicator measures the number of suicide attempts reported for consumers in the Provider's non-residential caseload.

SECLUSION/RESTRAINT: Indicator measures the number of seclusions and restraints reported by community providers. Seclusion – The involuntary confinement of a client alone in a room or an area where the client is physically prevented from leaving. Restraint – Any manual or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely.

30-DAY READMISSIONS: Indicator measures the number and the reasons/factors leading to readmissions to an inpatient facility that occurs within 30 days of a previous discharge from the same facility.

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Revised: 03-17-09
Revised: 02-11-11

APPENDIX C
CONFIDENTIALITY AGREEMENT

Mental Illness Division: Governing Body Members and Governing Body Committee/Subcommittee Members
CONFIDENTIALITY AGREEMENT

As an appointed member of the MI Governing Body and/or Governing Body Committees/Subcommittees, I understand that one of my responsibilities/functions may include the periodic review of quality assurance and improvement data from the mental illness division, state psychiatric facilities and certified community providers. As such, I acknowledge that in my role as a committee/subcommittee member, I will have access to sensitive and confidential quality assurance data regarding patient/client care, staff member performance, and performance issues of individual certified community providers and state psychiatric facilities. Data may include information related to adverse events –including sentinel events.

- I agree that I will hold all such information as confidential and shall not disclose it to anyone outside of the Governing Body Committee/subcommittee structure or other authorized employees or agents of the Alabama Department of Mental Health such as those involved in facility or division level performance improvement processes.
- Although individual client or staff member names are not disclosed within the context of the Committee or Subcommittee Meetings, there are occasions where specific details of an event and/or performance monitoring indicator may provide sufficient information (alone or combined with other public sources of information (media, other regulatory agencies, etc.), where one may be able to ascertain the identity of an individual client or staff member. Therefore, in the case of client information, there may also be information that meets the definition of Protected Health Information (PHI) and hence its confidentiality would also be regulated under the Federal Health Insurance Portability and Accountability Act (HIPAA). I agree to uphold all such requirements for protected health information.
- In the case of employee/agent/or LIP performance issues, I recognize that any information regarding clinical competency or performance of individuals is likewise held in strictest confidence among those present during such proceedings and others authorized by the Associate Commissioner for Mental Illness or designee.
- I likewise agree to hold any information that may reflect on the performance of an individual staff member(s) or agent(s) of a state psychiatric facility or certified community program as confidential for quality assurance purposes only.

Examples of data that should be held as confidential include, but are not necessarily limited to, the following:

1. Any data that could identify a specific client/patient or staff member of a certified community program and/or of a state psychiatric facility *(see below specific HIPAA provisions regarding PHI).

2. Any data that would identify an individual provider's (certified community provider and/or state psychiatric facility) performance on any PI indicator/measure or monitor.

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Revised: 07-15-04
Revised: 11-07-07
Revised: 03-17-09
Revised: 02-11-11

3. Any data that would identify NASMHPD Research Institute (NRI) National Mean numbers on any NRI performance indicators such as seclusion/restraint rates, elopement rates, etc. National mean data is copyrighted and any release of it outside of the Committee/Subcommittee could result in the cancellation of our participation in the system by NRI and/or possible sanctions related to breach of contract.

*Provisions regarding review/knowledge of data that may include PHI- for Quality Assurance Purposes Only (HIPAA)

Please review and initial each statement to indicate agreement:

_____ I understand and agree that any information about any client/patient who has been served in or has been located at an MI Facility/Certified Community Program is confidential.

_____ I understand and agree that even the fact that a client/patient is, or has been, located in a facility/program is confidential.

_____ I understand and agree that any health information, especially any treatment for drug or alcohol dependence, HIV/AIDS, etc., are protected under state and federal laws.

_____ I understand and agree that any client/patient information of which I become aware by reading, hearing, by sight or otherwise, cannot under any circumstances be shared with any other person, except as authorized or required by law.

_____ I understand and agree that I cannot make copies of any documents with any client/patient information.

_____ I understand and agree that any and all client/patient information remains confidential even after my work or other interactions with the Governing Body and/or Committee/Subcommittee have ended.

_____ I understand and agree that any and all medical staff credentialing information shall remain confidential.

My signature below attests that I agree to hold all information described in this CONFIDENTIALITY AGREEMENT in confidence and I acknowledge that any intentional or inadvertent release of confidential information will result in my removal from the committee/subcommittee.

Signature of Committee/Subcommittee Member Date

Name (s) of Committee/Subcommittee I serve on (if you serve on more than one, please indicate all).

Effective: 02-27-02
Revised: 07-15-04
Revised: 11-07-07
Revised: 03-17-09
Revised: 02-11-11

ALABAMA DEPARTMENT OF MENTAL HEALTH

DIVISION OF MENTAL ILLNESS

PERFORMANCE IMPROVEMENT PLAN

APPROVED BY
MI PI COMMITTEE: _____ _____

Danielle Rowe — Date
Director, Office of Performance Improvement
Chairperson, MI Division Performance Improvement Committee

APPROVED BY
ASSOCIATE
COMMISSIONER
MI DIVISION _____ _____

Susan P. Chambers — Date
Associate Commissioner for MI

Effective: 02-27-02
Revised: 07-15-04
Revised: 11-07-07
Revised: 03-17-09
Revised: 02-11-11

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Section IV: Narrative Plan G. Consultation with Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Alabama is home to only one federally recognized Indian Tribe. Operating as a sovereign nation since 1985, the Poarch Band of Creek Indians consists of descendants of a segment of the original Creek Nation which once covered almost all of the state, as well as, Georgia. The Poarch Creeks have lived together for almost 200 years in and around the reservation, which is located fifty-seven (57) miles from Mobile in Poarch, Alabama.

The Alabama Department of Mental Health (ADMH) does not currently have ties with the Poarch Band of Creek Indians, but understands the significance and value of pursuing such. DMH will, thus, seek to establish and implement an ongoing relationship with the Poarch Creek Indian Tribe that will enable regular, meaningful, government-to-government consultation and collaboration in the areas of planning, operating, and funding substance abuse and mental health services in Alabama. To accomplish this goal, ADMH will implement the following strategies by March 31, 2012:

1. ADMH Commissioner Zelia Baugh will consult with Governor Robert Bentley to identify government-to-government protocol relative to initiation of contact with the Poarch Creek Tribal Leaders.

2. As directed by the Governor's office, ADMH will establish contact with the Tribe and identify a mutually agreeable meeting date and location.

3 The ADMH Commissioner and designated staff of the Mental Illness /Substance Abuse Division will meet with Tribal officials, as needed, to affirm ADMH's desires for collaboration; to assess the degree of involvement with ADMH wanted and/or needed by the Poarch Creek Tribe; to explore areas of need if identified, along with other identified collaborative opportunities and explore strategies to address such; and to identify opportunities for shared resources and resource development

4. Establish clearly defined parameters of the relationship between ADMH and the Poarch Creek Tribe, identify goals and strategies for implementation during FY 2012-21013, and begin strategy implementation.

5. Identify the need for and resources to provide bi-directional cultural competency training to enhance development of the relationship between ADMH and the Poarch Creek Tribe and to support implementation of collaborative activities.

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IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

H. Service Management Strategies

Section IV: Narrative Plan H. Service Management Strategies

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SAPTBG or MHSBG funded services.
2. The strategies that your State will deploy to address these utilization issues.
3. The intended results of your State's utilization management strategies.
4. The resources needed to implement utilization management strategies.
5. The proposed timeframes for implementing these strategies

The process that your state will employ over the next planning period to identify trends in over/under utilization of SAPTBG or MHSBG funded services

1. The Alabama Substance Abuse Information System (ASAIS) collects a wealth of information on the service utilization patterns of our consumers. We plan to work over the next year on developing the reports based on this data that will allow us to do more specific analysis of the under/over utilization of services in our system. Currently, we monitor providers to the extent that they expend their contract (along with our annual onsite reviews), and have begun to look at utilization by level of care. We also have begun to identify "friends of the SSA", those consumers who have utilized a high number of service dollars over the years to be able to build profiles of who those clients are.

The strategies that your State will employ to address these utilization issues

2. The next step will be to isolate individual providers within each level of care to determine where there may be significant over/under utilization and work with those providers to address the issue. This will help us to make better use of the dollars we have and ensure we are providing quality care across our system.

The intended results of your State's utilization management strategies

3. Alabama DMH wants to see an increase in effectiveness of dollars utilized through ensuring that utilization in ways that help aid in meeting identified needs and helping the people we serve live in recovery.

The resources needed to implement utilization management strategies

4. We have the tools necessary to complete this task, the biggest barrier is adequate staff and time amongst all of the other issues that come up on a day-to-day basis. Our plan is to, within the next six months, have the systems analyst develop the reports needed to do the analysis and turn those over to the clinical team. The clinical team will then work over the following year to identify over/under utilization based on previously established criteria. The objective being to reduce both under and over utilization of dollars at the provider level.

The proposed timeframe for implementing these strategies

5. DMH plans to develop the necessary reports and begin its analysis within the next six months.

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2013

Priority	Performance Indicator	Selected
Compliance with SABG Statutory Requirements	IDU admissions to ADMH funded treatment programs will increase by 10% by the end of FY 14.	¢
Compliance with SABG Statutory Requirements	Admissions of pregnant women and women with dependent children to ADMH funded treatment programs will increase by 10%. All programs serving pregnant women and women with dependent children will utilize evidence-based practices by September 30, 2013.	¢
Compliance with SABG Statutory Requirements	The SA Office of Treatment Services will document providers affected by ADPH TST changes. Formal memorandum of understanding and / or letter of agreement are on file with each provider agency for the provision of TB services as outlined in 45 CFR 96.127.	¢
Diversification of Service Populations	Individuals and organizations serving LGBTQ will be formally involved in ADMH planning activities.	¢
Diversification of Service Populations	Activities implemented that engage medical providers, existing rural community providers, and current/prospective SA providers. Participation in SBIRT. Use of SBIRT billing code. Grants and/or request for proposals (RFP) specific to rural communities.	¢
Health Care Reform	Self assessments will be completed by at least 50% of ADMH's contract providers. Resource development, information dissemination, and technical assistance activities will be documented. Participation in collaborative state activities will be documented.	þ
Adolescent/Young Adult Services	The Substance Abuse Certification standards initiated by the SA Office of Treatment Services will require the use of EBP/BP. 2. The SA Office of Treatment Services will recommend incentives for use of EBP/BP to the Associate Comm of SA and MH.	¢
Adolescent/Young Adult Services	Increase in the number of coalitions/collaborative efforts in Alabama that lead local coalition/task force efforts. 2. Increase and/or implementation of policies or procedures related to underage drinking.	¢
Adolescent/Young Adult Services	Services to Veterans or members of their family by ADMH funded programs will increase by 20% in FY 2013.	þ
	Report number and language preference of any consumer	

Linguistic and Culturally Competent Services	who is LEP. Report number of hours of free language assistance provided.	é
Linguistic and Culturally Competent Services	Service outcomes regarding access, receipt of services, quality of care, and client satisfaction. Training provided and results of training evaluations.	é
Suicide Prevention	ADMH workgroup established. ADMH's documented participation in federal, state and local collaborative efforts. Development of an ADMH specific plan. 4. Strategy implementation, including steps taken to determine feasibility of Mental Health First Aid.	é
Community Populations for Environmental Prevention Activities	Increase in the number of coalitions/prevention collaborative efforts in Alabama that lead to an increase and/or implementation of policies or procedures relative to Environmental prevention activities utilizing the Strategic Prevention Framework process.	þ
Workforce Development	Documented relationships with universities for internship/practicum placement. Address licensing laws and reciprocity with the Alabama Board of Medical Examiners. Research and pursue opportunities to expand use of telemedicine.	é
Information Technology	ADMH will develop an analysis of its current info. system infrastructure identifying strengths, needs, and gaps and present it to the Comm. & to the Exe. Staff. ADMH will develop user groups for a variety of new technologies for which there is interest	é
Implementation of a Good and Modern Service System	All programs funded by ADMH will have access to and utilize an expanded array of services to address the needs of their identified clientele. Increase revenue for providers.	é
Implementation of a Good and Modern Service System	Consumers & families are actively involved in planning their services & supports. Consumers & families receive services based on their needs & preferences as identified in their placement assessment. The # of certified service providers reporting ROSC.	é
Implementation of a Good and Modern Service System	Establish the integration and utilization of mental health promotion within the prevention discipline.	é
Implementation of a Good and Modern Service System	The SA Office of Treatment Services will monitor the number of activities implemented that raise awareness of SBIRT. As a result of engaging current SBIRT providers, the SA Office of Treatment Services will see increased use of SBIRT billing code.	þ
Implementation of a Good and Modern Service System	A process for self assessment will be developed and completed by all ADMH treatment providers. Access to trauma specific services will be available to all ADMH funded treatment programs.	é

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Section IV: Narrative Plan J. Suicide Prevention

- In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Alabama's Suicide Prevention Plan

In 2001, the Commissioner of the Alabama Department of Mental Health and the State Health Officer of the Department of Public Health joined forces to establish the Alabama Suicide Prevention Task Force (ASPTF). In response to identified state needs, ASPTF would function to: (1) promote recognition of suicide as a problem affecting Alabama; (2) outline a strategy for the prevention of suicide in Alabama; and (3) identify federal, state, and local resources to support implementation of Alabama's Suicide Prevention Plan. Consisting of twenty seven (27) representatives of multidisciplinary public and private agencies, members of the faith community, as well as survivors, ASPTF published the State's first Suicide Prevention Plan in 2004. ADMH has maintained active representation on ASPTF since its inception.

The Alabama Suicide Prevention Task Force (ASPTF) reorganized during FY10. Evolving from task force status to a structured non-profit membership organization with a governing board, the ASPTF became the Alabama Suicide Prevention and Resource Coalition (ASPARC). ADMH continues to serve as an active participant in ASPARC activities, with a member of its staff elected to serve as its first president in 2010. The organization is currently seeking 501(c)(3) Tax Exempt Status. ASPARC began revision of Alabama's 2004 Suicide Prevention Plan in June, 2010 and is currently nearing completion of this task. Both the 2004 document and the planned revisions are attached.

For ten (10) years ADMH has worked collaboratively with others to develop and implement strategies to prevent suicide in Alabama. Yet, suicide continues as a significant public health problem that impacts hundreds of families in this State each year. A recent news report indicates the suicide rate in Alabama reached an all-time high of 14.2 suicides per 100,000 people in 2009, as reported by the Alabama Department of Public Health. After five years of steady growth, the State's suicide rate is at its highest point since 1960, outpacing the national rate, and prompting health experts to call for a public discussion on how suicide can be prevented. ADMH, has thus identified "Suicide Prevention" as a priority to be addressed during FY 2012-2013 as described in Section II of this Block Grant Application.

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Section IV: Narrative Plan K. Technical Assistance Needs

- Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

The Substance Abuse (Mental Illness) State Plan outlined in this application has been developed for implementation through utilization of resources and expertise currently available to the Alabama Department of Mental Health (ADMH), its provider network, and its stakeholders. As the agency advances in the merger of its distinct mental illness and substance abuse service divisions into a single integrated behavioral health system of care, while concurrently implementing the State Plan, areas of need for technical assistance will become more apparent and concise.

Even though Alabama has chosen to file separate Mental Health and Substance Abuse Block Grant Applications for FY 2012-2013, there has been a concerted effort to begin to unify the planning process which will serve as the foundation for the State's future joint application. ADMH is committed to using the Block Grant Application as the "working document" to move Alabama toward establishment of a good and modern behavioral health system.

Thus, no formal request for technical assistance will be made at this time. To ensure a thoughtful and measured use of valuable technical assistance resources from SAMHSA, ADMH will begin implementation of the strategies outlined in the Substance Abuse (Mental Illness) State Plan with a focus on maximizing the strengths within our current organizational structure, as well as, those available through the agency's partnerships. As the process of systems integration unfolds and technical assistance needs become more evident, ADMH will pursue a formal request for SAMHSA technical assistance to address the identified needs.

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Section IV: Narrative Plan L. Involvement of Individuals and Families

- The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:
  - How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
  - Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
  - Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
  - How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
  - How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The Alabama Department of Mental Health encourages and supports the development and expansion of the **Recovery Advocacy Movement**. Historically, addiction recovery has occurred within "anonymous" communities such as AA, NA and other groups who follow predominantly the twelve step recovery model. The department fully endorses the continuation of this wonderful system of anonymity and support. However, there are many individuals who have stepped forward into what has been called the Recovery Advocacy Movement. Recovering addicts and/or family members are now organizing into advocacy groups that OPENLY work to advance the cause of better care and public respect for those in recovery from addiction illness.

The department assists two **Recovery Advocacy Groups**. Alabama Voices for Recovery is the Alabama chapter of National Voices for Recovery. FORMLL is a regional group that works with "Voices" and receives financial support from ADMH for peer activities.

In 2006, the Substance Abuse Services Division also established an **Alabama Substance Abuse Advocacy Task Force**. The Task Force has conducted workshops throughout the state of Alabama to increase awareness of advocacy efforts for consumers, families and other interested parties. Consumer advocates are involved in the department's decision-making processes. Consumer representation/consultation is reflected in all aspects of the

department's operations. Consumers are consistently informed on pertinent issues and mechanisms are created for input.

Consumer Advocacy Services

The Rights Protection and Advocacy Services for persons in **state facilities** have long been a top priority for the Alabama Department of Mental Health. In October 1997, DMH greatly enhanced this effort, when the Internal Rights Protection and Advocacy Program officially expanded its role, and began providing services to persons being served in **community programs** that were under contract with DMH or programs which were certified by DMH. Services provided include: information and referral services; complaint intake, investigation and resolution services; participation in certification reviews of community programs to ensure standard compliance; unannounced monitoring of community residential and program areas; and rights education and training. These advocates have also been responsive to the children and families with SED who receive state-supported services, but the need for and advocacy groups devoted to the efforts of promoting children's mental health issues was evident.

With a staff of 26 certified advocates working out of five service area offices across the state and in the central administrative offices, the internal advocacy program provides a non-adversarial system of rights protection and advocacy that focuses on rights awareness and prevention of rights violations. A number of the advocates are family members or consumers. Community advocates are no longer scheduled for routine certification visits, but conduct random or for cause unannounced visits to community residential and day program providers, now including foster care facilities. The Office of Advocacy Services has an after-hours telephone response capability to address emergency rights-related issues and also is notified of all community Serious Special Incidents within 24 hours of occurrence.

The Office of Advocacy Services meets at least quarterly with the Advocacy Advisory Board. The community and facility advocacy services are integral to the quality of services and DMH's commitment to respect and enforce consumer rights.

1) **How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?**

Consumer advocates are involved in the department's decision-making processes. Consumer representation/consultation is reflected in all aspects of the department's operations. Consumers are consistently informed on pertinent issues and mechanisms are created for input. Peer Support/Recovery Coach trainings are conducted throughout the state.

2) **Does the State conduct ongoing training and technical assistance for child, adult, and family members; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and**

help develop the skills necessary to match goals with services and to advocate for individual and family needs?

The Alabama Substance Abuse Task Force and Friends of Recovery (FORMLL), the statewide advocacy organization has conducted workshops throughout the state of Alabama to increase awareness of advocacy efforts for consumers, families and other interested parties. The workshops are scheduled according to the identified needs of the consumer. This means that some workshops are held in the late evenings, weekends, or whatever time is conducive to the consumers of the designated area. The workshops are also conducted in locations that most convenient for the consumer – "We come to you" approach.

3) **Does the State sponsor meetings that specifically identify individual and family members? Issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?**

State-sponsored meetings were conducted for consumers during the Alabama Department of Mental Health's planning processes. Meetings were scheduled based on the identified needs of the consumer. Consumers were given the opportunity to be informed of the Department's current initiatives and make decisions regarding future priorities for the Department.

A State administrative change occurred in January 2011. The newly-appointed Commissioner and Associate Commissioner conducted Town Hall Meetings throughout the state to specifically hear from the consumer and family members regarding what works, what does not work, and how can we make things better. This was an opportunity for consumers and family members to voice their concerns and give their input to upper-level management and understand that they are an integral part of the Department's entire process. Continuous meetings/forums are conducted to ensure that consumer concerns and/or needs are addressed.

4) How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision-making, and the behavioral health service delivery system?

Consumer and family member advocates are involved in the department's decision-making processes. Consumer/family member representation/consultation is reflected in all aspects of the department's operations. Consumers and family members are consistently informed on pertinent issues and mechanisms are created for input. Examples of Department involvement include: Substance Abuse Coordinating Subcommittee, Mental Illness Coordinating Subcommittee, Alabama Substance Abuse Advocacy Task Force, Management Steering Committee, Department of Mental Health Advisory Board, etc.

4) **How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

The department assists two Recovery Advocacy Groups**.** Alabama Voices for Recovery is the Alabama chapter of National Voices for Recovery. FORMLL is a regional group that works with "Voices." The department also serves as a resource to several other recovery groups throughout the state by serving on various committees, facilitating programs and providing linkages to community resources. The department also provides scholarships/per diem to consumers for meetings, peer support trainings, the annual Alabama School of Alcohol and Other Drug Studies, out-of-state recovery-oriented conferences/meetings, etc.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Section IV: Narrative Plan M. Use of Technology

- Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:
  a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
  b. What specific applications of ICTs does the State plan to promote over the next two years?
  c. What incentives is the State planning to put in place to encourage their use?
  d. What support systems does the State plan to provide to encourage their use?
  e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
  f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
  g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
  h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Interactive Communication Technologies (ICTs) are already being used in treatment settings across Alabama, but the state must take a stronger leadership role in ensuring that these technologies are being used to their maximum effect and are available to as many of the individuals we serve as possible. Currently, the Alabama Department of Mental Health does ensure that providers are aware of technology resources through the distribution of e-mails and other invitations the state agency receives and passes along. However, Alabama DMH has not played as strong of a leadership role in the area of information technology as is needed and we recognize that we have largely been falling behind some of our more forward-thinking providers in this respect. Over the next eighteen months, Alabama DMH plans to be more proactive in identifying and pushing out ICTs to its community providers in a more aggressive manner. This will be done through presentations to our various committees as well as separate webinars or teleconferences specifically dedicated to the topic. We will therefore develop more use of text messaging, outreach, recovery tools, emotional support, prompts, case manager support and telemedicine by service providers across the state and by the department.

We seek to work with our providers to develop incentives that will encourage the use of these technologies on a broader scale, including ensuring that reimbursement is available for the use of such technologies in practice. We also plan to foster provider user groups so that those who are interested in a particular technology are able to get work with others who have a similar interest and even potentially develop economies of scale for particular technologies.

There is an amazing array of technologies just in the mobile application field that we can better leverage to improve outcomes for our consumers. The iPromises application (http://www.ipromises.org/) was specifically designed to help clients in residential substance abuse treatment track their progress and could have great utility for our service delivery system. We are also excited about the work being done by federal agencies in this area, such as the PTSD

Coach application developed by the US Department of Veterans Affairs (http://www.ptsd.va.gov/public/pages/PTSDCoach.asp) and T2 Mood Tracker from the US Department of Defense (http://www.ptsd.va.gov/public/pages/PTSDCoach.asp). These types of applications do not take a great amount of effort to publicize and get in the hands of consumers and stakeholders throughout the state, but DMH must invest more time and resources in doing just that.

The barriers to adoption of technology are varied. We are a very rural state and many types of technology are slow to come to these areas. Broadband is still a challenge, which makes expansion of telemedicine and other interactive technologies difficult to implement on a widespread basis. Many of these initiatives will need to begin in our urban centers, where the technology is more well-known and widespread, but will be slower to come to rural areas, who will need to be more creative with selection and deployment of technology.

The state does plan to continue its outreach efforts to hospitals, FQHC's and other community-based organizations to identify ways that these technologies could help enhance integration with primary care. We plan to continue to keep these technologies as a topic of discussion in our healthcare reform workgroups and other arenas where we are at the same table with primary care providers.

Currently, the state does not have plans to collect program evaluation data at either the client or provider level utilizing these technologies, but will work with the user groups of the various technologies to identify where that would be possible and helpful in monitoring and enhancing client care.

Alabama DMH does plan to use the technology user-groups as a mechanism to judge interest in various technologies, as well as collecting data on their use and effectiveness across the service delivery system. The information collected from the user-groups can then be shared with the various planning bodies to make decisions about more widespread adoption and areas where additional incentives may be needed.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

Section IV: Narrative Plan N. Support of State Partners

The success of a State's MHSBG and SAPTBG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

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One of ADMH's strengths is its history of collaborating with a number of state agencies relative to individuals who have or are impacted by substance use in Alabama. ADMH has identified the agencies below as key partners with which it now works on a number of initiatives. These agencies will assist the state with implementation of priorities identified in this application. The roles they will play in this process are identified in the table below.

ADMH will seek to identify additional existing, as well as, new partnerships that can assist the agency in addressing its SABG priorities. Letters of Agreement will be developed with each of these entities by March 31, 2012.

Agency	Role in Implementation of Priorities
Alabama Medicaid Agency	(a) Support ADMH's need for developing State Plan Amendments and Waivers to increase availability of and access to recovery support services and implementation of self directed care initiatives. (b) Collaboration in the development of health homes and integration of care; (c) Serve on Alabama Epidemiological Workgroup (AEOW). (d) Technical assistance and consultation in regard to ADMH Health Information Technology (HIT) Plan. (e) Assist in promotion of SBIRT;
Alabama Department of Public Health (Maternal and Child Health,	(a) Insuring continuity of Tuberculosis support services to ADMH provider Community. (b) Assistance in the provision of tobacco cessation services. (c) Continued data collection and reporting for SYNAR. (d) Collaborate in regard to in programs for parents and pregnant women; (e) Assist in promoting parental enrollment of their children in the state's Children's Health Insurance Program.(f) Serve on AEOW.
Alabama Department of Human Resources (Child Welfare Authority)	(a) Resource development in regard to services for abused and neglected children; (b) assistance in the provision of parenting education and training; (c) Collaboration in regard to multiple needs children.
Alabama Department of Education	(a) Collaboration in regard to substance abuse prevention in schools. (b) Assist in development of workforce development; strategy. (c) Collaborate on use of technological advances relative to adolescents and young adults. (d) Serve on AEOW. (e) Assist in establishment of policies, procedures and practices to support children experiencing trauma and their families
Alabama Department of Vocational Rehabilitation Services	Assistance in development of plan to address workforce issues for providers as well as clients in programs served by clients.
Alabama Department of Corrections (State Adult Correctional Agency)	(a) Collaboration in regard to community reentry services
Alabama Department of Youth Services (State Juvenile Justice Authority)	(a) Collaboration to assist ADMH in the development of trauma informed services for adolescents.; (b) Collaborate for implementation of evidence-based substance abuse services for adolescents in the state's legal system.
Alabama Administrative Office of the Courts	Assist in development of strategies for trauma informed services for individuals involved in the legal system. Development of Drug Courts.
Alabama Head Start Agency	Collaborate in the development of policies and practices relative to early childhood needs.
Alabama Health Insurance Exchange	Collaborate with ADMH in development of the Alabama Health Insurance Exchange and insure that the needs of

	individuals with substance use disorders are met.
Alabama Primary Care Association	Assist in developing strategies to promote integration of behavioral health and primary care services.
Alabama State Service Commission	Assist Alabama citizens in disaster preparedness and links to local committees and volunteers in the devastated areas.
Executive Order 23: Alabama Commission for the Prevention and Treatment of Substance Abuse	DMH is the lead agency for substance abuse services for the State of Alabama and responsible for coordinating the Alabama Commission for the Prevention and Treatment of Substance Abuse. The Alabama Commission for the Prevention and Treatment of Substance Abuse function is to: (a) Support the efforts of the Alabama Department of Mental Health in fulfilling 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; (b) Recommend initiatives to minimize the impact of substance abuse and addiction in Alabama; (c) Identify areas of interrelationship and opportunities for collaboration between substance abuse prevention, treatment, education, health, and enforcement programs and resources; and (d) Develop formal policies and procedures for coordination and efficient utilization of these programs and resources. Members are listed below; 1. State Health Officer of the Alabama Department of Public Health; 2. Superintendent of the Alabama Department of Education; 3. State Attorney General; 4. Commissioner of the Alabama Medicaid Agency; 5. Commissioner of the Alabama Department of Human Resources; 6. Commissioner of the Alabama Department of Children Affairs; 7. Commissioner of the Alabama Department of Rehabilitation; 8. Commissioner of the Alabama Department of Corrections; 9. Commissioner of the Alabama Department of Youth Services; 10. Commissioner of the Department of Senior Services; 11. Director of the Alabama Department of Public Safety; 12. Director of the Alabama Beverage Control Board;

	13. Director of the Alabama Board of Pardons and Paroles; 14. Director of the Alabama Department of Economic and Community Affairs; 15. Director of the Alabama Administrative Office of the Courts; 16. Director of the Governor's Office of Faith-Based and Community Initiatives; Executive Director of the Alabama Council of Community Mental Health Boards; 17. President of the Alabama Alcohol and Drug Association; 18. President of the Alabama Association of Addiction Counselors; 19. President of the Alabama Recovery Network; 20. Associate Commissioner for Developmental Disabilities, DMH; 21. One representative of the Alabama State House of Representatives, appointed by the Governor; 22. One representative of the Alabama Senate, appointed by the Governor; 23. One representative of the Office of the Governor; and; 24. One recovering substance abuse consumer, appointed by the Governor.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

Behavioral Health Advisory Council.

As the Division moves forward with plans to functionally integrate the substance abuse services division and the mental illness division, reorganization of ADMH's current Mental Health Advisory Council to incorporate representatives of the substance abuse community will be considered. Until such time, however, substance abuse services will continue to be planned and implemented as follows:

ADMH has established a formal committee structure through which service providers, service recipients, families, and advocates actively participate in the Department's planning and budgeting processes. Created in 1994, a Management Steering Committee provides for the development and oversight of a planning process for the provision of mental illness, developmental disabilities, and substance abuse services. This committee, in accordance with guidelines established by the ADMH Commissioner, is charged with the following responsibilities:

1. Develop strategic direction for the provision of developmental disabilities, mental illness, and substance abuse services;

2. Develop the Departmental legislative budget requests consistent with established priorities;

3. Develop budget allocations and major reallocations (e.g., proration, revenue changes, etc.) which impact the plan;

4. Review quarterly the progress on plan implementation;

5. Establish a conflict-resolution procedure, including criteria and guidelines under which issues shall be determined to be subject to such procedure;

The Management Steering Committee also has responsibility for establishing Coordinating Subcommittees to facilitate the development of plans for developmental disabilities, mental illness, and substance abuse services, respectively. The Coordinating Subcommittees, chaired by the Associate Commissioner for each departmental division, function to integrate local and regional planning efforts with statewide planning, consistent with the strategic directions established by the Management Steering Committee. Plans and recommendations developed by the Coordinating Subcommittees are sent to the Management Steering Committee for review and appropriate action. Actions and recommendations of the Management Steering Committee are advisory to the Commissioner and do not circumvent or diminish ADMH's statutory authority.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	0	
Individuals in Recovery (from Mental Illness and Addictions)	0	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	0	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	0	0%
State Employees	0	
Providers	0	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	0	0%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

P. Comment on the State Plan

ADMH announced the availability of access to the SABG Application for public comment on August 18, 2011 with widespread distribution of the BGAS web address and the state's public password to its planning partners and others. In addition to its plans to keep the application posted on its website throughout the year, the Division Plans to disseminate the application, as submitted to SAMHSA, to key stakeholders, to its entire email list, to each of its planning bodies, and to the state's Federally recognized tribal leaders. As additional comments are received, the Division will process them through its coordinating subcommittee planning processes. As determined necessary, requests to update the SABG Plan will be submitted to SAMHSA.