I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

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
Beverly

Last Name
Bell-Shambley, Ph.D.

Agency Name
Alabama Department of Mental Health

Mailing Address
100 North Union Street

City
Montgomery

Zip Code
36130-1410

Telephone
334-242-3642

Fax
334-242-3025

Email Address
beverly.bell-shambley@mh.alabama.gov

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

From

To

IV. Date Submitted

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

Submission Date
10/1/2013 11:26:02 PM

Revision Date
3/7/2014 4:46:14 PM

V. Contact Person Responsible for Application Submission

First Name
Sarah

Last Name
Harkless

Telephone
334-242-3953

Fax
334-242-0759

Email Address
sarah.harkless@mh.alabama.gov

Footnotes:

I: State Information

Assurance - 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	James Reddoch, J.D.
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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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.
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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).
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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.
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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	James Reddoch, J.D.
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature:  Date: 8·27·13

Footnotes:

I: State Information

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 wit h 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), (c), (d), (e), 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. Sub mission 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 sub-awards 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	James Reddoch, J.D.
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

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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

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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

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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.)
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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.

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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	James Reddoch, J.D.
Title	Commissioner
Organization	Alabama Department of Mental Health

Signature: _____ Date: 5.27.13

Footnotes:

Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3)

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and 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 of Chief Executive Officer (CEO) or Designee: Robert J. Bentley, M.D.

Title: Commissioner

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
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Name of Chief Executive Officer (CEO) or Designee: Robert J. Bentley, M.D.

Title: Commissioner

Signature of CEO or Designee[1]: Robert Bentley Date: Aug 29, 2013

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

OFFICE OF THE GOVERNOR

ROBERT BENTLEY
GOVERNOR

STATE CAPITOL
MONTGOMERY, ALABAMA 36130

(334) 242-7100
FAX: (334) 242-3282

STATE OF ALABAMA

July 25, 2012

Ms. Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry, Room 7-1103
Rockville, Maryland 20850

Dear Ms. Simmons:

I hereby delegate Mr. Jim Reddoch, Commissioner for the State of Alabama Department of Mental Health, authority to act on my behalf in making application and certifications related to the Unified Block Grant for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant administered by the United States Department of Health and Human Services. This delegation of authority is effective immediately and shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

Robert Bentley
Governor

JR/lf

I: State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

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

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 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, tribal, 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.

Footnotes:

PLANNING STEP 1

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

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

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 14 and FY 15.

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 14 – FY 15 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 in the early stages of development.

B. 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 seventy-six (76) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of fourteen (14) 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 use disorders, in the following order of priorities.

    - Drug injecting pregnant women (with diagnostic criteria).
    - Pregnant women (with diagnostic criteria)
    - Parenting women (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. Adolescents (under the age of 19) must be screened using the CRAFFT which is a six (6) question instrument. Adults (19 and older) must be screened using the UNCOPE which is also a six (6) question instrument. Potential co-occurring clients must be screened using the MINI KID Screener for adolescents and the MINI Screener for adults.

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, which is based on an established sliding fee scale. 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 2R 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 V diagnosis or diagnostic impression indicating the existence of a substance use 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 (6) 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 (University of Rhode Island Change Assessment Scale), MINI and MINI KID 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 Regulations 580-9-44-.01-.29, effective January 1, 2013, authorize the following levels of care:

1. **Medically Monitored Residential Detoxification (Level III.7-D):** An organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set physician-approved policies and physician-monitored procedures or clinical protocols. This Level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with observation, monitoring and treatment being available.

2. **Clinical Managed Residential Detoxification (III.2-D):** An organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicate or experiencing withdrawal. This Level of care is characterized by its emphasis on peer and social support.

3 **Ambulatory Detoxification with Extended On-Site Monitoring (Level II.D):** An organized outpatient service, which may be delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services. Outpatient detoxification services shall be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering substances and to effectively facilitate the patient's entry into ongoing treatment and recovery.

4. **Ambulatory Detoxification With Out On-Site Monitoring (Level I-D):** An organized outpatient service, which may be delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a pre-determined schedule. Such services are provided in regularly scheduled sessions under a defined medical protocol. Outpatient detoxification services shall be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering substances and to effectively facilitate the patient's entry into ongoing treatment and recovery.

5. **Medically Monitored Residential Treatment (Level III.7):** A planned regime of 24-hour professional directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. This Level of care is appropriate for those individuals whose sub-acute, biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital.

6. **Residential Treatment (Level III.5):** Highly structured, short term (14-21 day), intensive chemical dependency treatment service and intensive therapeutic activities. This Level is conducted in a 24-hour supervised living arrangement operated by the facility using around the clock awake staff. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect global change in patients' lifestyles, attitudes and values.

7. **Medium Intensity Adult Residential Treatment (Level III.3**): A structured recovery environment in combination with medium intensity clinical services to support recovery from substance related disorders. Individuals seen at this Level are often older, cognitively impaired or developmentally delayed, or are those in whom the chronicity and intensity of the primary disease process requires a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives.

8. **Low Intensity Residential Treatment Adult (Level III.1):** The program offers a minimum of five (5) hours per week of low-intensity treatment of substance related disorders.

Treatment is directed toward applying skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery and reintegrating the individual into school, work and family life.

9. **Transitional Residential (Level III.01):** A residential service that provides chemical dependency supportive services and therapeutic activities conducted in a residential setting designed to provide the environment conducive to recovery and to promote reintegration into the mainstream of society.

10. **Partial Hospitalization (Level II.5):** A program that is delivered in an outpatient setting and generally features twenty (20) or more hours of clinically intensive programming per week. There is daily or near-daily contact, as specified in the patient's service plan. Patients often have direct access to or close referral relationship with psychiatric, medical and lab services.

11. **Intensive Outpatient (Level II.1):** A combination of time limited, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle. The amount of time and frequency of services for Level II.1 are established on the basis of the unique needs of each client served, but services shall be available a minimum of nine (9) hours per week for adults and a minimum of six (6) hours per week for adolescents.

12. **General Outpatient Services (Level I):** Organized outpatient treatment services, which may be delivered in a wide range of settings. Professionally qualified addiction counselors deliver directed evaluations, treatment and recovery services. Such services are provided in regularly scheduled sessions of fewer than nine (9) contact hours per week for adults and fewer than six (6) hours per week for adolescents.

13. **Early Intervention (Level 0.5):** Organized service that may be delivered in a wide variety of settings. This Level of Care is designed to explore and address problems or risk factors that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use.

14. **Opiate Maintenance Therapy (Level I-O):** 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.

The authorized levels of care consist of a modification of those established in the ASAM PPC-2R. As indicated in **TABLE 2,** specialty levels of care are available for adolescents, individuals with co-occurring disorders, and pregnant and parenting women.

TABLE 2

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.

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 parenting women, 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 substate region in **TABLE 3.**

TABLE 3

Adult and Adolescent Regional Service Locations	Region 1		Region 2		Region 3		Region 4		TOTAL
	Adult	Adoles	Adult	Adoles	Adult	Adoles	Adult	Adoles	
Level 0.5	1	1	2	2	3	1	4	0	14
Level I	22	11	23	10	19	4	22	7	118
Level I/Special Women Services	1	0	1	0	1	0	0	0	3
Level I/Co-occurring Services	2	1	1	0	1	0	0	0	5
Level I-D/Ambulatory Detoxification w/o Extended On-Site Monitoring	3	2	3	3	2	0	1	1	15
Level II-D/Ambulatory Detoxification with Extended On-Site Monitoring	0	0	0	0	0	0	0	0	0
Level II.1	30	6	20	8	20	6	14	3	107
Level II.1/Special Women Services	1	0	2	0	1	0	2	0	6
Level II.1/Co-occurring Services	2	0	0	0	1	0	0	0	3
Level II.5/Partial Hospitalization	1	1	2	0	0	0	0	0	4
Level III.01/Transitional Residential	3	0	0	0	0	0	0	0	3
Level III.01/Special Women Services	0	0	0	0	0	0	0	0	0
Level III.01/Co-occurring Services	0	0	0	0	0	0	0	0	0
Level III.1/Clinically Managed Low Intensity Residential	6	0	4	0	0	0	5	0	15
Level III.1 Special Women Services	0	0	0	0	0	0	0	0	0
Level III.1/Co-occurring Services	0	0	0	0	0	0	0	0	0
Level III.2-D/Clinically Managed Residential Detoxification	0	0	0	0	0	0	0	0	0
Level III.3/Clinically Managed Medium Intensity Residential	0	0	3	0	1	0	1	0	5
Level III.3/Special Women Services	1	0	1	0	1	0	0	0	3
Level III.3/Co-occurring Services	0	0	1	0	0	0	0	0	1
Level III.5/Clinically Managed High Intensity Residential (adult)	4	0	2	0	1	0	3	0	10
Level III.5/Special Women Services	0	0	0	0	0	0	0	0	0
Level III.5/Co-occurring Services	0	0	0	0	0	0	1	0	1
Level III.5/ Clinically Managed Medium Intensity Residential (adolescent)	0	2	0	1	0	0	0	1	4
Level III.7/Medically Monitored Intensity Residential	1	0	0	0	O	0	0	0	0
Level III.7/Special Women Services	0	0	0	0	0	0	0	0	0
Level III.7/Co-occurring Services	0	0	0	0	0	0	0	0	0
Level III.7/Medically Monitored High Intensity Residential (adolescent)	0	1	0	0	0	0	0	0	1
Level III.7-D/ Medically Monitored Residential	1	1	3	0	0	0	0	0	4

Detoxification									
Level I-O Opioid Maintenance Treatment	**8**		**7**		**2**		**5**		**22**
Total Number of Levels of Care by Region	**87**	**26**	**75**	**23**	**53**	**11**	**58**	**12**	**345**

In addition to funding for the fourteen (14) levels of care, ADMH also provides funding for the services identified in TABLE 4. These services may be provided within the levels of care and specialized programs described above:

TABLE 4

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
Basic Living Skills	Non-Emergency Transportation
Medication Monitoring	Peer Counseling
Crisis Intervention	Mental Health Consultation
Injectable Medication Administration	Oral Medication Administration
Assessment Services	Brief Intervention
Activity Therapy	Child Sitting Services
Non-Emergency Transportation	

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:

Primary 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.

ADMH does not operate any substance abuse prevention, or directly provide any related services. The agency currently enlists the services of twenty-nine (29) certified prevention programs across the state. ADMH has established the state's public system of services through

the execution of contractual agreements with these private and public entities located throughout Alabama, representing all four regions of the state.
Less operating and administrative prevention provider costs, the majority of prevention funding is directed towards environmental, education, and alternative activities. Based upon the MHSASD (Mental Health Substance Abuse Service Division) established billable rate system, each of these organizations receives annual funds from ADMH to provide one or more of the six (6) primary preventions strategies. The SAPT BG provided by SAMHSA is the primary funding source for Alabama's public system of substance abuse services.

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. Representatives of the office of the State Attorney General, the Department of Corrections, the Department of Children Affairs, the Department of Rehabilitation, the Department of Corrections, the Department of Public Health, and the Department of Education serve on the SPAB, as well as, the AEOW (Alabama Epidemiological Outcomes Workgroup).

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 problems, 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. The composition of the SPAB and the AEOW contribute towards the resources of the system to assist in the provision of prevention services.

Regional Clearinghouses

The ADMH has supported two regional clearinghouses, in North and South Alabama, to disseminate information and training on substance abuse and substance abuse related problems to prevention providers, coalitions, schools and communities. The North Regional Information Clearinghouse was provided by the Agency for Substance Abuse Prevention (ASAP) and provided services to thirty-three (33) counties in the northern part of the state. Due to funding contrasts and shifting of responsibilities of service delivery, support for the North Clearinghouse ended in June 2013. The South Regional Information Clearinghouse is provided by the Drug

Education Council, Inc., providing the same services to the remaining thirty-four (34) counties in the southern part of the state.

The Clearinghouses provide training to prevention providers throughout the year. Training topics include, but are not limited to, bullying, HIV and other STIs, managing disruptive audiences, SPF SIG and ethics. Trainings are determined through an assessment of prevention plans and the identification of training and technical assistance needs. Once the clearinghouse is on-site to provide the necessary trainings, follow-up training schedules and needs are determined. Clearinghouse-provided trainings are offered at no cost to Alabama prevention professionals. Prevention providers and communities are informed of training opportunities through e-mail distribution, clearinghouse websites, various workshops and planning meetings.

The Clearinghouses are accessible to providers, as well as the community, and serves as an informational resource to include the distribution of pamphlets, brochures, booklets, publications and reports in the substance abuse and mental health fields. A toll-free number allows providers and communities to readily access clearinghouses for technical assistance needs, as well as, information dissemination. The clearinghouse receives requests for technical assistance, information dissemination, and/or health fairs from providers and the community. The clearinghouse will then check personnel/resource availability to fulfill the request at the specified date and time. In the event the clearinghouse cannot fulfill the request, coordination with the alternative clearinghouse is made to fulfill needs. Examples of technical assistance provided by the clearinghouses include, but are not limited to, assistance with prevention plans, environmental strategy implementation and prevention standards compliance. The operation of clearinghouses was under the auspices of two certified prevention providers until the loss of the North Clearinghouse in June 2013.

Other Prevention Services

ADMH currently funds three coalitions dedicated to the reduction of substance use in Alabama: Council on Substance Abuse Montgomery Unified Prevention System (MUPS), Elmore County Partnership for Children, and Selma Dallas Prevention Collaborative. Together, the coalitions annually receive a total of approximately $200,000 (prior to effects of sequestration). These coalitions consist of youth, parents, teachers, churches, civic and business leader's, et al., that are making positive influences and changes throughout their communities. Extensive efforts have been focused on excessive alcohol use, illicit drugs, and alcohol and tobacco ordinances all resulting in reduction of substance use and abuse.

Alabama, also has seven (7) regular Drug-Free Community (DFC) grantees, which are community-based coalitions organized to prevent youth substance use. The philosophy behind the DFC program is that local drug problems require local solutions. Through training, technical assistance, awareness and availability of additional resources, DFC capacity is be increased.

Prevention Funding

Utilizing the Strategic Prevention Framework to guide the process, ADMH requires providers to submit data informed plans to ensure the needs of their diverse communities are addressed. In FY 2013, provider prevention plans focused on a comprehensive approach across the six primary

strategies addressing underage drinking; prevention or reduction of illicit and prescription drug misuse, use, and abuse; and prevention across the lifespan with an emphasis on adolescents and baby boomers.

RECOVERY SUPPORT

ADMH has not traditionally funded recovery support services as a part of its substance abuse service delivery system. As part of it movement to establish a recovery oriented system of care, however, the agency included these services in its recommended State Plan Amendment for expansion of the Medicaid Rehabilitation Service Option. In addition, ADMH has provided funding for peer support training and certification. Through this effort, more than one hundred and fifty (150) individuals have been trained and certified as peer support specialists. Peer specialists are now employed at a number of certified contract provider locations, especially in residential care settings.

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 in **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 over 45,000 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

C. 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.

D. 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	2009	2010	2011	2012
TOTAL	**19,925**	**18,914**	**18,443**	**17,511**
Sex				
Male	71.0	70.1	**69.8**	**68.2**
Female	29.0	29.9	**30.2**	**31.8**
Age at Admission				
0-11	0.0	0.0	**0.0**	**0.0**
12-17	3.3	6.3	**6.9**	**7.4**
18-20	5.6	7.1	**7.0**	**6.6**
21-25	12.3	12.5	**12.7**	**12.3**
26-30	14.2	14.0	**13.9**	**14.3**
31-35	11.6	10.4	**11.3**	**11.6**
36-40	9.2	8.8	**8.8**	**9.3**
41-45	7.8	7.8	**7.5**	**7.6**
46-50	7.8	7.7	**7.1**	**7.4**
51-55	6.1	5.1	**5.2**	**5.7**
56-60	3.2	2.7	**2.6**	**2.9**
61-65	1.2	1.0	**1.2**	**1.2**
66+	0.6	0.5	**0.6**	**0.6**
Unknown	17.1	16.1	**15.2**	**13.1**
Race				
White	55.3	56.5	**55.9**	**55.9**
African American	38.2	36.1	**34.7**	**32.6**
American Indian or Alaska Native	0.3	0.3	**0.3**	**0.3**
Asian or Native Hawaiian or Other Pacific Islander	0.1	0.2	**0.1**	**0.2**
Other	1	1.2	**1.3**	**1.3**
Unknown	5.1	5.7	**7.6**	**9.7**
Ethnicity				
Hispanic or Latino	0.9	0.8	**0.9**	**0.8**
Not Hispanic or Latino	99.1	99.2	**99.1**	**99.2**
Unknown	0	0	**0.00**	**0.00**

E. 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.
- **Relationship with the Alabama Department of Public Health:** ADMH's partnership with the Alabama Department of Public Health enables the agency to meet many of its SABG compliance requirements, as, the TB maintenance of effort and Synar.
- 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 is dedicated, resourceful, and has a wealth of experience, education, and training to move the Division forward during this time of extreme system change. The staff, also, reflects the diversity of Alabama's population.
- A strong **Substate Prevention System** that provides stability to the statewide prevention delivery system. The prevention system in the State has been in place for almost 25 years and has many long-term staff at the local levels.

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 few requests of its treatment providers to meet performance standards;
- **Service Need:** ADMH serves less than 10% of the estimated need for substance abuse treatment in Alabama.
- **Systems Change:** System change has been a very slow process in Alabama. 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. As a result, the state is now

struggling to keep up with the fast pace of a multitude of simultaneous changes brought about by the Affordable Care Act, and the survival of some programs is now questionable.

II: Planning Steps

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

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:

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

Leading Alabama's efforts to enhance the health and well-being of individuals, families, and communities impacted by mental illness, developmental disabilities, substance abuse and addiction, the Alabama Department of Mental Health (ADMH) will be challenged on many fronts in 2014 as it strives to adapt to the uncertainties of significant changes in health care laws and practices. For the state's substance abuse service delivery system, these challenges include:

- Transformation of the Alabama Medicaid Agency's service delivery which will end ADMH's role as the management entity for Medicaid providers with which it contracts;
- No expansion of Medicaid eligibility in Alabama;
- Flat state funding for substance abuse services;
- Reduction of the Substance Abuse Block Grant;
- System erosion due to funding cuts;
- Greater demands for services;
- Greater demands for accountability.

The greatest challenge facing the agency, however, is its obligation to sustain a quality, needs responsive system of services in spite of hurdles created by the challenges listed above. The rigorous use of data will greatly aid the ADMH in accomplishing this task.

The information that follows establishes the basis for Alabama's Substance Abuse Block Grant (SABG) priorities for FY 2014 and FY 2015. ADMH has identified unmet needs and critical gaps in the state's publicly funded substance abuse service delivery system through a process of review and analysis of information retrieved from data collection processes that addressed:

- Consumption of Alcohol, Tobacco, and Other Drugs in Alabama;
- Vulnerable/Underserved Populations; and
- System Issues.

The following state and national resources were included in this data review and analysis process:

National
- National Survey on Drug Use and Health (NSDUH)
- Treatment Episode Data Set (TEDS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Uniform Crime Report (UCR)

State
- Alabama Criminal Justice Information Center (ACJIC)
- Alabama Department of Public Safety (ADPS)

- Alabama Department of Public Health (ADPH)
- Alabama Substance Abuse Information System (ASAIS)
- Alabama Department of Mental Health Behavioral Health Needs Assessment (ADMH Needs Assessment)
- 2014 Alabama Drug Threat Assessment Gulf Coast HIDTA (ADTA)

IDENTIFICATION OF ALABAMA'S PRIORITIES

Alabama Epidemiological Workgroup

The State's Epidemiological Outcomes Workgroup is an active participant in the selection of priorities for the SABG. Since its establishment by ADMH's Substance Abuse Services Division in 2006, the Alabama Epidemiological Outcomes Workgroup (AEOW) has focused its efforts on the systematic assessment of alcohol, tobacco, and other drug (ATOD) use and related consequences throughout the state. The AEOW utilizes a data-driven process to ensure the availability of accurate information for the public's use in planning, programming, and service prioritization.

The AEOW functions to support state and community efforts to prevent substance abuse, dependency, and related problems; to collect, analyze, and disseminate data; and to describe the prevalence, consumption, and consequences of alcohol, tobacco, and other drug use in Alabama. The AEOW continuously contributes to ADMH's planning processes by providing ongoing system surveillance, assessment, analysis, monitoring, and dissemination of data describing ATOD consumption patterns and consequences in the State. Additional activities include ongoing review of changes in data indicators to identify improvements or gaps that need to be addressed.

The AEOW collects data at the state and community level to inform assessment of the prevalence of substance abuse issues and the impact of such in Alabama. Data includes indicators on substance use, consequences, and ATOD use risk/protective factors. Data identifying the magnitude, severity, trends, and comparison with US indicators is also collected and examined.

The AEOW's methodology for assisting ADMH in establishing SABG service priorities begins with an environmental scan of potential national and state data sources apropos for determining needs relative to ATOD use in Alabama. A data quality screening process is then conducted to identify those sources that would be appropriate for assessment purposes. Selected data sources are considered eligible for use in assessment based on the following criteria: availability, validity, consistency, and periodic collection over at least three to five past years. Data is then collected by ADMH's Epidemiologist and presented to the AEOW for discussion of consumption patterns, consequences of use, risk and protective factors, and other ATOD related needs of the people of Alabama as revealed by the data. Indicators discussed include measures used in the Healthy People Initiatives 2020. Consensus of the AEOW, after its review and analysis of data and related information collected, results in recommendations to ADMH for Alabama's substance abuse priority areas to address system needs and gaps.

The AEOW is chaired by ADMH's Epidemiologist and its Prevention Services Director. Through the AEOW's partnerships with state agencies, the Epidemiologist has ready access to data from several state agencies, including the Alabama Administrative Office of Courts, Alabama State Department of Education, Alabama Department of Human Resources, Alabama Department of Youth Services, Alabama Department of Public Safety, and the Alabama Criminal Justice Information Center. These partnerships provide essential support for ADMH's data-driven decision making process for priority setting and service planning. The partnerships also enhance ADMH's capacity to monitor the impact of its funded services on alcohol, tobacco, and other drug use in Alabama.

Alabama Needs Assessment

In March 2012, the Alabama Department of Mental Health engaged Collaborative Research, LLC for the purpose of assessing existing needs, barriers, and gaps in the state's public mental health and substance abuse service delivery system. The study was conducted on a local and national basis through development and implementation of primary and secondary research methodologies. The profile for this study included all twenty-two (22) mental health and substance abuse service delivery networks by geographic regions known as 310 Boards, nineteen (19) free-standing substance abuse prevention and treatment providers, and sixteen (16) target consumer populations as follows:

1. Adults (ages 19 and older);
2. Children;
3. Adolescents;
4. Pregnant women;
5. Parents with dependent children;
6. Intravenous drug users (IVDUs);
7. Persons with or at risk for HIV/AIDS;
8. Persons with tuberculosis or other communicable diseases;
9. Persons with disabilities;
10. Racial and ethnic minorities;
11. Foreign born individuals;
12. LBGTQ populations (Lesbian, Bisexual, Gay, Transgender, Questioning);
13. Military personnel;
14. Veterans;
15. Persons living below the Federal Poverty Level of 133%; and
16. Persons who are deaf and hard of hearing.

Primary research consisted of a Provider Survey of forty-one agencies, and a Consumer Survey and Focus Groups in which representatives of the target groups listed above were participants. Secondary research was comprised of a comprehensive literature review and policy scan, and through development of county profiles specific to demographic, socioeconomic, and behavioral risk factors for behavioral health clients in Alabama. A comparison of rural and urban county profiles and substance abuse, through the use of SAMHSA (Substance Abuse and Mental Health Services Administration) data, provided contrasts of Alabama and national substance abuse

estimates. The needs of Alabama's behavioral health system are described within context of the following categories:

- Consumer awareness of services and service type;
- Access to services;
- Services for special populations;
- Presenting mental health and substance use disorders by frequency;
- The most common entry points into the behavioral healthcare system in Alabama by individuals with a mental illness or substance use disorder;
- Top unmet service need by service category;
- Provider findings; and
- Recommendations and an action plan based upon all findings.

ADMH established a Needs Assessment Guiding Council to monitor and manage the needs assessment process in collaboration with the contractor, Collaborative Research. The Guiding Council consisted of the following ADMH employees:

- Dr. Beverly Bell-Shambley, Associate Commissioner for Mental Health and Substance Abuse Services
- Sarah Harkless, SABG Manager
- Dr. Maranda Brown, Director of Substance Abuse Prevention Services
- Angie Astin, Acting Director Office of Performance Improvement
- Robert Wynn, Director of Substance Abuse Treatment Services
- Kim Hammack, Director of Mental Illness Community Programs
- Jessica Hales, Director of Mental Illness Adult Services
- Dr. Timothy Stone, Medical Director
- Steve Hamerdinger, Director of the Office of Deaf Services
- Catina James, Epidemiologist
- Melanie Harrison, IT Project Manager
- Kris Vilamaa, Chief Information Officer
- Katrina Nettles, Director of Program Certification
- Kristi Gates, Office of Public Information
- Shawn Stinson, Financial Data Analyst

Given the State's population, a sample frame for the Consumer Survey conducted as part of the Needs Assessment was established at a minimum of 1,500 responses. Administration of the survey was governed by an Institutional Review Board (IRB) protocol. Survey facilitators finalized the collection of consumer responses at 1,976 surveys resulting in a 99% confidence level with a confidence interval of 2.9.

CONSUMPTION OF ALCOHOL, TOBACCO, AND OTHER DRUGS IN ALABAMA

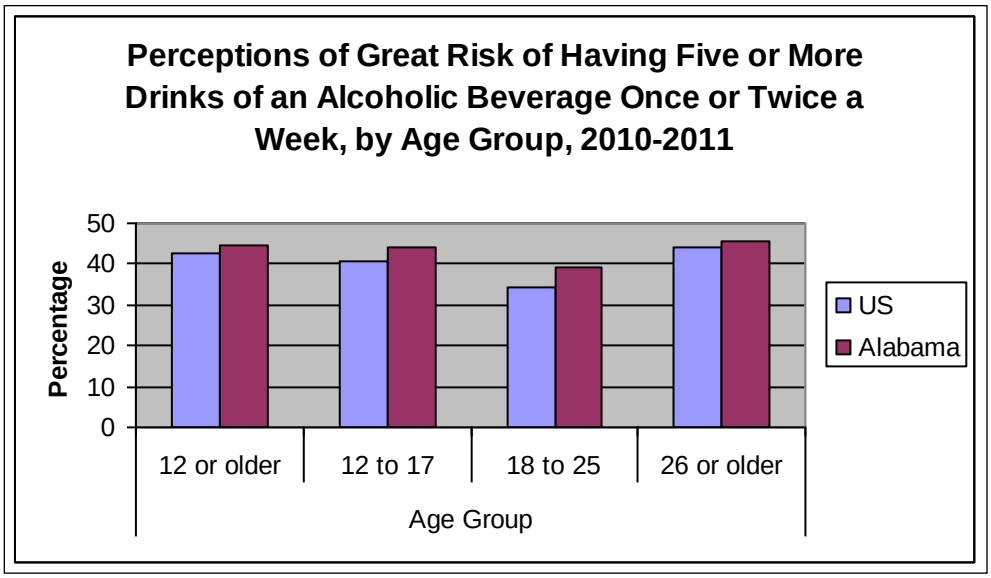
As identified by the AEOW, the following is a compilation of key data (consequences and consumption patterns) for alcohol, tobacco, and other drugs in Alabama.

Alcohol

In Alabama, alcohol is the most used substance, solely, and also in combination with other substances, followed by marijuana, prescription drugs not prescribed to the user, opiates, inhalants, methamphetamines and other drugs including cocaine, heroin, and spice. Alcohol use accounts for the most treatment admissions in the state. However, 58% of those with an alcohol related diagnosis are not receiving treatment for the condition according to the ADMH Needs Assessment's Consumer Survey.

In 2012, there were 26,852 people arrested for alcohol violations in the State: 44% were arrested for driving under the influence; 18 percent were arrested for liquor law violations; and 38 percent for public drunkenness (ACJIC). In 2010, causal drivers age 16 to 20 were involved in 495 alcohol-related crashes (ADPS). In 2011, 29% of persons killed in crashes were drivers who had blood alcohol concentrations levels of 0.08 or higher. Liver disease and cirrhosis deaths accounted for 1,053 deaths in Alabama in 2011 (ADPH).

Among youth 12-20 years old in Alabama, 20.59% reported consuming alcohol during the past month and 12.46% reported binge drinking (NSDUH, 2010-2011). Among Alabamians in 2010-2011, 11.7% of persons aged 12-17 reported alcohol use in the past month compared to 13.5% of persons in the US. Also, 6.6% of person 12-17 reported binge alcohol use in the past month (NSDUH). Among persons age 12 or older in Alabama, 44.5% perceive a great risk in having 5 or more drinks of alcoholic beverages once or twice a week.



Source: NSDUH

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. 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 under the age of 21 die as a result of underage drinking. Approximately 1,900 of these deaths are the result of motor vehicle crashes, 1,600 are the consequences of homicides, and hundreds from other injuries such as falls, burns, and drowning.

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%). Based on the 2011 YRBS, 23.6% of high school youth drank alcohol for the first time before age 13 years, with the average age of first alcohol use reported as 12.6. Alabama female high school youth (21.7%) were more likely to report first using alcohol before age 13 compared with US female high school youth (17.4%) in 2011. For Alabama high school youth, 35.6% reported having at least one drink of alcohol on at least one day during the 30 days before the survey (YRBS).

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 especially a very serious issue in the state of Alabama in the context of the value of sports. Fan allegiance and identification can lead to dangerous situations involving alcohol and other drugs.

Alabama attributes underage alcohol use being associated with risky behaviors such as drinking and driving. In 2009, 12.3% of 12^{th} 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 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 represent another possible consequence of excessive alcohol consumption that may lead to violent crimes, forcible rape, robbery and aggravated assault.

Tobacco

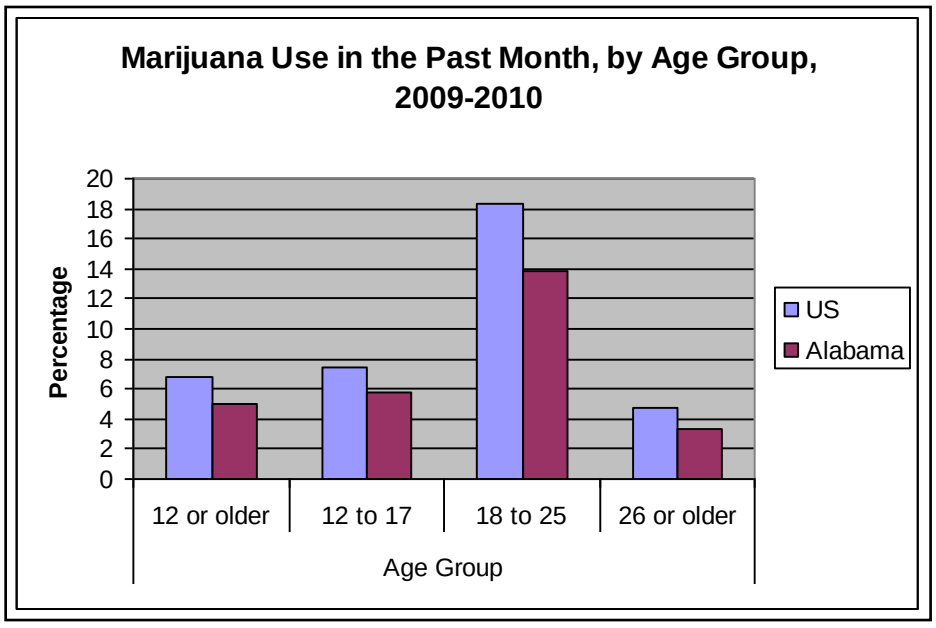
According to the Behavioral Risk Factor Surveillance System (BRFSS), 24.3% of Alabama adults are current cigarette smokers with 28.0% of males currently smoking and 21.0% of females currently smoking in 2011. In 2012, 23.8 % of adults are current smokers with 26.4% of males currently smoking and 21.4% of females currently smoking. In the 2011 Alabama PRAMS Surveillance Report, 2.2% of mothers reported they continued to smoke during pregnancy.

Alabama is ranked Number 41 in "smoking" based upon the United Health Foundation's 2012 Report of Leading Health Indicators. The higher the percentage of individuals within a state who are over age 18 and smoke on a regular basis, the higher the state's ranking.

The 2010 Youth Tobacco Survey, administered to Alabama middle school and high school students every two years, shows a decline in smoking among youth. From 2000 to 2010, the prevalence of smoking decreased by 38% (from 30.2% to 18.6%) among high school students and by 63% (from 19.1% to 7%) among middle school students. In high school, 22.2% of males smoke while 14.8% of females smoke. In middle school, African American students (4.5%) had lower smoking rates than white students (7.7%). The smoking disparity between these groups increased significantly in high school where the prevalence of smoking was almost ten percentage points higher for white students (22.5%) than for African American students (12.4%).

Marijuana

Marijuana continues to be a widely abused drug in Alabama. Intelligence indicates Marijuana remains a "gateway" drug for teens and young adults who are beginning to experiment with drugs. Vast rural areas throughout Alabama provide ideal cover and concealment for marijuana growers. This contributes heavily to the large quantities of marijuana produced in the state (ADTA). Marijuana accounts for the second highest diagnosed and treated substance use disorder, with 64% of those diagnosed being untreated per the ADMH Needs Assessment's consumer survey.



Source: NSDUH

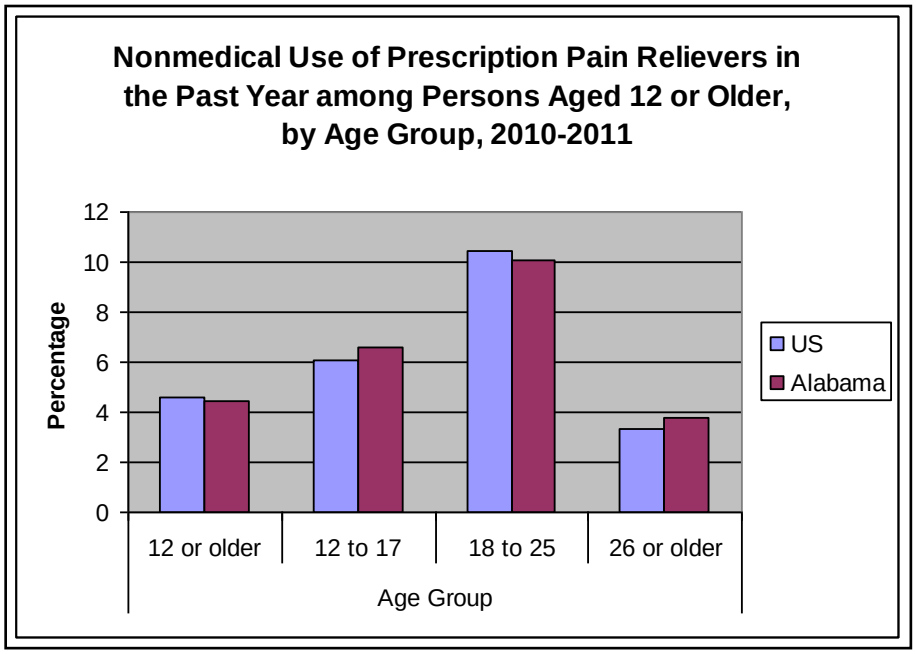
In the 2009-2010 NSDUH, 4.94% of individuals in Alabama age 12 and older reported marijuana use in the past month compared to 6.77% in the US. According to the Alabama Substance Abuse Management Information System (ASAIS), 5,636 individuals sought treatment at state funded programs for abuse of marijuana as a primary substance in 2012 compared to

6,597 individuals in 2011 (14 percent decrease). Perceptions of great risk of smoking marijuana once a month remained the same at 41% for individuals age 12 and older (NSDUH).

Prescription Drugs

Prescription drug abuse ranks third among respondents admitting to use but not in treatment, after alcohol and marijuana. Per the consumer survey, 16% of respondents who are currently receiving substance abuse treatment admitted to non-medical use of prescription drugs. (ADMH Needs Assessment)

The Drug Enforcement Administration reports diversion of hydrocodone products such as Lortab continues to be a problem in Alabama. Primary methods of diversion being reported include illicit sale and distribution by health care professionals, "doctor shopping", and the Internet. Oxycodone products, methadone, benzodiazepines, and phentermine were also identified among the most commonly abused and diverted pharmaceuticals in Alabama. Based on reports submitted to the Alabama Prescription Drug Monitoring Program (PDMP), hydrocodone with/acetaminophen is the top dispensed controlled substance in Alabama. (ADTA)



Source: NSDUH

According to the Centers for Disease Control and Prevention, in 2012 Alabama had one of the highest rates in the nation of prescription painkillers sold per 10,000 people. Three bills that were approved during the state's 2013 Legislative Session are aimed at decreasing the abuse of prescription drugs. Governor Robert Bentley has also established a Task Force, which includes ADMH representation, to seek additional solutions to the problem.

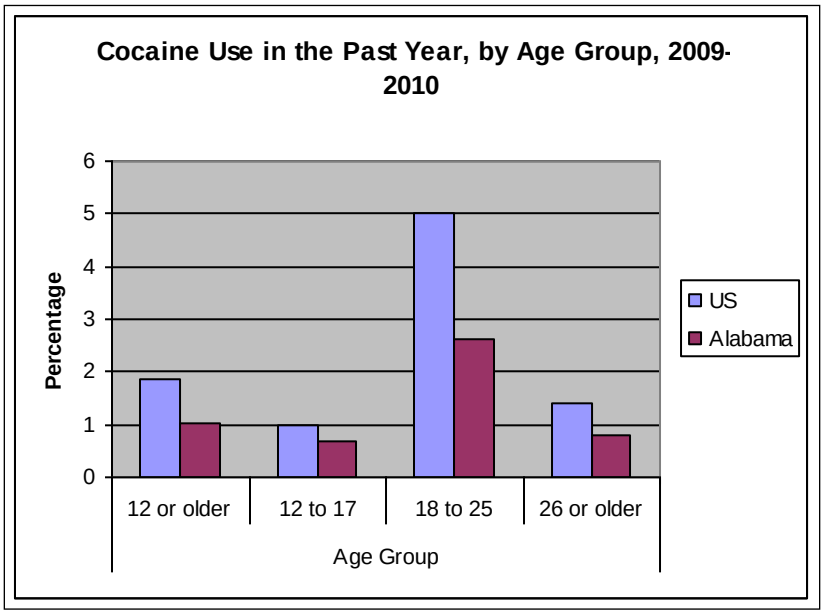
In Alabama, 4.43 % of persons aged 12 or older reported nonmedical use of prescription pain relievers in the past year compared to 4.57% in the US (NSDUH, 2010-2011). In 2011, 17.9% of high school youth had taken prescription drugs one or more times without a doctor's

prescription. Males (20.8%) were significantly more likely to ever take prescription drugs one or more times without a doctor's prescription than females (15.0%). (YRBS)

Cocaine

Cocaine continues to be the primary drug threat to the urban areas of the state of Alabama. Crack cocaine distribution and abuse is associated with more incidents of violent and property crimes than any other drug. The number of violent and property crimes increased in Alabama from 2010 to 2011. In the Uniform Crime Report, 20,174 violent crimes (420.1 violent crimes per 100,000 inhabitants) were reported in 2011 which is an increase from 18,056 violent crimes (377.8 violent crimes per 100,000 inhabitants) in 2010. Also, 173,190 property crimes (3,606.1 property crimes per 100,000 inhabitants) were reported in 2011 which is an increase from 168,092 property crimes (3,516.8 per 100,000 inhabitants) in 2010.

In the 2009-2010 NSDUH, 1.04% of individuals age 12 and older reported cocaine/crack use in the past month compared to 1.85% in the US. According to the ASAIS, 2,295 individuals sought treatment at state-funded programs for use of cocaine/crack in 2012 compared to 2,653 individuals in 2011 (13 percent decrease).



Source: NSDUH

Heroin

Heroin is becoming increasingly available in the college areas as well as urban areas in the state (ADTA). In the US, urban admissions (21.8%) were more likely than rural admissions (3.1%) to report primary abuse of heroin via TEDS report. Overall, Alabama treatment programs have reported an increase in admissions for heroin abuse. Based on ASAIS, there were 319 treatment admissions for heroin as the primary substance in 2011 vs. 436 in 2012. In 2011, 3.1% of high school youth had used heroin at least once. Males (4.9%) were significantly more likely to use heroin at least once than females (1.4%) (YRBS).

Based on the ADTA, heroin is increasingly becoming an alternate drug of choice for hydrocodone users. The resurgence of heroin is a major factor in overdose deaths due to the high purity of the drug. Areas in and around Alabama's largest city, Birmingham (Jefferson, Shelby, and Tuscaloosa Counties), have experienced an increase in heroin related deaths resulting from overdoses. From a low of 17 in 2010, heroin overdose deaths skyrocketed in the area during 2011 to 44, and in 2012 to 83. Local, state, and federal law enforcement met and began aggressive efforts to address the sources of heroin in North Alabama during 2012. More than 100 overdose deaths occurred in the three-county area from January of 2012 through August 2013.

Inhalants

Per the consumer survey, 6% of respondents who are currently receiving substance abuse treatment admitted to use of inhalants. Inhalant abuse ranks sixth admitting to use but not in treatment after alcohol, marijuana, prescription drugs, opiates, and other substances (ADMH Needs Assessment). Based on ASAIS, there were 16 treatment admissions relative to use of inhalants in 2011 compared to 12 admissions in 2012.

Methamphetamine

Methamphetamine continues to be a major drug threat to the rural areas of the state. In Alabama, ice methamphetamine is predominantly abused by Whites and Hispanics in rural areas of the state. Abuse among Blacks is not as prevalent but is reportedly increasing. (ADTA). According to ASAIS, 1,719 individuals sought treatment at state-operated or funded institutions for abuse of methamphetamine in 2012 compared to 1,783 in 2011 (4 percent decrease). Methamphetamine generates violent crime and affects public safety, public health, and environmental concerns during its production and distribution.

Synthetic Drugs (i.e. Bath Salts, Spice, K2)

Synthetic drugs such as spice have become more popular over the past year in Alabama, and are smoked as an alternative to marijuana. Bath salts such as Ivory Wave are consumed as a synthetic methamphetamine according to the ADTA.

K2 or Spice is a mixture of herbs and spices that is typically sprayed with a synthetic compound chemically similar to THC, the psychoactive ingredients in marijuana. The chemical compounds typically include HU-210, HU-211, JWH-018, and JWH-073. K2 is commonly purchased in head shops, tobacco shops, various retail outlets, and over the Internet. It is often marketed as incense or fake weed allowing for easy access. The misperception that Spice products are "natural" and therefore harmless has likely contributed to their attractiveness. Plus, the chemicals used in Spice are not easily detected in standard drug tests and the chemicals are changed rapidly.

An emergency ban initiated by the Alabama Department of Public Health on the sale of the designer drug "Spice" went into effect in October of 2011 in Alabama. Then, Alabama State Senate Bill 208 and House Bill 158, often referred to as the "Spice Bills", were passed in 2012. Both laws regulate synthetic marijuana and other similar substances. In February 2011, the Alabama Attorney General's Office issued an emergency order banning mephedrone and

methylenedioxpyrovalerone, the two ingredients in bath salts that are believed to provide a high similar to that produced by cocaine and methamphetamine.

Ivory Wave is an over-the-counter abused substance which is being marketed as bath salts. Abusers can smoke, snort or inject the crystal-like substance which contains several chemicals, including methylenedioxypyrovalerone (MPDV). MPDV is a potent psychoactive chemical which acts as a stimulant. Abuse of this product produces effects similar to cocaine, ecstasy and other illegal drugs; however, the side effects diminish quickly, thus forcing the abuser to take larger quantities in shorter intervals. While this mind altering drug is highly addictive, many abusers stop re-dosing after several uses due to the unpleasant side effects, such as insomnia and paranoia. Ivory Wave is also marketed under other names such as Vanilla Sky, Charge and Sextascy (ADTA).

Synthetic substances that mimic marijuana or other drugs, often referred to as "spice", "bath salts" or various other names, are continuously being created with chemical compounds which had not been identified and/or prohibited as controlled substances under state law.

VULNERABLE/UNDERSERVED POPULATIONS

High Risk Youth

The potential for problematic alcohol and/or other drug use increases as the number of risk factors experienced increases. At the same time, protective factors may reduce the risk of youth engaging in substance use that can lead to substance abuse research shows. The more a program reduces risk factors and increases protective factors, the more it is likely to succeed in preventing substance abuse among children and youth.

RISK/PROTECTIVE FACTOR CHART		
DOMAIN	**RISK FACTOR**	**PROTECTIVE FACTOR**
Individual	• Rebelliousness • 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	• Opportunities for pro-social 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	• Bonding (positive attachments) • Healthy beliefs and clear standards for behavior

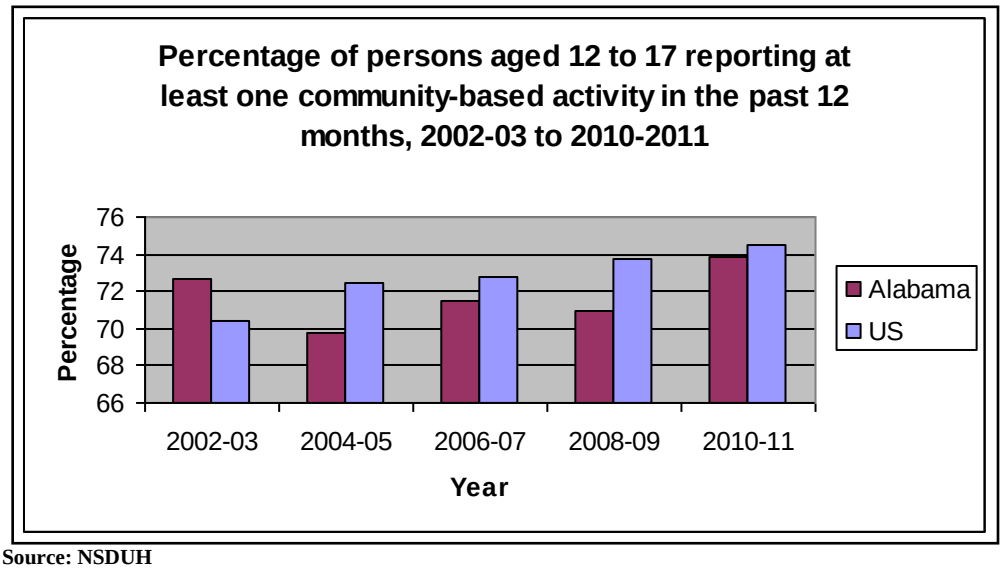
	• Parental attitudes and involvement in the problem behavior	• High parental expectations • A sense of basic trust • Positive family dynamics
School	• Early and persistent antisocial behavior • Academic failure beginning in elementary school • Low commitment to school	• Opportunities for pro-social involvement • 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

In Alabama, 28.2% of persons are under the age of 21 years old. Of the total population, 343,471 persons (7.2%) are 15 to 19 years. (Census 2010). The total fall enrollment in Alabama degree-granting institutions for 2010 was 327,327 students. Enrollment in degree-granting institutions increased by 11 percent between 1990 and 2000. Between 2000 and 2010, enrollment increased 37 percent, from 15.3 million to 21.0 million.

Risk factors associated with a potential increase in substance abuse include poverty, child abuse neglect or abuse, academic problems, and lack of parental involvement. According to data from the Child Welfare League, children in Alabama face many risks:

- In 2010, Alabama had 20,159 total referrals for child abuse and neglect. Of those, 19,900 reports were referred for investigation.
- In 2010, 9,586 children were victims of abuse or neglect in Alabama, a rate of 8.5 per 1,000 children, representing a 15.6% increase from 2009. Of these children, 37.6% were neglected, 50.0% were physically abused, and 22.5% were sexually abused.
- The number of child victims has increased 2.2% in comparison to the number of victims in 2006.
- In 2010, 13 children in Alabama died as a result of abuse or neglect.

- In 2010, 277 children aged out of out-of-home care—exited foster care to emancipation—in Alabama.
- In 2010, 21,000 Alabama teens ages 16–19 were not enrolled in school and were not working.
- In 2010, 101,000 young adults ages 18–24 were not enrolled in school, were not working, and had no degree beyond high school.
- In 2008, approximately 14,000 children ages 12–17 in Alabama needed but had not received treatment for illicit drug use in the past year.



Source: NSDUH

The overall graduation percentage for Alabama is 75% and the dropout percentage is 6% for 2012 according to the Alabama State Department of Education. According to the Census's Small Area Income and Poverty Estimates, 25.8% of persons aged 5 to 17 live in poverty which is significantly higher than 20.8% in the US. In addition, suicide is third leading cause of death among young (15-24) Americans. In Alabama, 82 youth suicides occurred in 2011, and more than 90% were males of all races (ADPH).

Protective factors associated with lessen the likelihood of substance abuse includes parental involvement, involvement in activities, and religious beliefs influence. In 2010-2011, 73.9% of persons aged 12 to 17 reported at least one community-based activity in the past 12 months and 83.6% in least one school-based activity in the past 12 months.

Military Families

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. 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.

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. 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).

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.

As of September 30, 2012, there were 418,035 Veterans living in Alabama. 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 (20). On February 8, 2010, the Alabama National Guard had 515 soldiers deployed overseas. In 2010 the Alabama National Guard reported three (3) completed suicides.

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.

Alabama's public substance abuse service delivery system admitted 840 veterans in 2012 as indicated below.

Veteran Status	Alabama Treatment Admissions
Military Dependent	8
Veteran	840
Currently on Active duty	19
Previously on Active Duty	122
Total Admissions	21,550

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 in the past year One quarter of veterans aged 18 to 25 met the criteria for substance use disorder 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 There was no difference in substance use disorder between male and female veterans (7.2 vs. 5.8 percent) (The NSDUH Report, 2007).

According to TEDS data for 2010 for veterans aged 21 to 39, there were 17,641 admissions. This is an age group that includes veterans with relatively recent service in the US. Veteran admissions were more likely than nonveteran admissions to report alcohol as their primary substance of abuse (50.7 vs. 34.4 percent) and were less likely to report heroin as the primary substance of abuse (9.0 vs. 16.8 percent). Other Opiates (12.2%) and marijuana (12.2%) is second behind alcohol followed by cocaine/crack (6.3%) and methamphetamine (6.2%).

The 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.

Racial/Ethnic Minorities

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. Nearly 5 % of the state's population report they speak a language other than English at home. 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.

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**

Data from ASAIS indicates the top 3 primary substances used and the number of admissions to treatment in 2012 for minority races in Alabama are as follows:

- African-Americans - Marijuana/Hashish (2619), Alcohol (2195), Cocaine/Crack (1410)
- Asians - Marijuana/Hashish (14), Alcohol (7), Methamphetamine (6)
- American Indian/Alaska Native: Alcohol (26), Marijuana/Hashish (13), Methamphetamine (10), Other Opiates and Synthetics (10)
- Native Hawaiian/Other Pacific Islander: Marijuana/Hashish (2), Alcohol (1), Other Opiates and Synthetics (1)

The findings of the Consumer Survey for three populations, Asian/Pacific Islander, Hispanic, and Native American/American Indians merited further exploration of under-utilization of services for Asian Pacific and Hispanics and over-utilization for Native American/American Indians. A Focus Group session was conducted with Asian Pacific in Bayou La Batre and

interviews were held with key informants representing the Hispanic and Native American/ American Indian groups. A summary of the concerns, nature of interview and key informant are presented below:

Focus Group	Findings
Asian/ Pacific Islanders	Barriers to Care included: ▪ Fear of deportation due to Alabama's restrictive immigration law; ▪ Lack of adequate translators; ▪ Lack of knowledge/sensitivity to culture; ▪ Lack of medical providers that know language; ▪ Mental Health /Substance Abuse are taboo in the Asian Pacific culture; ▪ Lack of awareness of available services; ▪ Further outreach efforts that could welcome Asians and Pacific Islanders include: 1. A linguistically and culturally aligned medical provider 2. Advertise behavioral health services by word of mouth.
Hispanics	▪ Fear of deportation due to Alabama's stringent immigration law; ▪ Language barriers; ▪ Cultural stigma; ▪ Lack of awareness; ▪ Lack of insurance; ▪ Lack of advocacy
Native Americans/ American Indian	▪ View of behavioral health is that mental illness and substance abuse issues are frowned upon, but "talking" about the issue is a vital component of therapy; ▪ Lack of cultural sensitivity with outside providers and of "historical trauma"-disconnection with Indian heritage; ▪ Lack of point person to talk to on the State level to espouse more cooperation and progress with regard to raising awareness of healthcare issues the Poarch Band of Creek Indians experience

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". 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." 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." 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.

Individuals Who are Deaf and Hard of Hearing

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 (40).

None of the present evidence-based practices have been adapted or studied for use with the deaf and hard of hearing population. 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
- Materials (videos, workbooks, etc.) that are deaf and hard of hearing-focused

Rural Residents

Of the entire Alabama population 2,031,229 residents or 43.6% live in rural areas. Fifty-five out of 67 counties are considered rural. In many rural communities, substance abuse services are not available. Even when services are available nearby, the social stigma attached to substance use disorders may loom larger in rural areas.

A comparison of Consumer survey data to Treatment Episode Data Set (TEDS) explores the characteristics of rural and urban admissions at substance abuse treatment entry. A comparison explores the following characteristics of rural and urban substance abusers as found in the consumer survey: gender, racial/ethnic composition, employment status, and substances of abuse.

Characteristic	Total N=710	Urban, n=558	Rural, n=240
Gender	**Per Consumer Survey-%**		
Male	59%	56%	45%
Female	40%	43%	54%
Transgender	1%	1%	1%
Race/Ethnicity			
Caucasian/White	67.7%	62%	62%
African American/ Black	25.6%	32%	33%
Hispanic	1.1%	1%	
American Indian / Native American	1.4%	1%	1%
Asian Pacific	0.4%	1%	
Multi-Racial	3.0%	2.3%	4%
Other	0.7%	0.7%	
Age			
12 to 17	5.1%	9%	13%
18 to 25	16.3%	12%	8%
26 to 49	60.8%	52%	52%
50 and Older	17.7%	27%	28%
Employment Status			

Full Time	25.5%	12%	8%
Part Time	7.3%	8%	4%
Not/Working/Disabled	68.6%	72%	84%
Disabled	25.8%	55%	73%
Student	3.0%	3%	2%
Retired	2.4%	5%	2%

Consumer survey results showed almost identical racial composition with more ethnic diversity in urban areas, and rural substance abusers beginning sooner, but after age 25 urban substance abuse and rural substance abuse ages were almost identical. The employment status of not working/disabled (84% vs. 72%) and disabled (73% vs. 55%) is higher in rural areas than urban areas respectively (ADMH Needs Assessment).

Substances abused by rural users were alcohol 30%, marijuana 24%, prescription drugs not prescribed for user at 16%, opiates at 16% inhalant use at 5% and other drugs at 11% including methamphetamines, ecstasy and cocaine. The most frequent poly-substance abuse combination for the rural population was alcohol at 29%, and then marijuana at 25% and prescription drugs not prescribed to the user at 18% (ADMH Needs Assessment).

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%. 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. 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%.

% 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

Pregnant Women and Parenting Women

There are many health-related risks associated with pregnancy in combination with alcohol, tobacco, and other drug use. In Alabama another alarming risk is the potential for imprisonment. With stories appearing in the New York Times and USA today, Alabama has quickly gained a national reputation for its prosecution of pregnant women who use illicit drugs.

More than fifty (50) pregnant women have been arrested since enactment of the state's chemical endangerment law in 2006. Intended to protect children exposed to meth labs, the law makes it a crime, punishable by one (1) to ten (10) years in prison to expose a child to illegal drugs or drug paraphernalia. For the past three (3) years efforts have been put forth in the state legislature to

strengthen this law by expanding the definition of "child" to include unborn children. A challenge to the use of the existing law to prosecute pregnant women was recently defeated when the Alabama Court of Criminal Appeals ruled that the general term "child" in Alabama's chemical endangerment law is broad enough to encompass a "viable fetus."

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 the data below, there has been little change in the number of pregnant women participating in the state's treatment system throughout the years. In addition, Alabama lags behind the nation in such admissions.

# Women Pregnant at Admission to Treatment	2009	2010	2011	2012
Alabama	281	262	267	275

According to the 2011 Pregnancy Risk Assessment Monitoring System (PRAMS) Surveillance Report conducted by the Alabama Department of Public Health, 2.2 % 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. The Division's admission data indicates 11.9 % of the pregnant women admitted to treatment in 2009 identified as IUDs.

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 response services are even more limited as indicated in the table below.

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**

Parenting Individuals

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. 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. In FY 10, Alabama's Child Protection Agency removed 882 children from their homes as a result of child/parent alcohol or drug abuse. 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.

Fathers have an important role in mitigating the effects of parental substance use. From birth, children who have an involved father, including non-custodial fathers, are more likely to be emotionally secure, exhibit better self-control and pro-social behavior, have better educational outcomes, and have lower rates of alcohol and drug use. However, most strategies employed to prevent or intervene on these adverse consequences have been directed toward pregnant women and women with dependent children, as is the case in Alabama's public substance abuse service delivery system.

Individuals With or at Risk for Tuberculosis

Requirements regarding Tuberculosis (TB) as outlined in 45 CFR 96.127, the ADMH SASD ensures that TB services are available and provided to individuals receiving SA treatment. ADMH contractual providers are required by contract 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.

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.

SYSTEM ISSUES

Prevention

Data was collected by ADMH from providers as a part of the prevention system needs assessment conducted in the summer and fall of 2011 concerning service gaps and barriers at the community-level prevention system. Thirty (30) of thirty-two (32) prevention providers that represent the entire State responded to the survey (provider number at time of survey). These providers are representative of all four regions of the state and serve diverse populations. System needs and gaps identified include the following:

- There is a lack of awareness relative to the state prevention system, which often leads to state and local service overlap. Alabama has a prevention infrastructure of which many individuals are not aware, or are uncertain as to its existence and/or function. This includes funding stream awareness.
- There is a state-level need for increased prevention workforce development. Identified gaps in the area of training and technical assistance include SPF-SIG processes, evidence based programs and policies related to the priority, local evaluation and Community-Level Instrument (CLI) data collection, a process for securing and delivering training, and technical assistance to prevention partners.
- Alabama does not have a current state-wide data warehouse in which all data related to

substance abuse in the state resides. Instead, SAMHSA's interactive, web-based data monitoring Behavioral Health Information System (BHIS) is the state's primary resource for substance use/abuse data. Although BHIS provides very useful information, gaps in Alabama data is still a significant problem. State agencies at this time do not submit data to BHIS, but there is the option for the state to require such.

- Alabama has other challenges to contend with concerning data capacity. Limitations to the available data sources hinder identification of some substance abuse prevention needs for some populations. For example, students who attend Alabama public schools are no longer surveyed by the Alabama State Department of Education (ALSDE) PRIDE Survey because of funding cuts.

A 2011 SAMSHA Alabama Substance Abuse Prevention and SYNAR System Review revealed challenges/needs of the service system. These challenges/needs include the following:

- State infrastructure for prevention has been negatively impacted by the loss of State and Federal funds.
- Prevention resources are inadequate for serving all counties, particularly sparsely populated counties.

Treatment

Unmet Service Needs

Alabama's Behavioral Health Needs Assessment defined unmet service need as the number of consumer survey respondents that identified as having a behavioral health issue for which they were not receiving care. According to the survey's results, 5% of survey respondents did not receive mental health services according to their mental health needs, 19% of survey respondents did not receive the substance abuse treatment services according to their substance abuse needs, and 91% of the survey respondents did not receive co-occurring disorder services according to their co-occurring disorder needs.

Treatment Barriers and Gaps

Alabama Behavioral Health Needs Assessment identified the top 3 barriers and gaps identified by consumers for Substance Abuse Treatment. Barrier and gap analysis is critical in determining issues for clients that may lead to unmet service need or to interrupted or incomplete treatment regimens.

Top Three Substance Abuse Treatment Barriers		
Service	**Barrier**	**Gap**
Assessment of issue		
Education to help deal with the issue		
Specialist	**1**	
Emergency placement	**2**	
Outpatient mental health services		
Transportation to/from services	**3**	**2**
After hours or weekend services		**1**
Other: Dental		**3**
Other: Vision		

Recommendations from ADMH's Behavioral Health Assessment

Based on findings from secondary and primary research directed by the goals and objectives outlined in the project plan by the Alabama Department of Mental Health, recommendations were made to address unmet service needs of clients with the aim of reducing unmet need, barriers, and gaps within Alabama's behavioral health delivery system.

These recommendations are summarized below:

1. **Analyze health outcomes to determine return on expenditures** for all (Mental Illness, Substance Abuse-Treatment and Substance Abuse-Prevention).

2. Define the Ideal Behavioral Health Continuum of Care.
   - Prioritize services to create a continuum of care by special population based on the consumer survey results.
   - Develop pathways to care based on continuum of care access points (drug court→ case management →IOP services→ day treatment services→ group therapy).
   - Educate professionals at critical care access points particularly for youth. Professionals that would benefit from education include Pediatricians for substance abuse treatment and Guidance Counselors for mental health treatment.
   - Consider use of system navigators via Case Management for clients with high acuity to reduce Barriers and Gaps in Care (perceived or real).

3. **Define related Workforce Requirements given the Capacity of the Delivery System**
   - Examine creative use of other practitioners including primary care physicians to leverage the national and statewide deficit of psychiatrists
   - Explore statewide development of a behavioral health training curriculum
   - Consider development of a licensing and certification track for front-line behavioral health staff tied to commitments to retention to work in public behavioral health

4. **Funding**
   - Establish a formula-based allocation that encompasses population shifts, special needs and local resources that can assist in handling behavioral health to fairly and consistently allocate reimbursement for substance abuse and mental illness.
   - Communicate the funding formula to the State from SAMHSA and to each region from the State
   - Consider ongoing development of grants infrastructure at the 310 Board level

5. **Information Technology**
   - Ensure total implementation of Electronic Health Records and Tele-health
   - The use of Electronic Health records will boost performance measures and more readily highlight a client's true condition by assisting Case Managers in unearthing unmet service needs.

6. **Barrier Reduction or Elimination**

- Examine barriers and gaps and means for client to see Specialists, access Transportation to and from services and for non-English speaking clients to access a translator or interpreter.
- Work with Federally Qualified Health Centers (FQHC's) to treat behavioral health clients after hours and weekends, which was the top Gap(defined as a Service that is Needed but Not Available) overall for Substance Abuse Treatment clients and for six of the sixteen special populations.

7. **Showcase and Replicate Best Practices**
   - Encourage sharing of best practices and collaboration in establishing programs that address new threats to mental health and/or substance abuse treatment and prevention. For example some 310 Board agencies and some substance abuse facilities show great client awareness of substance abuse prevention and services. Replicate these efforts to agencies that are not getting the substance abuse prevention message out efficiently.

8. **Increase Awareness of Services**
   - Promote available services targeting those services relevant to special populations, e.g. Priority admission for Pregnant Women to Pregnant Women and Translation and Interpretation Services for non-English speaking prospective clients.

9. **Increase Access to Services**
   - Recruit Asian speaking and Hispanic primary medical caregivers and promote care that is not tied to citizenship. Establish Hispanic Alcohol and Narcotic Anonymous groups that are linguistically and culturally in tune with their clients.
   - Connect Alabama mental health personnel with Native American/American Indian groups to tailor mental health classes in a historic, cultural framework.

10. **Reduce Unmet Service Needs outlined in the client and provider findings**
    - As mentioned in Action Point #5, use Electronic Health records to more readily highlight a client's true condition by assisting Case Managers in unearthing unmet service needs.

    - Streamline intake questions and focus on unearthing the client's true behavioral health issues and coordinate the intake survey to cover mental health and substance abuse issues in the same evaluation appointment.

Others:

1. Integrate mental health and substance abuse services through the 310 Boards.
2. Leverage local inpatient resources to serve acute care needs of local communities
3. Expand the definition of qualified non-physician practitioners to address workforce shortages
4. Implement a comprehensive public reporting process on the performance of mental health and substance abuse contractors
5. Redesign outcome measures to align them with national best practices

ADMH 2014 SABG PRIORITIES

Based upon review and analysis of findings of the Alabama Epidemiological Workgroup and the ADMH's Behavioral Health Needs Assessment, recommendations of the State Prevention Advisory Board, the Needs Assessment Guiding Council, and ADMH's Substance Abuse Coordinating Subcommittee, the Substance Abuse Services executive staff reached consensus on the following priorities for the FY 14 - FY15 SABG. These priorities are representative of some of the state's most critical needs, and provide ADMH with the opportunity to enhance the lives and well-being of thousands of Alabamians impacted by the use of alcohol, tobacco, and other drugs.

1. **UNDERAGE DRINKING**

   Unmet Need / Gap: The Alabama Epidemiological Outcomes Workgroup has worked diligently on state Epidemiological profiles for the past four (6) years. Data clearly indicates Alabama's 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.

2. **IV DRUG USE**

   Unmet Need/Gap: Although substance abuse treatment for IDU supports efforts to prevent the spread of blood borne infections, there continues to be 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 the rapidly rising use of heroin in the state, along with Alabama's treatment admission rate for IDUs at nearly 50% less than the national rate, strategies to more adequately engage this population are needed.

3. **TUBERCULOSIS SERVICES**

Unmet Need/Gap: (revise) Effective June 1, 2011, the Alabama Department of Public Health informed ADMH 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 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.

4. PREGNANT AND PARENTING WOMEN

Unmet Need / Gap: REVISE In 2011 there were 59,322 live births in Alabama. In order to combat both the potential health related consequences of drug use and pregnancy, along with the impact of actions in the state to criminalize pregnant women who have substance use disorders, the need exists to develop and implement strategies to strongly promote the efficacy and availability of treatment, and to improve service accessibility, and to establish sustainable, gender responsive services. These efforts will also support closure in the gap between Alabama's rate of service for this population and that of the country as a whole.

5. PARENTING MEN

Unmet Need/Gap: In 2012, over 15,000 men received substance abuse treatment in programs funded by ADMH. The agency does not currently have data on how many of these men are parents with children under age eighteen (18). It is known that none of these men receive education, training, and skill development that link parental substance abuse with the prevention of mental, emotional, and behavioral disorders in their children. This is not only a significant gap in Alabama's service delivery system, but also a tremendous opportunity to make a significant, long-term impact on the lives of Alabama's children.

6. MILITARY FAMILIES

Unmet Need / Gap: In 2012, Alabama's public substance abuse service delivery system admitted only 840 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 value of the service members to this country cannot be underscored. 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.

7. VULNERABLE/UNDERSERVED POPULATIONS

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. Strategies to eliminate the disparities in access to care for minority populations, people in need of language assistance, and individuals living in rural Alabama of must be employed.

The needs of rural residents is also of great concern. Alabama is 23rd in population among the 50 states that have over four million residents. Almost half of this population is deemed to be rural. 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.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

#	Priority Area	Priority Type	Population	Action
1	Underage Drinking	SAP	Other	View

#	Performance Indicator	
1	The number of ADMH providers identifying underage drinking as a priority for prevention strategies.	View

#	Priority Area	Priority Type	Population	Action
2	Intravenous Drug Use	SAT	IVDUs	View

#	Performance Indicator	
1	Increase the number of IVDUs accessing treatment	View
2	Increase in number of ADMH certified facilities in full compliance with outreach requirements for IVDUs.	View
3	Increase in number of ADMH certified facilities offering interim services to IVDUs.	View
4	Increase in number of ADMH certified contract facilities using technology (texting, skyping, apps, etc.) in the provision of substance abuse services for IVDUs.	View
5	Increase in the number of IVDU's who receive opiate maintenance therapy in combination with other treatment modalities.	View

#	Priority Area	Priority Type	Population	Action
3	Tuberculosis Services for Individuals Enrolled in Substance Abuse Treatment Programs	SAT	TB	View

#	Performance Indicator	

	1	ADMH Contract Providers will be in full compliance with SABG Tuberculosis requirements (45 CFR 96.127)		View
4	Pregnant and Parenting Women	SAT	PWWDC	View
	#	Performance Indicator		
	1	Consumer satisfaction with the quality of care offered to pregnant women and parenting women receiving substance abuse treatment.		View
	2	The establishment of quality metrics for programs serving pregnant women and women with dependent children.		View
5	Parents of Underage Children	SAT	Other	View
	#	Performance Indicator		
	1	The number of men admitted to substance abuse treatment and participate in parenting training.		View
	2	The number of parents admitted to substance abuse treatment programs who have underage children and receive parenting education during a treatment episode.		View
6	Military Families	SAT	Other	View
	#	Performance Indicator		
	1	Increase in number of veterans and their families accessing treatment services.		View
	2	Increase in number of ADMH certified contract facilities that offer veterans and veterans' family specific services, including trauma specific services.		View
7	Vulnerable/Underserved Populations	SAT	Other	View
	#	Performance Indicator		

	1	The establisment of a fully functioning Cultural Competency Advisory Workgroup	View

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$33,621,076		$16,673,262	$98,822	$24,421,690	$	$1,472,916
a. Pregnant Women and Women with Dependent Children*	$4,795,716						
b. All Other	$28,825,360		$16,673,262	$98,822	$24,421,690		$1,472,916
2. Substance Abuse Primary Prevention	$8,965,620			$3,160,974			
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$2,241,406			$335,228	$2,269,174		
11. Total	$44,828,102	$	$16,673,262	$3,595,024	$26,690,864	$	$1,472,916

* Prevention other than primary prevention

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$6,225
Specialized Outpatient Medical Services	0	0.00	$
Acute Primary Care	0	0.00	$
General Health Screens, Tests and Immunizations	0	0.00	$
Comprehensive Care Management	0	0.00	$
Care coordination and Health Promotion	122	255.00	$6,225
Comprehensive Transitional Care	0	0.00	$
Individual and Family Support	0	0.00	$
Referral to Community Services Dissemination	0	0.00	$
Prevention (Including Promotion)			$
Screening, Brief Intervention and Referral to Treatment	0	0.00	$

Brief Motivational Interviews	0	0.00	$
Screening and Brief Intervention for Tobacco Cessation	0	0.00	$
Parent Training	0	0.00	$
Facilitated Referrals	0	0.00	$
Relapse Prevention/Wellness Recovery Support	0	0.00	$
Warm Line	0	0.00	$
Substance Abuse (Primary Prevention)			$5,608,100
Classroom and/or small group sessions (Education)	25000	40159.00	$1,152,981
Media campaigns (Information Dissemination)	100000	9973.00	$127,750
Systematic Planning/Coalition and Community Team Building(Community Based Process)	35000	16385.00	$225,734
Parenting and family management (Education)	12500	20000.00	$576,490
Education programs for youth groups (Education)	12500	20000.00	$576,490
Community Service Activities (Alternatives)	15000	47142.00	$1,739,232
Student Assistance Programs (Problem Identification and Referral)	500	705.00	$10,815
Employee Assistance programs (Problem Identification and Referral)	0	0.00	$

Community Team Building (Community Based Process)	0	0.00	$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)	100000	57642.00	$1,198,608
Engagement Services			$2,466,531
Assessment	21246	25021.00	$2,391,318
Specialized Evaluations (Psychological and Neurological)	135	459.00	$38,207
Service Planning (including crisis planning)	801	1316.00	$23,804
Consumer/Family Education	126	1586.00	$13,202
Outreach	0	0.00	$
Outpatient Services			$2,599,418
Evidenced-based Therapies	11460	47471.00	$1,642,183
Group Therapy	900	34615.00	$331,062
Family Therapy	1045	20292.00	$548,827
Multi-family Therapy	238	4800.00	$72,594
Consultation to Caregivers	95	250.00	$4,752
Medication Services			$671,205

Medication Management	150	7642.00	$88,141
Pharmacotherapy (including MAT)	173	63036.00	$583,064
Laboratory services	0	0.00	$
Community Support (Rehabilitative)			$183,626
Parent/Caregiver Support	0	0.00	$
Skill Building (social, daily living, cognitive)	425	48899.00	$183,626
Case Management	0	0.00	$
Behavior Management	0	0.00	$
Supported Employment	0	0.00	$
Permanent Supported Housing	0	0.00	$
Recovery Housing	0	0.00	$
Therapeutic Mentoring	0	0.00	$
Traditional Healing Services	0	0.00	$
Recovery Supports			$144,246
Peer Support	266	25884.00	$144,246
Recovery Support Coaching	0	0.00	$

Recovery Support Center Services	0	0.00	$
Supports for Self-directed Care	0	0.00	$
Other Supports (Habilitative)			$
Personal Care	0	0.00	$
Homemaker	0	0.00	$
Respite	0	0.00	$
Supported Education	0	0.00	$
Transportation	0	0.00	$
Assisted Living Services	0	0.00	$
Recreational Services	0	0.00	$
Trained Behavioral Health Interpreters	0	0.00	$
Interactive Communication Technology Devices	0	0.00	$
Intensive Support Services			$16,398,864
Substance Abuse Intensive Outpatient (IOP)	15134	887452.75	$16,397,368
Partial Hospital	0	0.00	$

Assertive Community Treatment	0	0.00	$
Intensive Home-based Services	26	81.00	$1,496
Multi-systemic Therapy	0	0.00	$
Intensive Case Management	0	0.00	$
Out-of-Home Residential Services			$11,412,883
Children's Mental Health Residential Services	0	0.00	$
Crisis Residential/Stabilization	3175	58603.00	$6,520,796
Clinically Managed 24 Hour Care (SA)	2212	9082.00	$3,643,322
Clinically Managed Medium Intensity Care (SA)	376	15558.00	$1,248,765
Adult Mental Health Residential	0	0.00	$
Youth Substance Abuse Residential Services	0	0.00	$
Therapeutic Foster Care	0	0.00	$
Acute Intensive Services			$1,855,151
Mobile Crisis	0	0.00	$
Peer-based Crisis Services	0	0.00	$

Urgent Care	0	0.00	$
23-hour Observation Bed	0	0.00	$
Medically Monitored Intensive Inpatient (SA)	1348	8989.00	$1,855,151
24/7 Crisis Hotline Services	0	0.00	$
Other (please list)			$

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$17,194,549	
2 . Substance Abuse Primary Prevention	$4,585,214	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	$1,146,303	
6. Total	$22,926,066	

* Prevention other than primary prevention

** HIV Early Intervention Services

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$229,261	
	Selective		
	Indicated		
	Unspecified		
	Total	$229,261	
Education	Universal	$552,059	
	Selective	$641,930	
	Indicated	$89,870	
	Unspecified		
	Total	$1,283,859	
Alternatives	Universal	$77,031	
	Selective	$660,272	
	Indicated	$363,149	
	Unspecified		
	Total	$1,100,452	
Problem Identification and Referral	Universal		
	Selective		
	Indicated	$91,704	
	Unspecified		

	Total	$91,704	
Community-Based Process	Universal	$229,261	
	Selective		
	Indicated		
	Unspecified		
	Total	$229,261	
Environmental	Universal	$1,650,677	
	Selective		
	Indicated		
	Unspecified		
	Total	$1,650,677	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Total Prevention Expenditures	$4,585,214		
Total SABG Award*	$22,926,066		
Planned Primary Prevention Percentage	20.00 %		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$637,344	
Universal Indirect	$2,109,198	
Selective	$1,311,372	
Indicated	$527,300	
Column Total	$4,585,214	
Total SABG Award*	$22,926,066	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	þ
Heroin	þ
Inhalants	þ
Methamphetamine	þ
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	þ
Military Families	þ
LGBTQ	þ
American Indians/Alaska Natives	þ
African American	þ
Hispanic	þ
Homeless	þ
Native Hawaiian/Other Pacific Islanders	þ
Asian	þ
Rural	þ
Underserved Racial and Ethnic Minorities	þ

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$	$	$					
2. Quality Assurance	$	$	$25,000	$25,000				
3. Training (Post-Employment)	$	$	$50,000	$50,000				
4. Education (Pre-Employment)	$	$	$					
5. Program Development	$	$	$50,000	$50,000				
6. Research and Evaluation	$	$	$					
7. Information Systems	$	$	$100,000	$100,000				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$	$350,000	$350,000				
9. Total			$575,000	$575,000				

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

- 1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

  The State of Alabama has opted out of Medicaid expansion and the operation of a state-run Marketplace. In addition, the public has not yet been informed of the benefits to be offered by QHP's in Alabama's federally operated Marketplace.

  Although, the Alabama Medicaid Agency is in the process of transformation from a fee-for-service system to a system of care managed by entities called Regional Care Organizations, Medicaid Rehabilitation Option Services (ROS) benefits for individual who have mental illness and substance use disorders remain intact at the current time. The following Table 3 services will be covered for substance use disorders under Medicaid's ROS on January 14, 2013. Yet, it is important to note that (1) no Medicaid eligibility changes will take place for Alabamians on January 1, 2014, and (2) Alabama's Medicaid eligibility criteria for the general population are among the most stringent in the nation. Thus, no significant changes are expected in regard to access to the available ROS services.

Table 3 Services Available in Alabama on January1, 2014

Assessment	Family Therapy	Skill Building
Specialized Evaluations	Multi-Family Therapy	Transportation
Consumer/Family Education	Medication Management	Substance Abuse Intensive Outpatient
Group Therapy	Pharmocotherapy	Individual Therapy

- 2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

  No

- 3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

  Any monitoring responsibilities in regard to activities of the QHPs falls within the authority of the Alabama Department of Insurance.

- 4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

  At the present time, ADMH will only be involved if authorized by the Governor, and if assistance by the Alabama Department of Insurance and/or Attorney General is needed in this regard.

- 5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

  Changes will depend upon the EHB package to be offered in Alabama, which remains unknown at this time.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Health Insurance Marketplaces

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

- 1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

  ADMH's plans to address this issue are currently under development.

- 2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

  ADMH has established an internal health care reform workgroup that has monitored implementation of the Patient Protection and Affordable Care act since its enactment. The efforts of this group have strengthened ADMH's partnership with the Alabama Department of Insurance, the Alabama Medicaid Agency, and staff of the Governor's office in regard to promotion of the needs of individuals who have behavioral health conditions. Members of this workgroup, including members of the SA staff, and the Alabama Medicaid agency have established a routine monthly meeting to discuss behavioral health concerns in regard to Medicaid transformation.

  SA staff has participated in each of CMS' Alabama specific stakeholder calls in regard to the operation of the federally operated Marketplace in the state. Information gained from these calls has been routinely disseminated to ADMH providers. Plans are under development to insure that each provider (1) utilizes the resources of the state's Navigators to reach individuals who have behavioral health disorders, and (2) selects staff to receive training and designation as Certified Application Counselors.

- 3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

ADMH will incorporate requirements for providers to (1) screen each admission for eligibility for Medicaid, CHIP, or enrollment in a QHP; to maintain staff trained as Certified Application Counselors; and to assist with enrollment, and bill Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services. ADMH will monitor this process through its review of data generated by ASAIS, as well as through a routine fiscal monitoring process that is currently under development.

- 4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

ADMH will secure the requirements for enrollment in the networks, when the QHPs are made known to the public in Alabama. That information is not currently available.

ADMH will assist providers in establishing and maintaining eligibility to participate in QHP networks through information dissemination, training, and technical assistance.

- 5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

From 2009 thru 2012 an annual average of 18,700 individuals were admitted to ADMH funded programs, received an assessment, and at least one other substance abuse treatment service. According to 1992-2010 Treatment Episode Data retrieved from the Substance Abuse and Mental Health Services Data Achieves (SAMHDA), 71.2% of treatment admissions reported for Alabama had no insurance. Assuming the average number of admissions and an uninsured rate as reported by SAMHDA, a total of 13,314 individuals served by the SABG would be uninsured in 2013.

- 6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

SAMHDA estimates indicate, on average, 33% of the individuals admitted to treatment in Alabama from 1992 – 2010 were employed. Making the broad assumption that 33% of the 71.2% reported as uninsured by SAMHDA would now qualify for health insurance in the Marketplace, results in approximately 8,920 individuals remaining uninsured in CY 2014 and CY 2015.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

Alabama's substance abuse treatment providers who wish to provide services for Medicaid recipients must be enrolled through ADMH. Thus ADMH can provide an accurate count of the entities from Table 8 that are currently enrolled in the state's Medicaid program. Twenty-eight (28) of the forty (40) providers listed in Table 8 are currently enrolled as Medicaid providers.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Encounter/utilization/performance analysis; and
    f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

- 1. Does the state have program integrity plan regarding the SABG and MHBG?

  A program integrity plan is currently under development by ADMH.

- 2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

  Although ADMH does not currently have a specific staff person responsible for program integrity, multiple processes and procedures have been implemented to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. The ultimate responsibility for program integrity is vested with ADMH’s Executive Management Team made up of the Commissioner, Associate Commissioner of Mental Health and Substance Abuse Services, Associate Commissioner of Administration, Director of Development, Director of Financial Management, Director of Performance Improvement, Director of Information Technology, and Director of Contracts and Grants. However, ultimately all ADMH staff share responsibility for insuring integrity. As ADMH moves to develop a formal program integrity plan for the SABG, the roles and responsibilities of all involved will be clearly defined and clarified.

- 3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
  a. Budget review;

     No

  b. Claims/payment adjudication;

     Yes. All payments of SABG funds made to providers are based upon fee for service claims. Provider claims are submitted to ADMH electronically through the Alabama Substance Abuse Management Information System (ASAIS), where the claims are reviewed electronically for payment eligibility, and for payment if the claims are deemed appropriate. ASAIS assigns each client a unique identifier upon enrollment and has a number of rules set up within the system that will cause a denial if the claim is not properly submitted.

  c. Expenditure report analysis;

     No. The ADMH Substance Abuse Information System (ASAIS) generates a number of clinical and financial reports, but ADMH does not currently conduct an analysis of provider expenditures reports.

  d. Compliance reviews;

     Yes. Program compliance monitoring reviews are conducted by Substance Abuse (SA) Services Staff which specifically address provider adherence to Federal requirements outlined in the SABG. These reviews are conducted annually with all SA contract providers and follow-up visits are conducted in the event a provider is found to be noncompliant. Providers are required to submit an action plan within thirty (30) days from the date of receiving the survey report for any sited findings of noncompliance.

  e. Encounter/utilization/performance analysis;

     Payment for services requires submission of client encounter and performance data to ASAIS. This data is used to monitor retention, length of stay, evidence-based practices and best practices, number of admissions, number of discharges, number of dropouts, number of successful completions, number of individuals on waiting list and number of days individuals remain on waiting list prior to admission. SA providers are required to review and appropriately respond to reports of deficiencies, requirements, and performance improvement recommendations received from ADMH monitoring reviews, ADMH certification reviews, patient advocacy visits, and/or from any other funding, auditing, regulatory, or accrediting bodies.

     ADMH also monitors data submitted by contract providers for the National Outcome Measures (NOMS): completed treatment, left treatment against advice, employment status, education status, abstinence, criminal justice activity, and social support.

f. Audits.

Yes. ADMH audit requirements are as follows:

Each entity that expends $100,000 or more of Federal financial assistance or other funds obtained from/through ADMH during a fiscal year may be required to have an audit performed at its own expense. Such audits shall be performed by an independent auditor (i.e., a CPA, a CPA firm, or the Alabama Department of Examiners of Public Accounts).

Not-for-Profit Entities and 310 Boards:

(1) Non-federal entities that expend $500,000 or more in a year in Federal awards (excluding Medicaid funding which are contracts for services and not federal financial assistance) shall have a Single Audit or Program Specific Audit conducted for that year in accordance with OMB Circular A-133, and any/all subsequent revisions or amendments.

(2) Non-federal entities that expend less than $500,000 in Federal awards, but expend $500,000 or more of any combination of funds (including Medicaid funding) obtained through DMH during a fiscal year, shall have an audit for that year that is in accordance with Government Auditing Standards ("Yellow Book").

(3) Any non-for-profit entity that expends $100,000 or more of any type of funds obtained through ADMH during a fiscal year shall have an audit for compliance with the ADMH contract, grant, or agreement, Provider Agreement (if any), and applicable Federal, State, and ADMH laws, regulations, and policies for that year.

310 Boards. All 310 Boards shall submit, at a minimum, an audit in accordance with Government Auditing Standards ("Yellow Book"). These audits must first be submitted to the State of Alabama Examiners of Public Accounts for review and release. These audits shall be in compliance with guidelines published by the State of Alabama, Examiners of Public Accounts and the ADMH Audit Guidelines.

For-profit entities are normally considered vendors. Although such entities will usually not be required to have an audit under ADMH's Audit Guidelines, such entities shall comply with ADMH's Records Retention Requirements.

OMB Circular A-133 also requires ADMH to establish requirements to ensure program compliance by for-profit subrecipients. This may include pre-award audits, monitoring during the contract/grant/agreement, and/or post-award audits. Unless the Federal Legislation that established the activity/program exempts the funding from audit/review, other ADMH rules specified in Sections 10, and 12 through 20 of its **Audit Guidelines** also shall apply when $300,000 or more is paid through ADMH to a for-profit subrecipient entity during the entity's fiscal year. As such, an audit for compliance may be required to be submitted to ADMH by for-profit subrecipient entities in this situation.

Entities that expend less than $100,000 obtained from/through ADMH. These entities shall not be required to have an audit. However, ADMH reserves the right to perform on-site reviews and/or have ADMH funds audited (including matching funds) if deemed necessary by means and requirements deemed appropriate by ADMH. Such entities must comply with the record retention requirements described in Section 5 of ADMH's **Audit Guidelines.**

- 4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

ADMH establishes and manages standard fee for service rates for all allowable substance use disorders treatment and recovery support services. Service rates are established based on SA's rate setting methodology developed as a result of technical assistance provided by SAMHSA, along with national reimbursement models.

- 5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

ADMH has statutory responsibility for establishing standards of care for the delivery of substance abuse services in Alabama. The standards of care are published in the Alabama Administrative Code as program certification regulations. The certification regulations are developed and maintained on the basis of state of the art standards of practice for substance abuse prevention and treatment. ADMH also maintains rigorous regulations for facility safety.

To become a state SA provider an entity must be certified by ADMH. This is a multi-level process that begins with a potential applicant being required to attend a day long orientation class facilitated by ADMH. This class is to educate the applicant about ADMH and to provide information about the process of what is required to become a certified provider. It is stressed to the applicant from the beginning that in order to become a certified provider they must comply with a variety of quality of care and safety standards. ADMH onsite technical assistance is also available to the applicant throughout the entire process. Before an applicant can become certified to provide SA services, the building in which these services will be delivered must pass a life safety inspection. A life safety inspection is conducted annually at all certified programs with the exception of residential programs, which are inspected bi-annually.

ADMH assists providers in complying with program certification regulations through the provision of training, conducting certification and life safety inspections, conducting SABG monitoring reviews, and providing technical assistance upon request. Throughout the year the network of SA providers have the opportunity to receive training from ADMH staff on service documentation, best treatment and prevention practices, and recovery oriented service delivery.

- 6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

  ADMH's Management Information System, (ASAIS) is designed to monitor the proper use of SABG funds, as well as state funds and payments received from Medicaid. All SABG, state, and Medicaid claims for payment of services provided by ADMH contract providers are adjudicated by ASAIS. A number of business rules built into ASAIS help to prevent inappropriate payments. As a contractual requirement, providers are to consider ADMH as a "payer of last resort" for behavioral health services. With technical assistance provided by SAMHSA, ADMH is currently developing formal policies and procedures to enhance fiscal monitoring of providers to further insure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and for services that are not covered by private insurance and/or Medicaid.

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

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- 1. Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

  No, for prevention and treatment services.

  For prevention services, providers are required to submit their evidence based program/practice in its prevention plan, within the planning section, as well as within the education strategy. Thus, there is the ability for ADMH to track at that level although a specific staff member is not responsible for this tracking or for disseminating.

- 2. Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

  Yes, for prevention and treatment services.

  a) What information did you use?

  ADMH requires the use of evidence-based or promising practices for program certification as well as for continued funding.

  b) What information was most useful?

  - Demonstrated effectiveness.
  - Costs associated with implementation of the practice.
  - Populations for which the practice has been demonstrated to be effective.
  - Cost of maintaining fidelity to the practice.

  3) How have you used information regarding evidence-based practices?

  - To respond to numerous inquiries and surveys from our national partners and within the NPN.
  - To advocate for use of a service methodology.

  a) Educating State Medicaid agencies and other purchasers regarding this information?

  - . As a quality indicator.

b) Making decisions about what you buy with funds that are under your control?

- Yes. For prevention services, if a provider attempts to administer an education strategy and does not have an EBP, execution of that strategy will not be permitted and the provider will not receive funds.
- All ADMH Requests for Proposals for substance abuse prevention and treatment services require the use of evidence-based practices.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
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Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
  - Increase in high school graduation rate by county (prevention).
  - Reduction in wait time between initial program contact and admission to treatment (treatment).
  - Client satisfaction with service delivery (prevention and treatment).
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
  - Graduation rates by county will be determined through data provided to the ADMH by the Alabama State Department of Education.
  - Data entered into ASAIS by providers will identify the initial client contact for screening, as well as, the date of admission to treatment.
  - Client satisfaction surveys will be administered on a scheduled basis at provider locations and submitted to ADMH for evaluation and dissemination of findings.
- 3) What are your states specific priority areas to address the issues identified by the data?
  - Preventing adverse consequences for high risk youth.
  - Improving access to care for programs funded by ADMH.
  - Maintenance of high levels of client satisfaction within the ADMH service delivery system.
- 4) What are the milestones and plans for addressing each of your priority areas?
  - Plans and milestones to address priority areas are currently under development.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

- 1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

  While the state does not have a specific policy directing providers to screen for a personal history of trauma, certified agencies are required to use the state approved Adult or Adolescent ASAM Integrated Placement Assessment. In Dimension 3 of this Assessment, Emotional/Behavioral/Cognitive Conditions and Complications, there are a series of questions related to trauma which include the following: 1) as a child, were there any serious physical injuries or mental illnesses causing trauma; 2) have you ever been the victim of abuse (with follow up questions); and 3) have you ever been the perpetrator of abuse (with follow up questions). Follow up questions include information on the type of abuse that occurred, whether it was reported and to whom, and was any intervention received. The assessor may also indicate if there is a need for further assessment regarding the trauma. There are also questions related to family and interaction with family members which can lead to a disclosure of trauma issues.

  In addition to the ASAM Integrated Placement Assessment, some agencies do use a more specific screening tool. Some of the tools used by different agencies include the Mini-International Neuropsychiatric Interview (M.I.N.I), Trauma Inventory, and Mental Health Screening Form III (MHSF-III).

- 2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

  Agencies are required to have a process to provide client access to support services and to psychological services, on site or through consultation. Any agency that provides services to women and dependent children must be able to document their capacity to provide specific services which address issues of abuse and trauma. They must also be able provide therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

- 3. Does your state have any policies that promote the provision of trauma-informed care?

  The Alabama Department of Mental Health promotes the use of SAMHSA’s Implementation of a Good and Modern Service System. As part of the strategies from the previous years, the state has developed a survey as a way to allow providers to self assess if their internal policies and procedures are supportive of the needs of trauma survivors. An average of 60%

of certified women's service providers report that trauma informed care has been integrated into their treatment protocols.

In addition, ADMH's policies support the basic principles of a trauma-informed care which include, but are not limited to: empowerment, voice and choice, safety, peer support, mutual self help and resilience, and strengths based care. The Alabama Department of Mental Health, Substance Abuse Services, Administrative Code: March 2012, requires providers to have written documentation of a Performance Improvement System. Components of the system must include Consumer and Family Satisfaction along with opportunities for clients and family members to provide meaningful input (voice and choice, empowerment). In the Individual Service Planning Process, agencies are required to develop a service plan in partnership with the client and the client is be provided with the opportunity to involve family or significant others in that process (voice and choice, empowerment). The service plans are also required to representative of the client's strengths, needs, abilities and preference (resilience and strengths based, empowerment). As part of the Continuing Stay Criteria, agencies must consider a client's preference when it comes to a need for a client's continued services (voice and choice, empowerment). As part of the Levels of Care, agencies must demonstrate the capacity to provide certain core services. Part of those core services include peer counseling services and recovery support services (peer support and mutual self help). They must also offer mutual self help groups that are tailored to the needs of the specific client population they serve (peer support and self help). Service strategies must also include interpersonal choice and decision making skill development (voice and choice, empowerment). Each agency must also incorporate a "welcoming policy" into the agency's philosophy and mission statement and demonstrate implementation of this policy through staff training, business and clinical practice and performance improvement efforts (safety). The purpose of this policy is to establish a welcoming, accessible, culturally and linguistically competent system of care for all.

- 4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

There are several evidenced-based trauma specific interventions that are offered at different agencies across the state. Currently only a small percentage of agencies, other than the special women's services providers, offer a trauma specific intervention. Most of the agencies use one of the following models:

Seeking Safety is designed to be a therapy for trauma, post-traumatic stress disorder (PTSD), and substance abuse. It is designed to be used with individuals or with groups, with men, women, or with mixed-gender groups, and can be used in a variety of settings (e.g. outpatient, inpatient, residential). The key principles of Seeking Safety are safety as the overarching goal, integrated treatment, a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse, knowledge of four content areas (cognitive, behavioral, interpersonal, and case management), and attention to clinician processes.

The Essence of Being Real model is a peer-to-peer structure intended to address the effects of trauma. The developer feels that this model is particularly helpful for survivor groups

(including abuse, disaster, crime, shelter populations, and others), first responders, and frontline service providers and agency staff. This model is appropriate for all populations and it is geared to promoting relationships rather than focusing on the "bad stuff that happened."

Risking Connection is intended to be a trauma-informed model aimed at mental health, public health, and substance abuse staff at various levels of education and training. There are several audience-specific adaptations of the model, including clergy, domestic violence advocates, and agencies serving children. Risking Connection emphasizes concepts of empowerment, connection, and collaboration. The model addresses issues like understanding how trauma hurts, using the relationship and connection as a treatment tool, keeping a trauma framework when responding to crisis such as self-injury and suicidal depression, working with dissociation and self-awareness, and transforming vicarious traumatization.

Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatment programs that, when combined, serve women in criminal justice or correctional settings who have substance use disorders and are likely to have co-occurring trauma histories (i.e., sexual or physical abuse). Helping Women Recover and Beyond Trauma sessions use cognitive behavioral skills training, mindfulness meditation, experiential therapies (e.g., guided imagery, visualization, art therapy, movement), psychoeducation, and relational techniques to help women understand the different forms of trauma, typical reactions to abuse, and how a history of victimization interacts with substance use to negatively impact lives. The community version of this intervention has been delivered in residential and outpatient substance abuse treatment settings, mental health clinics, and domestic violence shelters.

- 5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Each year, the Alabama School of Alcohol and Drug Studies (ASADS) holds a conference that provides a quality educational experience designed to enhance both professional growth and job performance. ADMH has representation on the ASADS' Board, assists in planning, and offers scholarships to ASADS to ensure that providers can send a large number of clinicians and non-clinicians. Trauma counselors, substance abuse treatment staff, and professionals from related disciplines are specifically invited to attend. Some of the classes offered in 2013 included An Overview of Cognitive Processing Therapy for PTSD; Updated Strategies for the Treatment of Co-Occurring Substance Use and Mental Health Disorders in Adults; Meeting Your Client Where They Are: Service Driven Case Management; Treatment of Trauma and Anxiety Related Symptoms; Addiction Survival and Resiliency (Trauma Specific); Lesbian, Gay, Bisexual, Transgender (LGBT) and Behavioral Health Issues; Mental Health First Aid; and Post-Traumatic Stress Disorder and the Traumatic Brain Injury in the Returning Veteran Population.

In addition, the Alabama Department of Mental Health also offers free trainings which are open to all providers and change agents in the community. ADMH responds to requests from

providers on the types of trainings they would like to see provided. Information regarding the National Center for Trauma Informed Care and the National Center for PTSD has been disseminated to providers.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

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Please answer the following questions:

- 1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

  Alabama's legislature and governor have not authorized Medicaid coverage expansion.

- 2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

  The Alabama Legislature recognizes that a critical need exists in this state for the criminal justice system to more effectively address the number of defendants who are involved with substance abuse or addiction.

  As a part of the Code of Alabama Title 12: Courts Section 12-23A-3 Legislative Intent: as a general proposition, all drug offenders should receive timely eligibility screening and, where indicated, assessment and the appropriate level of treatment. The criminal justice system should be used constructively to motivate drug offenders to accept treatment and engage in the treatment process.

As a part of the Code of Alabama Title 12: Courts Section 12-23A-6 Assessments and Recommendations, Treatment Services: as part of the assessment, each jurisdiction shall establish a system to ensure that drug offenders are placed into a substance abuse treatment program approved by the Department of Mental Health. To accomplish this, the entity conducting the assessment should make specific recommendations to the drug court team regarding the level of treatment program and duration necessary so that the individualized needs of a drug offender may be addressed. These assessments and resulting recommendations shall be performed by a certified or licensed alcohol and drug professional in accordance with the criteria certified by the Department of Mental Health, Substance Abuse Services Division. Treatment recommendations accepted by the court, pursuant to this chapter, shall be deemed to be reasonable and necessary.

As part of the Code of Alabama Title 12: Courts Section 12-23 A-9 Functions of Administrative Office of Courts: (a) The Administrative Office of Courts (AOC), shall assist in the planning, implementation, and development of drug courts statewide. AOC shall make recommendations to the Alabama Supreme Court and the Chief Justice concerning the legal, policy, and procedural issues confronting the drug courts in the state. (b) AOC shall provide state-level coordination and support for drug court judges and their programs and operate as a liaison between drug court judges and other state-level agencies providing services to or benefiting from drug court programs.

There are 68 Adult Drug Courts, 16 Family Dependency Treatment Courts, 1 Tribal Healing to Wellness Court, and 1 Designated DWI Court in Alabama. Sixteen (16) counties have Family/Juvenile Drug courts in operation.

Each drug court uses their own individual screening process to determine if a client has a substance use disorder. One of the screening tools that are currently being used is the GAIN Short Screener. All treatment components of drug court programs are certified by the Alabama Department of Mental Health.

As part of the Code of Alabama Title 12: Courts Section 12-23-15 Indigent Offender Alcohol and Drug Treatment Trust Fund-Established Fee; Sanctions for Failure to Remit Fees: The Indigent Offender Alcohol and Drug Treatment Trust Fund is hereby established and created as a separate fund in the State Treasury. Such fund shall provide for payment to eligible alcohol and drug treatment programs for treatment and rehabilitation of indigent offenders.

As part of the Code of Alabama Title 12: Courts Section 12-23-16 Indigent Offender Alcohol and Drug Treatment Fund-Criteria for Eligibility of Programs to Receive Payment From Fund: The Department of Mental Health shall establish criteria to determine which treatment programs shall be eligible to receive payment for treatment services for indigent offenders from this fund, and shall establish rates of reimbursement for treatment of indigent offenders. At a minimum, such programs must be nonprofit and certified by the Alabama Department of Mental Health or Joint Commission on Accreditation of Health-Care Organizations.

- 3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

  Alabama Department of Mental Health has a Recovery Support Services Coordinator that visits different prisons once a month. During her visit to each prison, she meets with groups of offenders and discusses addiction and services that are offered throughout the state. In addition, ADMH routinely collaborates with Alabama's Criminal and Juvenile Justice Agencies in regard to grant wring and other funding opportunities, and has staff representation on commissions, boards, and workgroups established by these entities.

  Alabama Department of Corrections (ADOC) has a Drug Program Supervisor who is involved in the supervisory and administrative tasks of planning, implementing, and evaluating a standardized drug treatment program for the entire state correctional system.

  Offenders returning from incarceration face many obstacles, including insufficient work opportunities, employment discrimination, and the inability to find suitable housing. Additionally, there is a lack of continuity between prison and community programs that causes a gap in services for many people returning to the community from incarceration.

  Lastly, the ADOC is in the early stages of implementing an assessment tool for identifying the needs of offenders upon arrival and prior to release. The assessment has been approved, the trainers have been qualified, and the implementation process is slated for the near future.

  The ADOC also has an Institutional Pre-Release/Re-Entry Program and Transitional Services Program. This program is monitored by the Correctional Reentry Coordinator.

  The ADOC's goals for prisoner re-entry are as follows: decrease the overall prison recidivism rates and overcrowding, promote public safety for the general community, reunite parents and children, decrease public health and social disparities within the offender populations, and offer referral linkages to inmates and ex-offenders transitioning back into the community. Information is also provided on the following items: accessing immediate food, clothing and shelter; obtaining a driver's license or personal id card; accessing faith based mentoring and support; obtaining medical and/or dental care; accessing substance abuse treatment and mental health services; and looking for job placement, vocational training and career development.

  The target populations for this program are inmates who are within 30 to 90 days of one of the following release statuses: SRP Transfers, End of Sentence, Split Sentence Probationers and Parole Candidates. The Pre-Release Program Model that is used is the Life Enrichment Modules.

- 4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

  Over 60% of admission to ADMH funded treatment programs are referred by the criminal or juvenile justice system. Provider enrollment and care coordination procedures of these

programs routinely address the needs of individuals involved in one or more of the state's correctional systems, and readily collaborate with state officials to accommodate those needs as per the State of Alabama DOC Administrative Regulation #700: The ADOC ensures that those in custody of ADOC have access to medical, dental, and mental health services and are housed in settings that can provide for their specific health care needs. It is the policy of the ADOC to ensure a continuity of care when an inmate is admitted into or released from the system. It is also the policy of ADOC to facilitate the coordination of efforts in the provision of mental health care between ADOC psychological services staff and contract mental health staff. Judges also have the ability to order substance use assessments and treatment. Individuals may enter the system through several avenues which may include probation, mental health courts, drug courts and other problem solving courts (e.g., juvenile, veterans, and family drug courts). Individuals are assessed for appropriate care either in the detention centers at the time of entry or in the community.

- 5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

The Alabama Department of Mental Health participates in the annual Alabama School of Alcohol and Drug Studies. Each year, a Board of prevention, treatment, and recovery specialists, educators and professionals from related fields spend 12 months planning the program. The program is open to professionals involved in the enforcement, prevention, assessment, treatment and rehabilitation of substance abuse. The ASADS Board of Directors includes professionals from colleges, the Administrative Office of Courts, Alabama Department of Mental Health and other state programs.

Specific trainings offered this year include Veteran's Justice Outreach Initiative and Problems Solving Courts; The Criminal Mind and Criminal Thinking; Cultural Competency: Understanding the Need to Provide Culture Specific Treatment in Substance Use Disorders Programs; On the Cutting Edge of Re-Entry; Meeting Your Client Where They Are; Service Driven Case Management; Medicaid Compliance for Alabama Behavioral Health Providers and many more.

In addition, trainings offered by the Alabama Department of Mental Health are open to anyone interested in attending. The Alabama Department of Corrections routinely sends professionals to those trainings as a way of improving the quality of care offered to offenders.

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J. Parity Education

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

- 1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

  ADMH has not developed a plan to address parity. However, information in regard to such is routinely disseminated to providers and advocates as the information is made known to ADMH's staff.

- 2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

  ADMH routinely uses its existing relationships with a variety of public and private agencies, as well as, its role on various planning bodies to relay information about the benefits of substance abuse treatment.

  3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

  ADMH has not addressed this issue specific to substance abuse services.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

- 1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

  - ADMH, including Substance Abuse Services staff, is working with the Alabama Medicaid Agency in its efforts to move from a fee-for-service to a managed care service delivery system. The Alabama Legislature has authorized the state's Medicaid agency to establish Regional Care Organizations (RCOs) to manage all physical and behavioral health services for Medicaid beneficiaries. As this process unfolds, ADMH, as the SSA for mental illness and substance abuse services, wants to make sure that the needs of individuals who have behavioral health disorders are appropriately addressed by the RCOs. ADMH and Medicaid meet once each month to plan for this behavioral health/physical health care integration initiative. ADMH, also, provided significant input into the development of Medicaid's Concept Paper for an 1115 Waiver to fund development of the RCOs. The Concept Paper was submitted to CMS in May 2013.
  - ADMH has developed a Medicaid Transformation committee consisting of behavioral health providers, consumers, advocates, the Alabama Hospital Association, Medicaid, and ADMH substance abuse and mental illness staff to aid in development of plans to help providers transition to a more integrated service delivery system.

- 2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

  None specific to the provision of substance abuse services.

- 3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

  Yes.

- 4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

  ADHM Administrative Code 580-9-44 includes the following requirements for certification of substance abuse facilities:

  > **Smoking.** The entity shall develop, maintain and document compliance with written policies and procedures governing smoking by the program's staff and clientele that include

compliance with federal, state and local ordinances, and at a minimum, the following specifications:

(a) Tobacco use shall be prohibited by all clients, employees, volunteers, contractors, and visitors in all indoor areas of the facility.

(b) Tobacco use shall be prohibited by minors on the premises of programs that provide services to minors.

(c) Smoking shall not be allowed within fifty (50) feet of any entry to a facility that houses children or adolescents.

(d) Written guidelines for personnel in regard to smoking on the premises shall be established.

(e) The entity shall directly or by referral provide a continuum of services for all clients enrolled in each level of care that addresses tobacco use.

ADMH is expanding provider requirements in regard to smoking. The following language will be incorporated in a soon to be released ADMH RFP for Women's Services as a basic requirement for eligibility to submit a proposal in response to the RFP:

(a) Each woman shall be screened for nicotine dependence. For those with positive screening results, an appropriate assessment shall follow. Basic treatment options shall also be provided and incorporated into the client's service plan.

(b) Smoking shall not be permitted within the residential treatment facility. Reasonable outside boundaries shall be established in order to assure a tobacco-free environment for the women and children enrolled in the program, as well as, staff and visitors.

- 5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

  Please see the response to #4 above.

- 6. Describe how your behavioral health providers are screening and referring for:
  a. heart disease,
  b. hypertension,
  c. high cholesterol, and/or
  d. diabetes.

  As part of the required initial placement assessment, each certified provider screens for the diseases listed above utilizing the following question.

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

Do you have / have you had any medical problems, including infectious communicable diseases? ☐ Yes ☐ No

If yes, explain: _____

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

- 1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

  Access and enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, and age are all currently tracked through data entered into ASAIS by ADMH contract providers. LGBTQ status is not tracked.

- 2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

  Questions in regard to language assistance needs are included as part of ADMH's required initial placement assessment. This information is currently being tracked through ASAIS. In addition, ADMH's 2014 budget for substance abuse services includes designated funding to assist providers in accessing language assistance services for clients who are deaf and hard of hearing.

- 3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

  This is a goal for the FY 2014 – FY 2015 SABG.

- 4. How will you use Block Grant funds to measure, track and respond to these disparities?

  Block grant funds will be utilized to:

(a) Further assess the needs of disparity-subpopulations;

(b) Improve access to care for individuals who, without such assistance, would not be able to access the care needed; and

(c) To monitor service utilization.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that 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:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

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?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

- 1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

  Yes

- 2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

  Yes

- 3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

  Yes

- 4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

  Yes

- 5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

  Yes

- 6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes

- 7. Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes

- 8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

ADMH has not implemented exemplary activities or initiatives relative to recovery support services for individuals who have substance use disorders.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that 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:

- 1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The Alabama Department of Mental Health supports the IOM (2006) recommendation regarding the participation of people in recovery and their families in all aspects of treatment and recovery. The Department also supports the SAMHSA Bringing Recovery Supports to Scale (BRSS TACS) and the assertion that the possibility of individual recovery is diminished without intentional support for family recovery.

From the Expert Panel Report: Promoting Family Recovery from Mental Health and Addiction (BRSS TACS) several recommendations were made to increase family empowerment and wellness. They include but are not limited to: 1) focus on the developmental aspects of children in family recovery to promote resiliency. In the Alabama Department of Mental Health, Substance Abuse Services, Administrative Code March 2012, the Continuous Assessment intake process for adolescents must include all aspects of an adolescent's functioning in relation to normative development for their chronological age. For women and dependent children, an assessment of all children participating in treatment with their mothers must be included; 2) empower various family members with age and culturally appropriate resources. In ADMH's Administrative Code, providers must demonstrate, as part of the Program Description, accessibility planning that addresses the needs of clients, family members, visitors, personnel and other stakeholders. They must also provide evidence of implementation of policies and

procedures that seek to establish a culturally and linguistically competent system of care for all. In the Staff Development section of the Code, it is required for all agency employees to have annual training that includes cultural competency relative to the program's target population.

Family members are given the opportunity to participate in consumer satisfaction surveys at the agency and state level. Part of the consumer satisfaction surveys must provide family members or significant others an opportunity to share their perception of access to care, knowledge of program information and staff helpfulness. In the State Administrative Code, ADMH providers are required to have a Performance Improvement System that provides opportunities for input, relative to the operation and improvement of services from key stakeholders which includes family members. Findings and recommendations from these meetings must also be communicated to all families and clients.

- 2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

ADMH has historically included consumers, families, and advocates in all aspects of its planning processes. The SA Coordinating Subcommittee, ADMH's primary planning body for its substance abuse service delivery system, meets monthly. T committee consists of various substance abuse stakeholders from around the state (consumers, advocates, individuals who represent family members, community council representatives, family members of children with substance use disorders, provider organizations and ADMH staff). In addition, ADMH/SA is currently developing an integrated consumer advisory committee to assist in the development of more community based advocate groups.

- 3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

In the Alabama Administrative Code, the Individual Service Planning Process requires that service plans shall be developed in partnership with the client and the client is provided the opportunity to involve family members or significant others of his/her choice in formulation, review, and update of the service plan. Agencies must also provide proof regarding the involvement of the family or significant others. The Code requires agencies at each ASAM Level of Care to provide directly or by referral family counseling/education, developmental delay and/or prevention services, parenting skills development (women specific), and family, community and school integration services (adolescent specific).

Many certified agencies also provide family days, open houses for family members, and family strengthening groups. Examples include:

- The Fellowship House which offers a Family Program in order provide information, peer support, and referral resources for family members of individuals seeking addiction and co-occurring treatment. The Fellowship House believes that a Recovery Oriented System of Care includes empowering family members to support each other and their respective loved ones in recovery, and to advocate for addiction and co-occurring recovery needs.

Family events, such as 'Back to School" parties, an annual Talent Show, and holiday gatherings, are used to encourage sober, positive interactions between clients, family and supportive friends.

- Bradford Health Services indicates that Family programs are a vital part of treatment. Family members join the patient and learn about addiction and the family's role in the recovery process.
- The Bridge, Inc., has a program called "Return and Recovery" for adolescents returning to the community after incarceration. Their program includes meeting individually with participants and their families/guardians to formulate an Individualized Case Management Plan. They then begin monthly home visits with parent(s)/guardian(s) whose involvement is strongly encouraged.
- The Shoulder offers Outpatient codependency groups for family and friends affected by someone else's addiction. No assessment is needed for this group so there is not a barrier to treatment for the family. The addictive disease is further viewed as a family disease. It is the goal of The Shoulder to restore entire families to wholeness, not just addicted individuals. The Shoulder is convinced that healthy families result in healthier communities.

ADMH is currently developing a consumer advisory committee to assist in the development of peer-delivered services that will include family members.

- 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?

As part of ADMH's Administrative Code, Levels of Care, agencies are required to offer certain core services either directly or through referrals. Some of the core services that must be offered are recovery support services, peer counseling services, and the development of a social network supportive of recovery. Some of the Levels of Care are also required to provide mutual self help groups. When considering the length of service and service access, agencies must take into consideration the needs of the target population, including school, work and parenting responsibilities.

The Alabama Department of Mental Health is a strong supporter of agencies that participate in Recovery Month. One of the goals of recovery month is spread the positive message that behavioral health is essential to overall health, that prevention works, treatment is effective and people can and do get better. Therefore, it is the goal of the Substance Abuse Recovery Support Services Coordinator employed by ADMH to be a part of any activity that is held in support of Recovery Month. Some of the activities that are to be held this year includes: Celebrate Recovery, Grace, and Redemption with Sheila Raye Charles. Sheila Raye Charles is the daughter of Ray Charles and she will deliver a heart wrenching story of abuse, crack cocaine addiction and prison through her music and story of her personal journey to salvation; TASC Recovery Walk-5K Fun Walk; 2013 National Recovery Month Fair at which community providers will have exhibits/booths disseminating helpful resources for clients. MI/SA clients/consumers will gather for fun and fellowship in a huge community support effort; Team Recovery: Knocking Addiction Out Of The Park!-SpectraCare Health Systems and Harvest

Church of Dothan are teaming up to "Knock Addiction Out of the Park!" The community is invited to a special screening of the motion picture "Home Run", starring Scott Elrod and Vivica A. Fox. "Home Run" reminds us that "freedom is possible" through recovery. Also, recovery information will be available for those who need assistance for themselves or someone they love; Fashion Show and Silent Auction.

As noted above, ADMH is currently developing a consumer advisory committee to assist with developing family peer advocacy, supportive networks, and recovery oriented services.

Housing

- 1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

  ADMH/SA does not have any current housing programs, but several DMH/SA certified providers are offering transitional housing for clients who complete treatment, that is less restrictive and provides an independent living environment.

- 2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

  DMH/SA is working to develop a relationship with the Jefferson County Faith-Based Coalition and the Jefferson County Homeless Coalition, along with other key stakeholders (HUD and other Housing Authorities) across the state. The goal is to create affordable and sustainable housing for individuals in need of community living, who have a substance use disorder and are receiving services or who are able to maintain their recovery. A key to the success of this goal will be to identity the essential and necessary support services needed for community living and be able to make available those essential support services to include: supported employment, subsidized housing, peer coaching, access to treatment and other creative options that might be available for the individual.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N. Evidence Based Prevention and Treatment Approaches for the SABG

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

- 1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

  The Alabama Epidemiological Outcomes Workgroup (AEOW) develops a State Epidemiological Profile (Epi Profile), which includes community level data, to inform assessment of the prevalence of substance abuse issues and its impact in Alabama. The Epi Profile contains data on substance use consumption patterns, consequences, and risk/protective factors on alcohol, tobacco, and other drugs while examining the magnitude, trends, comparison among with the US, and severity. The data found in the Epi Profile has helped the AEOW to identify and prioritize needs which aids in the selection of primary prevention strategies to address the needs identified.

  The AEOW reviews possible national and state data sources to include or exclude in the Epi Profile. The AEOW members conduct a data quality screening process to identify the data sources that would be appropriate for use in this assessment. The AEOW is comprised of members who are employees from different state agencies including the Alabama Department of Youth Services, Alabama Department of Public Health, and Alabama Department of Public Safety which gives ADMH access to data collected by those agencies

pertaining to substance abuse. After the data sources are found, their eligibility for inclusion in the Epi Profile is based on the following criteria: Availability, Validity, Consistency, and Periodic Collection over at least three to five past years.

Once the Epi profile is compiled, the AEOW works collaboratively with the State Prevention Advisory Board (SPAB) to discuss the consumption patterns, consequences of use, and risk and protective factors for Alabama. The SPAB is comprised of twenty-four cross-disciplinary agencies tasked with identifying gaps in prevention services and maximizing resources in order to address substance use issues in Alabama based off data provided by the AEOW.

Additionally, the ADMH receives specific alcohol and tobacco retailer compliance data from the Alabama Beverage Control Board. The data is disseminated to prevention agencies in order for them to better target areas which give underage drinkers easy access to retail sources that will sell them alcohol.

Finally, on the community level, per the ADMH prevention standards, each prevention agency is required to assess prevention needs based on State epidemiological data provided. Service provision is driven by cultural competency, local data, and demographics of the specific target population as well as consideration of risk/protective factors and contributing conditions (e.g. local policies, practices, community culture or population shifts) in relationship to the planning process. Prevention providers are able to formulate an effective plan for evidence based programs, practices and policies. A mix of strategies is optimal for a comprehensive approach to prevention.

- 2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

The state intends to fund the primary prevention programs that utilize the following evidenced-based curricula:

- Positive Action
- Staying Connected to Your Teen
- Too Good for Drugs
- Second Step
- EmpowerMe4Change
- Too Good for Violence
- Too Good for Drugs & Violence - H.S. & After School
- Safe Dates
- Girls Circle
- The Council
- Life Skills
- In My House
- Project ALERT
- Staying Connected with Your Teens
- Al's Pal's

- Prime For Life

Other practices and strategies include the following:
- Health/community fairs
- Media campaigns
- Advertising via: poster/newspaper contest, television, radio, movie theaters, billboards
- City and county ordinances
- Merchant education programs

These services were selected via needs assessment, along with national, state, and local data. In addition, subcontractors utilize the Alabama Epidemiological Outcomes Workgroup annual state and community profiles that identify consumption and consequences of ATOD information from several data sources including the Department of Education, Department of Justice, NSDUH, NIDAA et. al. All subcontractors for SABG prevention services are required to identify all collaborative partners including other funding sources. Monitoring of SABG prevention services are conducted via certification visits from the Office of Prevention.

- 3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

The Alabama Department of Mental Health (DMH), Office of Prevention staff will take advantage of training opportunities that expand upon the knowledge base in respect to the science and practice of prevention. When possible, new staff members will have priority selection for training opportunities. When this is not available, webinars, teleconference, state information request, etc. will be utilized. DMH will continue to provide training for prevention providers, coalitions, and various community entities to support the development and implementation of community-based prevention planning and programming.

DMH will provide on-going Technical Assistance (TA) so that local multisystem coalitions, prevention providers, local communities, and collaborative programming will support the inclusion of data, and the Strategic Prevention Framework (SPF) process. Prevention professionals implement programs throughout the state intended to reduce alcohol, tobacco, and other drug use and abuse within their communities. TA will provide the necessary preparation, support and guidance needed to successfully implement evidence-based substance abuse prevention strategies in their respective communities and ensure practical adaptation.

It is critical for the development of an infrastructure that supports the implementation of the most effective programs, policies and practices. Current community prevention infrastructure will be assessed and significant gaps will be identified. Upon reviewing the communities' infrastructure, TA will be designed to ensure communities have the capacity and readiness to implement evidence-based substance abuse prevention strategies and to adequately collect, analyze and report on data.

The Office of Prevention will provide T/TA to ensure that prevention providers, coalitions and various collaborative community entities will have the capability to:

- Convene bi-monthly meetings;
- Distinguish and understand the relevancy of direct and indirect services and their impact on communities;
- Train service providers and stakeholders;
- Conduct sustainability planning;
- Implement their strategic plan using appropriate Evidence Based Practices (EBPs);
- Collaborate with existing prevention-related coalitions to prevent duplication.

Pivotal to the success of substance abuse prevention in the State of Alabama will be an ongoing statewide epidemiological needs assessment process that assesses the magnitude of substance abuse and related mental health problems. ADMH's Epidemiologist will utilize various mechanisms and resources to enhance the epidemiological needs assessment process to refine the existing processes and outcomes. Our needs assessment efforts will involve comprehensive and culturally competent reviews of risk and protective factor data, service gaps, and community resources to determine how best to allocate limited prevention resources. Extensive training and technical assistance will be provided to communities statewide to build prevention capacity at both the state and local level. Training topics will include cultural competency, sustainability, evaluation, EBPs, environmental strategies, grant writing, needs assessment, strategic planning, and logic modeling. Additionally, we will continue to utilize national and regional TA resources such as the CAPT and various prevention consultants. In addition, all service practitioners will obtain prevention certification at the organizational level.

Program evaluation, to include on-site monitoring as well as quarterly reporting, will be conducted to monitor program service delivery, and to determine program effectiveness so that dysfunctional programs are improved or replaced, and service redundancies are eliminated. As the SPF model is incorporated into the state prevention certification standards, the evaluation, reporting and monitoring process will apply across the board to providers, as well as, SPF sub-recipients.

Lastly, the Office of Prevention will look at their current funding approach and determine if there is potential to sustain the two additional staff members that will be employed for the Strategic Prevention Framework State Incentive Grant (SPF-SIG) beyond the life of the award. If this is not plausible, office reorganization and work distribution will be explored to ensure the needs of the state are accomplished.

- 4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

ADMH intends to collect outcome data on the six funded prevention strategies: Information Dissemination, Education, Alternative Program/Activities, Problem Identification and Referral, Community based Process, and Environmental Strategies.

Outcome data will include collecting National Outcome Measures (NOMs) with respect to:

- Abstinence from Drug Abuse/Alcohol Use

- Return to/Stay in School
- Decreased Criminal Justice Involvement
- Increased Access to Service
- Increased Retention in Service Programs – Substance Abuse
- Cost-Effectiveness of Services (Average Cost)
- Use of Evidence-Based Practices

Indicators for the NOMs are to be tracked using a variety of national and state data sources. The national data sources included, but are not limited to, the National Survey of Drug Use and Health, Fatality Analysis Reporting System, Uniform Crime Reporting, and National Center for Education Statistics. State data sources include, but are not limited to, the Alabama Department of Public Health, Alabama Department of Public Safety, and Alabama Administrative Office of Courts.

Also, within ADMH, prevention providers must document of prevention strategies that are implemented on an ongoing basis and enter data in the information management system (ASAIS). Outcomes data on prevention activities intended for collection includes: Race, Ethnicity, Gender, Age, IOM Group Identifier (Universal, Selected, Indicated), Community Type, Community Size, Domain (Individual, Family, Peer, School, Community, and Society/Environmental), Prevention Strategy, number of participants. Supporting documentation must be maintained by the provider of services in accordance with guidelines within the Prevention Standards.

With the collected outcomes data, three primary questions can be evaluated:

1. Were substance use and its related problems prevented or reduced?

2. Did Alabama reach target populations and priority areas?

3. Was prevention capacity and infrastructure improved?

Outcomes will be monitored for increases in capacity building, strengthening of the substance abuse prevention system, and determination of the type and distribution of prevention strategies with an emphasis on cultural competency and sustainability of prevention efforts.

- 5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

The SAPT BG provided by SAMHSA is the primary funding source for Alabama’s public system of substance abuse services. Alabama expends block grant funds to maintain a continuum of substance abuse treatment services that meet treatment service needs. In addition, expenditures of no less than 20 percent are spent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies to include Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-based Process and Environmental.

The Alabama Department of Mental Health (DMH) was awarded the Strategic Prevention

Framework State Incentive Grant in 2010. The purpose of the five-year cooperative agreement is to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; reduce substance abuse-related problems; and build prevention capacity and infrastructure at the state, territorial tribal and community levels. Currently there are nine sub recipients to employ the SPF within 20 counties in the state.

The state prevention system includes thirty-two (32) certified prevention providers. Due to the SPF SIG cooperative agreement, Alabama obtained an additional two certified prevention providers, thus increasing prevention capacity. Operating under the guiding principles of Alabama's Administrative Code, Prevention Standards are enforced. Prevention standards guide practitioners in the areas of personnel, records, community planning, strategizing and performance improvement. The SPF model utilized by sub recipients has now been incorporated into the state prevention standards. Thus, the SPF model has become an integral part of the daily operations of SABG recipients as well.

- 6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

All of the prevention set-aside goes to community organizations.

- 7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Provider	EBP	Environmental
Drug Education Council	321,829.08	48,943.92
Franklin Primary	12,861.00	38,581.00
Agency for Substance Abuse Prevention	60,618.37	60,618.87
Baldwin County MHC	52,986.72	36,075.50
Cahaba Center for Mental Health	2,983.50	66,982.50
CED MHC	68,418.93	68,418.73
Cheaha MHC	74,494.60	45,043.60
Chilton-Shelby MHC	83,731.32	79,712.12
Council on Substance Abuse/ NCADD	135,957.15	88,054.28
East Alabama Mental Health Center	88,364.63	88,366.44
East Central Alabama MHC	65,957.00	
Tuscaloosa/Bibb County		78,500.00
Lighthouse Counseling Center, Inc.		45,567.37
Marshall-Jackson MHC	73,513.48	13,513.69
Mental Health of Cullman		67,860.57
MHC of Madison County	130,563.89	117,545.39

MHC of North Central Alabama	103,086.28	44,491.20
Northwest Alabama MHC	67,087.88	67,087.88
Riverbend Substance Abuse Services	88,696.80	68,727.43
Sayno, Inc.		32,098.00
Southwest Alabama MHC		55,028.65
Spectra Care	86,809.50	84,704.40
West Alabama MHC	22,950.00	51,771.00
Alcoholism Recovery Services	54,611.50	39,984.50
Aletheia House	75,022.43	67,178.80
Gateway	49,730.78	49,732.20
JCCEO	18,920.00	60,972.00
Oakmont Center	60,549.25	60,549.25
UAB Substance Abuse Programs	77,193.02	77,193.21

37.2% of funds were allocated towards environmental, which was the largest percentage of distribution towards strategies.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

Alabama has not identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services.

O. Children and Adolescents Behavioral Health Services

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Please answer the following questions:

- 1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

  Substance Abuse Services for children and adolescents ages 12-18 in Alabama are managed/ monitored by ADMH/SAS Office of Treatment Services. The ADMH contracts with thirteen (13) certified adolescent providers that offer anywhere from multiple to one of the following Levels of Care: Level 0.5 Early Intervention, Level I Outpatient Treatment, Level II.1 Intensive Outpatient Treatment and Level III.5 clinically managed medium intensity residential treatment. Alabama earmarks $4, 700,000.00 in SABG funds to support substance abuse services for children and adolescents. The Office of Treatment Services monitors the system of care for compliance with federal requirement through periodic monitoring visits. These monitoring visits are to ensure provider adherence to SABG requirements. If a provider is non compliant in a specific area, the provider is required to address the issue by developing and submitting a written corrective action plan. The provider's corrective action plans are time sensitive and must be approved by the original reviewer upon receipt. Children and youth certified providers are also held accountable for compliance with a host of uniform program standards, which is monitored through an on-site certification process.

  ADMH/SA has moved to the use of ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, which has had a positive impact on the system of care for children and youth in Alabama. All youth in need of treatment are assessed using a standardized assessment tool based on ASAM placement criteria. Regardless of what region of the state a youth receives an assessment that individual should ultimately be placed or referred to the same Level of Care.

- 2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

It is the expectation of ADMH that individualized plans of care be established for all children and adolescents entering substance use disorder treatment. As part of Individual Service Plans (ISP), clients are encouraged to participate in the delivery and recovery process of their own care and the client's actual involvement must be documented in the client's record. Clients are empowered to take charge of their treatment and to make responsible choices that are best for them. As a part of the Service Plan process the plans are reviewed and updated on a set schedule or whenever an event occurs that impacts the child's treatment. Service plans are written based on the identified individual needs and strengths of each person, with major input from the youth and family member(s).

- 3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

ADMH/SAS has established the Substance Abuse Adolescent Advisory Committee which is comprised of members from various child serving agencies to include juvenile justice, substance abuse treatment providers, Medicaid representation, substance abuse prevention providers, and advocacy representation. The committee is seeking opportunities for collaboration with both public and private entities to address the needs of children and youth who have substance use and co-occurring disorders. The charge of this committee is to make recommendations to the Associate Commissioner of MH/SA and the Coordinating Subcommittee regarding the development and implementation of any new changes to the service delivery system for children and youth within the State of Alabama.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

TREATMENT

To improve the competencies and skills of providers and staff serving youth with substance abuse disorders, ADMH collaborates with other entities to sponsor the Alabama School for Alcohol and Drug Studies annually. During the 2013 conference the following seminars relating to youth were offered:

- Adolescent Co-Occurring Issues and Treatment Strategies, which provided an overview of the problem of co-occurring disorders in the adolescent population and effective ways to identify, intervene, refer and treat those issues.
- Integrating Youth into Your Environmental Strategies, which provided participates with a way to get youth involved in prevention of substance abuse in communities.
- Cultural Competency, Understanding the need to provide culture specific treatment in substance use disorders programs, which provided an opportunity for participants to be aware of cultural difference that significantly affect retention and outcomes of adolescents receiving treatment for substance use disorders.

DMH/SA has sponsored extensive statewide training for children/adolescent providers on the use and implementation of Motivational Interviewing. Other evidence-based practices

currently in use by adolescent providers across the state include: Seven Challenges, Stages of Change, Structured Journaling and Cognitive Behavioral Therapy.

PREVENTION

Although prevention agencies and organizations have received training on evidence-based programs and policies, there is need for training on selecting programs and policies with practical fit and adaptation. Under the auspices of the SPF SIG, Alabama has created an Evidence Based Practice (EBP) Workgroup. The EBP Workgroup has representatives from all four mental health regions and meets formally four times a year.

The role of the EBP Workgroup is to: a) advise the on the use of evidence-based practices, b) explore various evidence-based resources, c) guide the formal process of selecting/approving evidence-based curricula, and d) identify potential research opportunities and make recommendations. The EBP Workgroup is actively involved in T/TA related to evidence based practices, program, and policies; as well as sustainability and cultural competence.

The EBP Workgroup will ensure adequate trainings and training needs are identified and met to meet the needs of Alabama's prevention system. These trainings will be incorporated into existing venues such as the Alabama School of Alcohol and Other Drug Studies (ASADS), the Alabama Alcohol and Drug Abuse Prevention Conference (AADAA), and the Alabama Council Community Mental Health Boards Conference (ACCMHB).

The Office of Prevention consistently consults with the Center for the Application of Prevention Technologies (CAPT) to identify training needs and explore additional training opportunities through on-line learning modules, webinars and on-site training and technical assistance.

The role of the EBP Workgroup, as well as trainings, will be ongoing to ensure interventions are evidence-based and training needs and/or gaps are identified and met.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The Alabama Substance Abuse Information System (ASAIS) is a web based management information system which collects TEDS and claims data from all certified contract providers. The system is capable of generating reports on service utilization, costs, and outcomes for tracking and monitoring purposes.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will 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 opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, 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 be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which 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. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

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Alabama is home to only one federally recognized Indian Tribe. Operating as a sovereign nation since 1984, 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. Under our previous administration, ADMH's previous administration attempted to establish and implement an ongoing relationship with the Poarch Creek Indian Tribe so as to 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.
No indication of the outcome of the previous administration's efforts was left behind.
DMH is dedicated to continue efforts in establishing and implementing an ongoing relationship with the Poarch Creek Indian Tribe but guidance and technical assistance will be needed to achieve this endeavor.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

O. Children and Adolescents Behavioral Health Services

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

- 1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

  Substance Abuse Services for children and adolescents ages 12-18 in Alabama are managed/ monitored by ADMH/SAS Office of Treatment Services. The ADMH contracts with thirteen (13) certified adolescent providers that offer anywhere from multiple to one of the following Levels of Care: Level 0.5 Early Intervention, Level I Outpatient Treatment, Level II.1 Intensive Outpatient Treatment and Level III.5 clinically managed medium intensity residential treatment. Alabama earmarks $4, 700,000.00 in SABG funds to support substance abuse services for children and adolescents. The Office of Treatment Services monitors the system of care for compliance with federal requirement through periodic monitoring visits. These monitoring visits are to ensure provider adherence to SABG requirements. If a provider is non compliant in a specific area, the provider is required to address the issue by developing and submitting a written corrective action plan. The provider's corrective action plans are time sensitive and must be approved by the original reviewer upon receipt. Children and youth certified providers are also held accountable for compliance with a host of uniform program standards, which is monitored through an on-site certification process.

  ADMH/SA has moved to the use of ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, which has had a positive impact on the system of care for children and youth in Alabama. All youth in need of treatment are assessed using a standardized assessment tool based on ASAM placement criteria. Regardless of what region of the state a youth receives an assessment that individual should ultimately be placed or referred to the same Level of Care.

- 2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

It is the expectation of ADMH that individualized plans of care be established for all children and adolescents entering substance use disorder treatment. As part of Individual Service Plans (ISP), clients are encouraged to participate in the delivery and recovery process of their own care and the client's actual involvement must be documented in the client's record. Clients are empowered to take charge of their treatment and to make responsible choices that are best for them. As a part of the Service Plan process the plans are reviewed and updated on a set schedule or whenever an event occurs that impacts the child's treatment. Service plans are written based on the identified individual needs and strengths of each person, with major input from the youth and family member(s).

- 3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

ADMH/SAS has established the Substance Abuse Adolescent Advisory Committee which is comprised of members from various child serving agencies to include juvenile justice, substance abuse treatment providers, Medicaid representation, substance abuse prevention providers, and advocacy representation. The committee is seeking opportunities for collaboration with both public and private entities to address the needs of children and youth who have substance use and co-occurring disorders. The charge of this committee is to make recommendations to the Associate Commissioner of MH/SA and the Coordinating Subcommittee regarding the development and implementation of any new changes to the service delivery system for children and youth within the State of Alabama.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

TREATMENT

To improve the competencies and skills of providers and staff serving youth with substance abuse disorders, ADMH collaborates with other entities to sponsor the Alabama School for Alcohol and Drug Studies annually. During the 2013 conference the following seminars relating to youth were offered:

- Adolescent Co-Occurring Issues and Treatment Strategies, which provided an overview of the problem of co-occurring disorders in the adolescent population and effective ways to identify, intervene, refer and treat those issues.
- Integrating Youth into Your Environmental Strategies, which provided participates with a way to get youth involved in prevention of substance abuse in communities.
- Cultural Competency, Understanding the need to provide culture specific treatment in substance use disorders programs, which provided an opportunity for participants to be aware of cultural difference that significantly affect retention and outcomes of adolescents receiving treatment for substance use disorders.

DMH/SA has sponsored extensive statewide training for children/adolescent providers on the use and implementation of Motivational Interviewing. Other evidence-based practices

currently in use by adolescent providers across the state include: Seven Challenges, Stages of Change, Structured Journaling and Cognitive Behavioral Therapy.

PREVENTION

Although prevention agencies and organizations have received training on evidence-based programs and policies, there is need for training on selecting programs and policies with practical fit and adaptation. Under the auspices of the SPF SIG, Alabama has created an Evidence Based Practice (EBP) Workgroup. The EBP Workgroup has representatives from all four mental health regions and meets formally four times a year.

The role of the EBP Workgroup is to: a) advise the on the use of evidence-based practices, b) explore various evidence-based resources, c) guide the formal process of selecting/approving evidence-based curricula, and d) identify potential research opportunities and make recommendations. The EBP Workgroup is actively involved in T/TA related to evidence based practices, program, and policies; as well as sustainability and cultural competence.

The EBP Workgroup will ensure adequate trainings and training needs are identified and met to meet the needs of Alabama's prevention system. These trainings will be incorporated into existing venues such as the Alabama School of Alcohol and Other Drug Studies (ASADS), the Alabama Alcohol and Drug Abuse Prevention Conference (AADAA), and the Alabama Council Community Mental Health Boards Conference (ACCMHB).

The Office of Prevention consistently consults with the Center for the Application of Prevention Technologies (CAPT) to identify training needs and explore additional training opportunities through on-line learning modules, webinars and on-site training and technical assistance.

The role of the EBP Workgroup, as well as trainings, will be ongoing to ensure interventions are evidence-based and training needs and/or gaps are identified and met.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The Alabama Substance Abuse Information System (ASAIS) is a web based management information system which collects TEDS and claims data from all certified contract providers. The system is capable of generating reports on service utilization, costs, and outcomes for tracking and monitoring purposes.

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

The Alabama Substance Abuse Information System (ASAIS) went live in June 2008. Since that time ADMH has had the capacity to provide unique client-level data for the substance abuse prevention and treatment services provided by entities under contract with the agency. ASAIS enables the following processes for the Substance Abuse Services Division:

• Initial assessment, eligibility, determination and enrollment;
• Needs determination, level of care assignment and admission;
• Utilization (waiting list) management;
• Provider network management;
• Budget and contract services management; and
• Claims processing.

ASAIS 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. Data is collected on services provided, including type and amount, through a standard 837 that can be submitted at any time during the fiscal year by ADMH 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 are 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.

ASAIS does not address the needs of ADMH's providers relative to Electronic Health Records (EHRs), however. In FY 2014, the Department will be dedicating significant effort to assist providers with developing and using EHRs, as described in Section X, Enrollment and Provider Business Practices, Including Billing Systems, of this plan.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked 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, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this 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 emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

R. Quality Improvement Plan

In the FY 2012/2013 Block Grant application, SAMHSA asked 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, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this 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 emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Alabama's CQI plan for substance abuse services is attached. The plan is currently in the process of revision to incorporate relevant quality management strategies for substance abuse prevention and treatment services, and the procedures to be utilized for their implementation. Although currently limited in scope, the plan outlines the goals for CQI system, which serve as a guide for the document's revision. The Plan's updates and approval process is expected to be completed by December 31, 2013.

Performance Improvement Plan for Substance Abuse Services Fiscal Year 2014

September 20, 2013

Division of Mental Health and Substance Abuse Services
Office of Performance Improvement

I. INTRODUCTION

Guided by the mission, vision, and values of the Alabama Department of Mental Health, the purpose of the Performance Improvement Plan for Substance Abuse Services is to provide a framework for operation of the performance improvement programs in contracted and/or certified Substance Abuse programs. Each certified and/or contracted Substance Abuse program shall have a site specific Performance Improvement Plan and program based on the Alabama Department of Mental Health's (ADMH) commitment to a consumer/family-driven system that is evidence-based, recovery oriented, easily accessible, and fosters continuous quality improvement in all aspects of services provided. In addition, the provider Performance Improvement Plan and Program shall be guided by the Alabama Department of Mental Health, Substance Abuse Services, Administrative Code, Chapter 580-9-44. Furthermore, the Alabama Department of Mental Health plans to utilize the SAMHSA Behavioral Health Barometer (when released) to improve planning processes and assist in the selection of priority areas for action development.

II. GOALS AND OBJECTIVES OF THE SUBSTANCE ABUSE PERFORMANCE IMPROVEMENT PROGRAM

The primary goal of the Department of Mental Health Substance Abuse Performance Improvement Program is to measure the improvement of selected key functions and processes designed to achieve departmental outcomes, while continuing to facilitate problem identification and resolution when desired outcomes are not met. Trends, patterns, and quality of care concerns identified are communicated to the Substance Use Disorder (SUD) Management staff. Quality management processes are used in the oversight of certified Substance Use Disorder providers. The processes include tracking critical outcomes and performance measures regarding the effectiveness of services. 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 SA Performance Improvement systems from consumers in recovery, family members of consumers in recovery, providers, consumer groups, advocacy organizations, and advocates.

2. To assist in the identification and/or development of performance indicators for certified substance abuse programs that measure accomplishment or positive contribution to selected aspects of the ADMH's mission and values for the Division of Mental Health and Substance Abuse Services.

3. To assess the Division of Mental Health and Substance Abuse Services success in providing a system of care and support that is person-centered, evidence-based, recovery-focused, outcome-oriented, easily accessible, and promotes choice and self-determination.

4. To assess the Division of Mental Health and Substance Abuse Services success in providing services and supports that uphold values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, resilience, accessibility, choice and compassion.

5. To assess the Division of Mental Health and Substance Abuse Services' success in providing mental health and addiction 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 critical incidents involving consumers.

6. To assess the Division of Mental Health and Substance Abuse Services success in ensuring SA Block Grant program integrity. (To be accomplished by Compliance reviews conducted by DMH staff through certification site visits and for cause visits)

7. To track performance of selected performance measures over time based on valid and reliable data in order to assess sustained improvements and/or to identify opportunities for improvement.

8. To gauge and benchmark the performance of SUD Treatment Providers statewide and nationally by review of TEDS data submitted for National Outcome Measures (NOMS) which includes:
    - Completed treatment
    - Left treatment against advice
    - Employment status
    - Education status
    - Abstinence
    - Criminal justice activity
    - Social support

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

10. To utilize feedback from consumers, families, practitioners, employees, payers, the community, accrediting agencies and other stakeholders 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 certified substance abuse agencies/programs.

13. To disseminate information to the appropriate committee(s), department(s), discipline(s) and/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 SA PI Program from stakeholders, Community Program Executive Directors, and SUD Management Treatment staff.

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

16. To provide information, consultation, training, and technical assistance at the provider level regarding performance improvement topics, issues, methods and requirements.

17. To develop and approve an SA Performance Improvement Plan that outlines the responsibilities and activities of the SA PI Program as described above.

III. STATEMENT OF AUTHORITY

The authority and responsibility for the Division of Mental Health and Substance Abuse Services Performance Improvement Program is vested by the Commissioner of ADMH and the Associate Commissioner for the Division of Mental Health and Substance Abuse Services who have delegated the authority for conducting the program to the Division of Mental Health and Substance Abuse Services 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 Associate Commissioner for Mental Health and Substance Abuse Services.

Certified SA 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, Substance Abuse Services Administrative Code* (Chapter 580-9-44). The Administrative Code requires that each "provider shall provide written documentation of the entity's operation and maintenance of a Performance Improvement System. The Performance Improvement System shall be designed to monitor and assess organizational processes and outcomes. At a minimum, identify and monitor important processes and outcomes for the six (6) components of Performance Improvement, Utilization Review, Consumer and Family Satisfaction, Review and Treatment Plans, and Seclusion and Restraint (if applicable) consistent with the definitions described in this section. Correct and follow up on identified organizational problems. Improve the quality of services provided." Section 5 (III) further specifies that "… the entity shall develop, maintain, and document implementation of written policies and procedures to be inclusive of indicators required by DMH." The SA community provider PI designee will submit periodic reports to the Office of Performance Improvement for identified system level indicators and pursuant to published incident/critical incident and performance measure reporting procedures.

APPENDIX A
CURRENT ACTIVE PERFORMANCE MEASURES
Applicable to Certified Substance Abuse Programs

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.

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 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).

CLIENT DEATH: Indicator measures the number of client deaths reported (from known or unknown causes) in 24- hour care settings, center contracted care certified by DMH, 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.

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, center contracted care certified by DMH, 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, center contracted care certified by DMH, 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 a wrong medicine, wrong dose, medication given at wrong time, and medication administered by wrong route. Additionally, a medication error occurs when the medication is not given for the right purpose or if there is 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)

SUICIDE ATTEMPTS: Indicator measures the number of reported suicide attempts in 24- hour care settings, center contracted care certified by DMH, 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 suicides 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. In addition, providers must also document any injuries associated with the seclusion and/or restraint event by using the NRI Severity of Injury Scale.

UNPLANNED RELOCATION: Indicator measures the number of clients that are relocated to an alternate site off grounds for reasons, including but not limited to, fires, floods, weather related conditions, utility or plumbing failure, hazardous materials events, etc. This applies to consumers in residential settings only.

MEDIA EVENT: Indicator measures the number of times that media is involved in unplanned manner regardless of location.

CONFIDENTIALITY/PRIVACY BREACH: Indicator measures the number of times that any violation of the confidentiality or privacy of protected client information occurs relative to the A*lcohol and Other Drug Confidentiality Rule* within 42 C.F.R Part 2 and Part 8, or the *Health Insurance Portability and Accountability Act Privacy Rule,* within 45 C.F.R. Parts 160 and 164.

LEGAL/CRIMINAL ACTIVITY: Indicator measures number of times events occur involving client(s) and/or staff that necessitates the intervention of law enforcement officials.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

S. Suicide Prevention

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at **here**.

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). ASPARC became a recipient of the Garrett Lee Smith Memorial Act grant in 2012. Thus, efforts have focused on the planning and implementation of the grant which has focused on providing QPR gatekeeping training and Lay My Burdens Down (LMBD). Ninety-nine (99) people in eleven (11) venues (colleges, high schools, churches, and social services and child focus agencies) have received QPR training. LMBD has been presented to 476 people. Through contributions of ASPARC members, a special edition on suicide was published in the peer reviewed Alabama Counseling Association Journal. At present ASPARC's annual meeting was held on September 27, 2013.

DMH 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 sought and attained 501(c) (3) Tax Exempt Status in 2011. The 1st Annual meeting was held September 14, 2011 in honor of Suicide Prevention Week. The 2011-2012 board consists of eleven members, representing the fields of social work and counseling, multiple universities, mental health, public health, numerous crisis centers, and the military. In addition to the board, ASPARC has membership, representing survivors, family members, hospice, students, private practice, counseling /

treatment facilities, and education. ASPARC board has discussed approaching the Tribal communities for inclusion but these efforts have not yet been implemented.

ASPARC began revision of Alabama's 2004 Suicide Prevention Plan in June, 2010 and the revisions were finalized in late 2011-2012. The revised plan is as follows:

Three Year Plan for Suicide Prevention

The primary goal of ASPARC is to reduce the prevalence and incidence of suicide and suicidal behaviors in Alabama. To that end, the following activities and programs are proposed:

- Promote public awareness throughout Alabama of the magnitude of suicide and suicidal behaviors in the state and the wide-ranging, serious consequences for all segments of the population. Use available information technology and resources to inform the public about: A) the prevalence, incidence and effects of suicidal behaviors; B) risk factors, signs and symptoms of suicidal behaviors; and, C) the existence of effective, evidence-based prevention programs. Specific activities may include the following:

  A. Develop a program to disseminate, on a continuing basis and using all available media, facts about the prevalence/incidence and effects of suicide and suicidal behaviors in all population groups and in all geographic areas of Alabama along with risk factors, signs and symptoms, and the availability of local prevention resources, including crisis centers as well as the national toll-free suicide prevention hotline.

  B. Enlist the support of the governor and legislators to declare "Suicide Prevention Awareness Week" each September. During that week inform the public and legislators and private benefactors about the importance and benefits of suicide prevention as well as the existence of feasible, evidence-based prevention programs.

  C. Revise and update the ASPARC/ADPH suicide prevention website with current information on suicide and suicide prevention in the state and nation and with a focus on current/future activities of ASPARC and the state health/mental health departments. Highlight on-going or planned suicide prevention activities in cities and rural areas. Invite new members to join ASPARC.

  D. Create, maintain, and update every 6 months state-wide resource directories for suicide prevention and mental illness treatment. Publish directories on-line and in print. Publicize and distribute to health professionals, schools, churches, police and fire personnel, crisis centers and the public at large.

- Select a limited number of feasible, evidence-based programs and activities for funding and implementation.

  A. Pilot tests these programs in communities, schools, colleges and other appropriate locations. Example: The promotion of firearm safety measures that reduce quick and easy access to guns. This involves ready-made materials such as the Harvard University publication, "Means Matter: Suicide, Guns and Public Health" and "Lok-it-Up". Dissemination to parents of school children as well as health care providers would be a simple, low cost activity. (NOTE: Alabama now has the 4th highest per capita firearm death rate. Most Alabama gun deaths are suicides.)

  B. Collaborate with Alabama crisis centers and hotlines in planning community-based suicide prevention activities. These might include educational, training and outreach programs, development of effective follow-up strategies for persons released from treatment, and publicizing available resources for survivors of suicide loss.

- Make gatekeeper training - on line or otherwise - for the identification and assessment of potentially suicidal persons available to health, mental health, substance abuse and human service professionals as well as to natural community helpers such as: coaches; hairdressers; bartenders; faith leaders; primary care

physicians; police and fire protection first responders; clergy; teachers; correctional workers; school counselors; adult and child protective service social workers; and other social workers.

A. Establish state-wide access to an evidence-based, low-cost source for on-line gatekeeper training, such as QPR, for a nominal fee.

B. Develop a state-wide cadre of licensed trainers to conduct training coordinated by ASPARC.

C. Maintain and update gatekeeper training/education for first responders on a continuing basis.

- Make gatekeeper training - on-line or otherwise - for the identification and assessment of suicidal behavior available to family members of persons at risk.

  A. Establish public access to an on-line gatekeeper training program, such as QPR, available for a nominal fee.

  B. Recruit private and public sector organizations to collaborate with the ASPARC in subsidizing public access to gatekeeper training.

- Develop new suicide bereavement resources for Alabama communities. This would primarily involve the following.

  A. Strengthen the network of Alabama support groups for survivors of suicide.

  B. Develop at least one survivor support group per mental health area.

- Collaborate with primary care providers to help at-risk patients acknowledge and seek treatment for depression, substance abuse, and other major mental illnesses.

  A. Identify a practical suicide screening and assessment tool for busy provider practices.

  B. Develop a physician's information page/link for the ASPARC website.

  C. Develop readable suicide awareness materials for primary care patients.

- Work with state and local organizations to carry out safe, effective programs in schools and colleges that address adolescent distress, provide crisis intervention, and include peer support for individuals seeking help.

  A. Partner with the Alabama Department of Education, and local schools to incorporate suicide prevention curricula into middle and high schools. Include a local resource directory of providers and youth-serving organizations.

  B. Provide gatekeeper training to teachers, school counselors, coaches and other personnel.

- Obtain more accurate data about the incidence of suicidal behaviors in Alabama from medical examiners, coroners, hospitals, clinics, and law enforcement.

  A. Support the development of a standardized reporting system for suicides and suicide attempts through the Alabama Department of Public Health.

For ten (10) years DMH 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. 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.

In FY2012, ADMH's Office of Prevention identified suicide and attempted suicide prevention as one of its goals. To address this goal the following objectives were established:

1. Improve mental, emotional, and behavioral health and well-being among those at high-risk (white non-Hispanic males, elderly – 70+, American Indian, military) for suicide; and
2. Increase public knowledge of the warning signs for suicide and action to take in response.

Action steps in progress to meet this goal include:

1. Participation and collaboration with ASPARC (DMH employee serves as ASPARC board member);
2. Ensure clearinghouses have educational materials on suicide prevention; and
3. Ensure suicide prevention is represented as a priority in prevention plans across CSAP strategies.

The prevention plan template now includes the following as a priority: Prevent suicides and attempted suicides (emphasis on populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives). This updated language is currently embedded in a prevention services request for proposal (RFP) for three counties (Bibb, Pickens & Tuscaloosa) which was released on July 29, 2013 and in preparation for FY15, a similar RFP with the same language will be released in January 2014 for all 67 counties within the state.

ADMH increased public knowledge through a feature on suicide in its January 2013 State Prevention Advisory Board Newsletter. Lastly, with the support of SAMHSA, ADMH sponsored a Mental Health First Aid (MHFA) training on September 28-29, 2012 as well as featured a MHFA track at the Alabama School of Addictions and Drug Studies on April 2-5, 2013. During the February 2013 Community Anti-Drug Coalitions of America training, ADMH staff attended the Building Framework to Promote the Mental Health of Young People and Prevent Mental, Emotional and Behavioral Health Disorders Workshops.

August 9, 2011: REVISION OF THE ALABAMA SUICIDE PREVENTION AND RESOURCE CENTER (ASPARC) SUICIDE PREVENTION PLAN

THREE YEAR PLAN FOR SUICIDE PREVENTION

THE PRIMARY GOAL OF THE ASPARC PLAN IS TO REDUCE THE PREVALENCE AND INCIDENCE OF SUICIDE AND SUICIDAL BEHAVIORS IN ALABAMA. TO THAT END THE FOLLOWING ACTIVITIES AND PROGRAMS ARE PROPOSED.

1. Promote public awareness throughout Alabama of the magnitude of suicide and suicidal behaviors in the state and the wide-ranging, serious consequences for all segments of the population. Use available information technology and resources to inform the public about: a. the prevalence, incidence and effects of suicidal behaviors; b. risk factors, signs and symptoms of suicidal behaviors; and, c. the existence of effective, evidence-based prevention programs.

Specific activities may include the following.

A. Develop a program to disseminate, on a continuing basis and using all available media, facts about the prevalence/incidence and effects of suicide and suicidal behaviors in all population groups and in all geographic areas of Alabama along with risk factors, signs and symptoms, and the availability of local prevention resources, including crisis centers as well as the national toll-free suicide prevention hotline.

B. Implement an anti-stigma education campaign using all available media throughout the state. Focus first on K through 12 schools, and colleges. Utilize innovative techniques such as a "BODY LOVE" type documentary or soap opera format.

C. Enlist the support of the Governor and legislators to declare Suicide Prevention Awareness Week each September. During that week inform the public and legislators and private benefactors about the importance and benefits of suicide prevention as well as the existence of feasible, evidence-based prevention programs.

D. Revise and update the ASPARC/AL. State Health Department suicide prevention website with current information on suicide and suicide prevention in the state and nation and with a focus on current/future activities of ASPARC and the state health/mental health departments. Highlight on-going or planned suicide prevention activities in cities and rural areas. Invite new members to join ASPARC.

E. Create, maintain, and update every 6 months state-wide resource directories for suicide prevention and mental illness treatment. Publish directories on-line and in print. Publicize and distribute to health professionals, schools, churches, police and fire Personnel, crisis centers and the public at large.

2. Select a limited number of feasible, evidence-based programs and activities for funding and implementation.

A. Pilot test these programs in communities, schools, colleges and other appropriate locations. Example: The promotion of firearm safety measures that reduce quick and easy access to guns. This involves ready-made materials such as the Harvard University publication, *"Means Matter: Suicide, Guns and Public Health"* and "Lok-it-Up". Dissemination to parents of school children as well as health care providers would be a

simple, low cost activity. **(NOTE: Alabama now has the 4th highest per capita firearm death rate. Most Alabama gun deaths are suicides).**

B. Collaborate with Alabama crisis centers and hotlines in planning community-based suicide prevention activities. These might include educational, training and outreach programs, development of effective follow-up strategies for persons released from treatment, and publicizing available resources for survivors of suicide loss.

3. **Make gatekeeper training—on line or otherwise—for the identification and assessment of potentially suicidal persons available to health, mental health, substance abuse and human service professionals as well as to natural community helpers such as: coaches; hairdressers; bartenders; faith leaders; primary care physicians; police and fire protection first responders; clergy; teachers; correctional workers; school counselors; adult and child protective service social workers; and other social workers.**

   A. Establish state-wide access to an evidence-based , low-cost source for on-line gatekeeper training, such as QPR, for a nominal fee.

   B. Develop a state-wide cadre of licensed trainers to conduct training coordinated by ASPARC.

   C. Maintain and update gatekeeper training/education for first responders on a continuing basis.

4. **Make gatekeeper training—on-line or otherwise–for the identification and assessment of suicidal behavior available to family members of persons at risk.**

   A. Establish public access to an on-line gatekeeper training program, such as QPR, available for a nominal fee.

   B. Recruit private and public sector organizations to collaborate with the ASPARC in subsidizing public access to gatekeeper training.

5. **Develop new suicide bereavement resources for Alabama communities. This would primarily involve the following.**

   A. Strengthen the network of Alabama support groups for survivors of suicide.

   B. Develop at least one survivor support group per mental health area.

6. **Collaborate with primary care providers to help at-risk patients acknowledge and seek treatment for depression, substance abuse, and other major mental illnesses.**

   A. Identify a practical suicide screening and assessment tool for busy provider practices.

   B. Develop a physician's information page/link for the ASPARC website.

   C. Develop readable suicide awareness materials for primary care patients.

7. **Work with state and local organizations to carry out safe, effective programs in schools and colleges that address adolescent distress, provide crisis intervention, and include peer support for individuals seeking help.**

A. Partner with the Alabama Department of Education, and local schools to incorporate suicide prevention curricula into middle and high schools. Include a local resource directory of providers and youth-serving organizations.

B. Provide gatekeeper training to teachers, school counselors, coaches and other personnel.

8. Obtain more accurate data about the incidence of suicidal behaviors in Alabama from medical examiners, coroners, hospitals, clinics, and law enforcement.

A. Support the development of a standardized reporting system for suicides and suicide attempts through the Alabama Department of Public Health.

9. Other Activities

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans 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;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

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- What strategies the state has deployed to support recovery in ways that leverage ICT;
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- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and;
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Interactive Communication Technologies (ICTs) are already being used in treatment settings across Alabama, and the state is taking 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. Alabama DMH recognized the need to play a stronger leadership role in the area of information technology. Alabama DMH has been more proactive in identifying and pushing out ICTs to its community providers over the last eighteen months, but we recognize we can always do more. We continue to desire to support the 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 continue to work with our providers to determine appropriate 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. Our plan to facilitate user groups on specific technologies has yet to come to fruition due to lack of staff time to accomplish the task.

We continue to be impressed with the tools being made available to help consumers with behavioral health challenges and see our role as promoting the use of those technologies throughout the provider community. 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, particularly the Department of Defense which has continued to make a number of useful apps available through the National Center for Telehealth and Technology (**http://www.t2health.org/products/mobile-apps**). There are also a

number of private firms developing useful apps as well, such as Mood Panda (**http://www.moodpanda.com**). 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, and DMH continues to 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 our providers to identify where that would be possible and helpful in monitoring and enhancing client care.

By not pursuing the user groups, we have lost one avenue of being able to accomplish our goals around data collection. We plan to develop surveys in the coming months to be able to understand the current use and desired use of technology throughout the service delivery system. Some baseline data was collected as part of a SAMHSA-funded needs assessment survey, but was limited to use of telemedicine and adoption of Electronic Health Records. In order to assist in growing the use of technology, we must deepen our knowledge about what is already going on.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. 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.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

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1. What areas of technical assistance is the state currently receiving?

   a) As a result of its 2012 SAMHSA Core Technical Review, ADMH is currently receiving technical assistance as identified in the Table below:

Prioritized TA	TA Objectives
1. Enhance statewide planning and needs assessment efforts. TA provided by Dave Wanser	(a.) Assess and plan for changing healthcare environment
	(b.) Evaluate meaningfulness and utility of needs assessment data
	(c.) Analyze assessed versus actual levels of care
2. Increase compliance with SABG capacity management requirements. TA provided by Dave Wanser.	Explore opportunities to increase compliance with capacity management requirements
3. Improve fiscal oversight of the service delivery system. TA provided by Woody Odoms.	Develop a fiscal monitoring system

   b) ADMH is receiving Technical Assistance from the Southeast CAPT to enhance the state's implementation of the SPF SIG.

   c) Leslie Schwalbe, former Deputy Director of the Arizona Department of Health Services/Division of Behavioral Health is assisting ADMH in system redesign as a result of Medicaid's transformation to a managed care service delivery system.

2. What are the sources of technical assistance?

   a) SAMHSA

   b) SAMHSA

   c) National Association of State Mental Health Directors

3. What technical assistance is most needed by state staff?

a) Work Force Development
b) Staff productivity, efficiency, and teamwork
c) Grant Writing
d) Provider Licensure
e) Performance Improvement
f) Implementation of the CLAS Standards

4. What technical assistance is most needed by behavioral health providers?

a) Work Force Development
b) Program Marketing and Branding
c) Nonprofit Board Development
d) Grant Writing
e) Primary Care/Behavioral Health Service Integration Strategies
f) Performance Improvement
g) Program Sustainability
h) Implementing and Sustaining Evidence-Based and Culturally Relevant Programs, Policies and Practices.
i) Collaboration with Higher Educational Institutions to Promote and Incentivize Students in the Behavioral Health Field.
j) Medication Assisted Treatment

U. Technical Assistance Needs: REVISION – November 7, 2013

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d) Provider Licensure
e) Performance Improvement
f) Implementation of the CLAS Standards
g) Strategic Planning

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f) Performance Improvement
g) Program Sustainability
h) Implementing and Sustaining Evidence-Based and Culturally Relevant Programs, Policies and Practices.
i) Collaboration with Higher Educational Institutions to Promote and Incentivize Students in the Behavioral Health Field.
j) Medication Assisted Treatment
k) Strategic Planning

5. 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 Alabama Department of Mental has utilized several strategies to address the training needs of its staff and community providers. The efforts include:

a) Partnering with the Alabama School of Alcohol and other Drug Studies Board, to provide scholarships for the state's annual Alcohol and Other Drug Studies School.
b) Participating in free and low cost training provided by local and state organizations.
c) Disseminating information to community providers about the availability of free and low cost training provided by local and state organizations.

d) Maintaining a continuing education website. The Agency's ***CEQuick*** portal site has been designed to meet the needs of mental health providers and independent mental health professionals. It was developed to provide cost effective, high quality, accessible training and education for these audiences. The interactive web-based trainings offered are designed to enhance the skills of those working with individuals who have intellectual disabilities, mental illnesses and/or substance use disorders. Some specific courses have been chosen or created to meet the requirements of the Alabama Department of Mental Health as well as various professional licensing boards.

e) Participating in on-site and webinar training made available through professional organizations as the National Association of State Mental Health Directors and the National Association of State Alcohol and Drug Abuse Directors.

f) Collaborating with the Southeast Regional ATTC for the provision of provider training.

g) Collaborating with the Southeast Collaborative for the Application of Prevention Technologies for staff and provider training.

h) Utilizing technical assistance made available through the SABG for staff and provider training to address needs primarily identified through SAMHSA's Core Technical; Reviews.

i) Participating in webinars presented by state and local agencies, as the Alabama Department of Public Health, CMS, OIG, and SAMHSA.

j) Collaborating with the State Cultural and Linguistic Competence Coordinators Network for staff and provider training.

k) Utilizing in-house expertise for staff and provider training.

The efforts identified above have enabled the availability of a broad spectrum of training for both the state's staff, as well as the provider community. However, training needs related to (1) strategic planning and (2) performance improvement, specific to transformation of the current behavioral healthcare environment, will require a sustained, state specific technical assistance effort. Without additional resources to support this effort, in-depth needs for training both the state's staff and community providers will remain unaddressed**.**

IV: Narrative Plan

V. Support of State Partners

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, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. 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, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and 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.[45] 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 justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in 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, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal 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 and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

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- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

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 new partnerships that can assist the agency in addressing its SABG priorities. Although formal Letters of Agreement have not been developed with any of these agencies, efforts to acquire such prior to the end of FY 2014 will be made by ADMH's current administration

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)	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	(a) Assist in development of strategies for trauma informed services for individuals involved in the legal system. (b) Development of Drug Courts.
Alabama Head Start Agency	Collaborate in the development of policies and practices relative to early childhood needs.
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.
Alabama Department of Insurance	ADMH collaborated with the Alabama Department of Insurance to develop a recommendation of a benchmark insurance plan that would serve as the benchmark for the for the State's Essential Health Benefits. ADM will also work with the Department of Insurance to develop a strategy for monitoring compliance with federal parity regulations for insurance coverage of substance use disorders.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

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 intellectual 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

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

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

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	0	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	0	
State Employees	0	
Providers	0	
Federally Recognized Tribe Representatives	0	
Vacancies		
Total State Employees & Providers	0	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and Provider Business Practices, Including Billing Systems

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- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

ADMH intends to set-a-side an amount equal to three percent of its FY 2014 SABG allocation, $672,421 to support its contract providers in improving their capacity to bill public and private insurance, and to support enrollment into health insurance for eligible individuals served in the public substance use disorder service system. Funding will be utilized to assist providers in the adoption of health information technology that meets meaningful use standards. In an August 13, 2013 provider meeting with Dr. Dave Wanser, the lack of electronic health records (EHRs) was identified as the most pressing need facing substance abuse treatment providers relative to their readiness to operate in the changing health care environment.

ADMH will reconvene the provider group in early October to clearly define the system's needs relative to EHRs, and to develop specific strategies to address the needs identified. Funding allocated to providers to assist in the adoption EHRs will be established through a competitive RFP process.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on the State BG Plan

- Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

On the Substance Abuse Services page of ADMH's website is a tab for the SABG. The SABG Application, along with related updates and documents remain posted throughout the year. A notification at the same location, from the Associate Commissioner for Mental Health and Substance Abuse Services, extends an open invitation to the public for comments and describes the process for submission of those comments.

In addition the ADMH's Substance Abuse Coordinating Subcommittee has established an SABG Task Group that will assist in the identification of priorities and goals, implementation of SABG strategies, responding to public comments, and monitoring progress. Training on the SABG was provided for this group of providers and consumers was provided by ADMH's SABG Manager in July 2013.