

Alabama

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 10/01/2015 10.18.15 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

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 Mental Health and Substance Abuse Services Division

Mailing Address 100 North Union Street, Suite 420

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, Suite 420

City Montgomery

Zip Code 36130-1410

Telephone 334-242-3642

Fax 334-242-3025

Email Address Beverly.Bell-Shambley@mh.alabama.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 10/1/2015 10:17:16 PM

Revision Date

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:



State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

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
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
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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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization 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 sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Robert Bentley

Signature of CEO or Designee¹: _____

Title: Governor

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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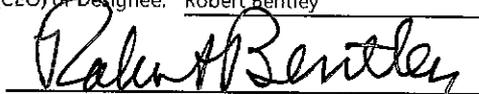
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Name of Chief Executive Officer (CEO) or Designee: Robert Bentley

Signature of CEO or Designee¹: 

Title: Governor

Date Signed: 09/10/2015

mm/dd/yyyy

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

Footnotes:

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	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature: _____ Date: _____

Footnotes:

The Alabama Department of Mental Health did not undertake any lobbying activities during State FY 2014.

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

SECTION II: ALABAMA PLANNING STEPS

STEP ONE: 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 illnesses, 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: (1) Administration, (2) Developmental Disabilities, and (3) Mental Health 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 Health and Substance Abuse Services Division have primary responsibility for accomplishment of these tasks.

Historically, ADMH’s responsibilities for mental health 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 illnesses, substance use disorders, and co-occurring mental illnesses 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 Health 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.

ADMH is designated as the single state agency (SSA) 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 16 – FY 17 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 remain in the early stages of development.

B. Organization of Alabama’s Substance Abuse Service Delivery System

1. The Role of the SSA: 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 the State’s plan for mental health and developmental disabilities services. This committee, in accordance with guidelines established by the ADMH Commissioner, is charged with the following responsibilities:

- Develop strategic direction for the provision of developmental disabilities, mental illness, and substance abuse services;
- Develop the Department’s legislative budget requests consistent with established priorities;
- Develop budget allocations and major reallocations (e.g., proration, revenue changes, etc.) which impact the plan;
- Review quarterly the progress on plan implementation;
- 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 that is 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 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	

2. Service Delivery Overview

ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services. The agency has established the State’s public system of services through the execution of contractual agreements with sixty-four (64) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of 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. The number of clients served by ADMH treatment services contractors in 2014 is provided in **TABLE 2**. ADMH also certifies twenty-nine (29) other providers with which there is no contractual relationship.

TABLE 2

Region	Adults	Adolescents	Total
1	5,014	881	5,895
2	7,714	382	8,096
3	3,068	503	3,571
4	3,823	528	4,351
All	19,619	2,294	21,913

The SABG provided by SAMHSA is the primary funding source for Alabama’s public system of substance abuse services. In addition, state funding is provided by the Alabama State Legislature. Utilizing ADMH as the payment conduit, the Alabama Medicaid Agency also makes available reimbursement to qualified provider organizations for services delivered to eligible Medicaid beneficiaries. These services are reimbursable through Medicaid’s nonemergency transportation and rehabilitation option programs. For all three funding sources, providers are reimbursed by ADMH on a fee for service basis.

3. Treatment Services

Contract providers are required to abide by the following eligibility requirements in order to bill ADMH for treatment of individuals who have substance use disorders:

- a. 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.
 - Each client 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.
 - (1) Drug injecting pregnant women (with diagnostic criteria).
 - (2) Pregnant women (with diagnostic criteria).
 - (3) Parenting women (with diagnostic criteria).
 - (4) Injection drug users (6 month history of injection drug use and injection drug use within the last 30 days, with diagnostic criteria).
 - (5) All other individuals who have substance use disorders.
 - A need for financial assistance must be established by an individual financial assessment based upon the client’s unique needs.
 - 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.

- 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 access.

4. Use of Treatment Placement Criteria

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

- Establish a need for immediate crisis intervention.
- Establish a DSM 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 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. 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.

5. 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:

- a. 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.
- b. **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 intoxicated or experiencing withdrawal. This Level of care is characterized by its emphasis on peer and social support.
 - c. **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.
 - d. **Ambulatory Detoxification Without 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.
 - e. **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.
 - f. **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.

- g. **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.
- h. **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.
- i. **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.
- j. **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.
- k. **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.
- l. **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.
- m. **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.

- n. **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.

TABLE 3

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.

The authorized levels of care are modifications of those established in the ASAM PPC-2R. As indicated in **TABLE 3** above, specialty levels of care are available in Alabama for adolescents, pregnant and parenting women, and individuals who have co-occurring disorders

In addition to certifying and funding 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	

C. SABG Priority Service Populations

1. Chapter 580-9-44-.13(9)(d) of the Alabama Department of Mental Health’s Administrative Code specifies that priority access to admission for treatment will be given to the following groups in order of priority:
 - a. Individuals who are pregnant and have intravenous substance use disorders.
 - b. Individuals who are pregnant and have substance use disorders.
 - c. Individuals who have intravenous substance use disorders.
 - d. Women with dependent children.
 - e. Individuals who are HIV positive.
 - f. All others with substance use disorders.

All programs certified by ADMH must adhere to the above rule. This includes those entities under contract with ADMH, as well as, those receiving no funds from the state. Compliance is monitored during bi-annual on-site certification site visits, as well as, during annual onsite SABG compliance reviews of funded programs. In addition, the following efforts are undertaken to assure the specific needs of the SABG’s priority populations are appropriately attended within ADMH’s substance abuse service delivery system:

2. Pregnant Women and Women with Dependent Children

The ADMH certifies and provides SABG women's set-aside funding for two comprehensive substance abuse programs that exclusively serve pregnant women and women with dependent children. Each of these programs is certified to provide the following Alabama modified ASAM levels of care:

- Outpatient Treatment.
- Intensive Outpatient Treatment.
- Clinically Managed Low Intensity Residential Treatment.
- Clinically Managed Medium Intensity Residential Treatment.
- Clinically Managed High Intensity Residential Treatment

Throughout ADMH's administrative code, rules addressing the specific needs of pregnant and parenting women have been published. Chapter 580-9-44-.13(11)(a)5, for example, specifies that the intake process in programs for pregnant women and women with dependent children at a minimum:

- Shall be family centered and gender responsive addressing:
 - a. Assessment of primary medical care to include prenatal care, primary pediatric care and immunization for their children.
 - b. Relationships.
 - c. Sexual & physical abuse.
 - d. Parenting skills and practices.
 - e. Childcare.
- Include assessment of children participating in treatment with their mothers which shall, at a minimum, evaluate:
 - a. Developmental, emotional, and physical health functioning and needs.
 - b. Sexual & physical abuse.
 - c. Neglect.
- Each entity shall specify in writing the procedures to ensure:
 - a. Pregnant women and/or women with dependent children are given preference in admission.
 - b. Sufficient case management to include transportation, publicizing the availability of service to women through street outreach programs, ongoing public service announcements, advertisements in print media, posters and other information placed in targeted areas, frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social service agencies.
 - c. Interim services are available and offered.

Annual onsite program reviews are conducted by ADMH's Women's Services Coordinator to assure compliance with all administrative code and contract requirements which incorporate Federal SABG requirements.

3. Injecting Drug Users

The needs of injecting drug users has taken on a renewed sense of urgency since the resurgence of heroin as the primary drug of choice for many Alabamians. For the very first time, admissions to the state's public service delivery system for individuals with opioid use disorders have exceeded those for alcohol use disorders. In 2014, efforts to improve access to care for injecting drug users were at the forefront of ADMH initiatives and included:

- Annual monitoring of ADMH contractors to insure compliance with SABG Federal regulations specific to injecting drug users.
- Advocating for removal of the state's moratorium prohibiting the opening of new opioid treatment programs.
- The provision of clinical documentation, case management, and recovery oriented system of care training for opioid treatment programs.

4. Persons With or at Risk for Tuberculosis

ADMH monitors the state's Tuberculosis infection rate through ongoing surveillance of data maintained by the Alabama Department of Public Health. In addition, the agency's Administrative Code requires each certified provider to maintain, and document compliance with a written plan for exposure control relative to infectious diseases that, at minimum, must include the following requirements:

- a. The plan shall be inclusive of the entity's staff, clients, and volunteers.
- b. The plan shall be consistent with protocols and guidelines established for infection control in healthcare settings by the Federal Center for Disease Control, and shall at a minimum include:
 - (1) Policies and procedures to mitigate the potential for transmission and spread of infectious diseases within the agency.
 - (2) The provision of TB education for all program admissions.
 - (3) A formal process for screening all program admissions for TB.
 - (4) TB testing for all employees prior to initiation of duties after hiring, and annually thereafter.
- c. The entity shall document compliance with all laws and regulations regarding reporting of communicable diseases to the Alabama Department of Public Health.

Program monitoring of SABG contract providers indicates 100% compliance with administrative code and contract requirements for compliance with SABG regulations specific to persons at risk for TB.

5. Persons at Risk for HIV

ADMH monitors the state's HIV infection rate through data maintained by the Alabama Department of Public Health and the Centers for Disease Control.

Alabama has not been an HIV designated state or used SABG funds for the expenditure of HIV Early intervention services since FY 2010. Despite this fact, ADMH's administrative code maintains regulations which require all certified substance abuse treatment providers to maintain, and document compliance with a written plan for exposure control relative to infectious diseases that includes:

Provisions to offer HIV early intervention services, directly or by referral, to all clients who voluntarily accept the offer to include HIV pre-test and post-test counseling, case management and referral services, and as needed, medical care.

In addition, each ADMH service delivery contract with substance abuse treatment providers specifies, "The Contractor, and its Subcontractor(s), will provide each client receiving substance abuse treatment services pursuant to this Contract with HIV risk education, including prevention information." ADMH's treatment services staff monitors compliance with these regulatory and contract requirements through annual onsite compliance reviews.

6. Primary Prevention Services

ADMH, in accordance with its regulatory authority, has established service delivery rules in the Alabama Administrative Code that are 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.

ADMH does not operate substance abuse prevention programs, or directly provide any related services. The agency currently enlists the services of twenty-nine (29) certified prevention programs across the state in this regard. 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 and include representation of all four substance abuse regional planning areas.

ADMH utilizes twenty percent (20%) of its SABG allocation for the provision of prevention services for individuals who do not require treatment for substance use disorders. Contractors are required to:

- a. Educate and counsel individuals on substance abuse.
- b. Provide for activities to reduce the risk of such abuse by the individuals.
- c. Give priority to populations that are at risk of developing a pattern of such abuse and develop community-based strategies for prevention of such abuse, including

- strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.
- d. Use funds provided for the provision of comprehensive primary prevention programs that include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance abuse.
 - e. Identify the type of target population for service provision based on the Institute of Medicine categories: Universal, Selective, or Indicated.
 - f. Use a variety of strategies, as appropriate for each target group, including but not limited to the following:
 - (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.

The majority of ADMH provided prevention funding is directed towards environmental, education, and alternative activities. A minimum of fifty percent (50%) of the contractor's ADMH provided funding must be expended for implementation of Environmental Strategies. All strategies must also incorporate the utilization of evidenced-based programs from the National Registry of Evidence-Based Programs and Practices.

Eligibility Criteria for Prevention Services:

Primary prevention services are provided for target populations as defined in ADMH'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. Contractors 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.

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 2014, 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.

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 was assigned responsibility for management of this State Incentive Grant and continues to work 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 problem, collect, analyze, and disseminate data, and to describe the prevalence, consumption, and consequences of alcohol, tobacco, and other drug use in Alabama. The AEOW is chaired by the Division's Epidemiologist and the Prevention Services Director. The composition of the SPAB and the AEOW contribute towards the resources of the system to assist in the provision of both treatment and prevention services.

Partnerships for Success

In Fiscal Year 2016, ADMH will begin execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Partnerships for Success (PFS) program opportunity. The SPF project director will be assigned responsibility for management of the PFS Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Other Prevention Services

ADMH currently funds two coalitions dedicated to the reduction of substance use in Alabama: Council on Substance Abuse Montgomery Unified Prevention System (MUPS), and Elmore County Partnership for Children. Together, the coalitions annually receive a total of approximately \$160,000. These coalitions consist of youth, parents, teachers, churches, civic and business leaders and others 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 four (4) 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 expected to be increased.

D. Recovery Support Services

In 2008, the Alabama Department of Mental Health (ADMH) developed and articulated a vision for implementation of a Recovery Oriented System of Care (ROSC) as the philosophical framework for the state's substance abuse service delivery system. Since that time, this vision has successfully guided execution of many of the agency's system improvement initiatives, including the 2011 merger of its separate Mental Illness and Substance Abuse Services Divisions. However, due to the complexities of such a merger occurring simultaneously with efforts to establish ROSC, some elements of the state's vision to this day remain unmaterialized. This includes a key component of the vision for ROSC, workforce development activities which encompass the systematic use of peers in service delivery for individuals who have substance use or co-occurring disorders. In 2014, ADMH initiated efforts to address this issue with the following goals as guidance:

1. Establish the infrastructure to support and sustain a workforce that routinely utilizes trained and certified peer specialists in the provision of services for individuals, families, and communities impacted by substance use disorders and mental illnesses.
2. Establish a well-trained and credentialed peer network, along with mechanisms to promote its use and sustain its effectiveness.
3. To the extent relevant to the needs of individuals, families, and communities, integrate workforce infrastructure development strategies, as established through this initiative, with existing ADMH peer support efforts which now exclusively target individuals who have serious mental illnesses (SMI).
4. Establish protocols to demonstrate the effectiveness of the state's utilization of peer support specialists in expanding service access, facilitating care transitions, enhancing treatment retention, and thereby improving the overall health and wellness of individuals, families, and communities impacted by substance use or co-occurring disorders.
5. Pilot test the organized use of trained and credentialed peer support specialists with at least one underserved population, monitor service implementation, and evaluate service impact.

ADMH has established a workgroup to guide efforts to attain the identified goals and to seek funding to support this effort. In addition, ADMH's Commissioner and its Associate Commissioner for Mental Health and Substance Abuse Services have demonstrated full support of the agency's vision for ROSC and the utilization of peers to facilitate the recovery process.

Consumers, family members, and advocates representing both mental illnesses and substance use disorders are active participants in all ADMH strategic planning processes. This includes their membership on various standing and ad hoc committees, workgroups, and on the agency’s Board of Trustees which serves in an advisory capacity to the Commissioner.

Also, the Associate Commissioner of Mental Health and Substance Abuse Services has established an advisory committee consisting of individuals who are in various stages of recovery from substance use disorders and mental illnesses. This committee meets with the Associate Commissioner on a quarterly basis to share their needs, successes, and the challenges experienced by the communities in which they live relative to recovery.

In January 2013, the ADMH hired an individual in recovery from substance use disorders to work in the position of Recovery Support Services Coordinator for the Mental Health and Substance Abuse Services Division. This individual has responsibility for managing implementation of ADMH’s vision for ROSC for individuals who have substance use and co-occurring disorders and also provides training throughout the state on the fundamentals of ROSC.

E. Role of Other State Agencies in the Delivery of Substance Abuse Services

1. Alabama Medicaid Agency

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

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

2. 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, as specified in **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

3. Regional, County, and Local Entities Providing Services in Alabama Service Delivery System

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:

a. 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, and funds twenty (20) of these Boards for the operation of substance abuse treatment and prevention programs operated by these entities. No management, monitoring or funding responsibilities of other service providers located within respective 310 regions are passed down from ADMH to the 310 Boards.

b. Free-Standing Private Not-For-Profit Organizations

Free-standing charitable agencies either contract directly with ADMH 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 not-for-profit organizations participate in ADMH's planning processes by invitation or as citizen participants in open public meetings.

c. 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. Representatives from private-for-profit organizations participate in ADMH's planning processes by invitation or as citizen participants in an open public meeting.

d. 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 (AS AIS). Provider contracts incorporate all SABG requirements and assurances.

F. Addressing the Needs of Diverse Racial, Ethnic and Sexual Gender Minorities.

Cultural/subcultural competence and addressing diversity through racial, ethnic, sexual gender, American Indian/Alaskan Native, English as a second language, and other linguistic barriers, are interwoven within the statewide substance abuse service delivery system through various mediums annually. In an effort to increase cultural relevancy and enhance the awareness of prevention and treatment resources available to individuals and communities served in this regard, consistent training, technical assistance and organizational

collaborations incorporating and promoting diversity are provided. ADMH has two representatives on the State Cultural and Linguistic Competency Network that is managed by Georgetown University.

Along with these efforts, ADMH is, also, currently

1. Conducting a data comparison study that will identify and map current substance abuse service locations and levels of care in relation to Alabama county health indicators, and population demographics.
2. Assessing the staff and service capacity of the public substance abuse system to serve the identified groups.
3. Assessing the policies and procedures of provider organizations to address the needs of cultural groups.
4. Developing practice strategies and standards to support improved service outcomes of diverse cultural groups.

In addition, ADMH has established provider contractual requirements for compliance with applicable federal and state laws relative to equal opportunity and discrimination, has promulgated comprehensive program certification standards relative to client rights and established procedures for service recipients to have uninhibited access to advocates as needed to address rights issues.

G. Strengths and Weaknesses of the System

1. Numerous **strengths** support the operations of Alabama's public substance abuse service delivery system, including:
 - a. ADMH's position on the Governor's Task Force for Health Care Improvement.
 - b. Collaborative Relationships: ADMH has a history of collaboration with other agencies which supports effective and efficient use of state resources.
 - c. Relationship with Medicaid: ADMH's partnership with the Alabama Medicaid agency has allowed for efficient use of state dollars to expand access to care.
 - d. 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.
 - e. The 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.

- f. **Stable Provider Base:** The vast majority of the division's providers have been its providers for over thirty years.
- g. **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.
- h. **ASAIS:** Developed as the substance abuse division's management information system, ASAIS 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.
- i. **Substance Abuse Staff Qualifications and Diversity:** The staff 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.
- j. A strong provider compliance monitoring process.
- k. Commitment of ADMH program management to systems improvement
- l. 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.
- m. **Coalition Readiness (SPF-SIG)**
 - (1) Increased perception of community influence on the important decisions made by the state prevention system.
 - (2) There is a consensus on a definition of substance abuse prevention that guides all participating agencies and coalitions.
 - (3) The state prevention system partners share a common understanding and use of evidence based substance abuse prevention practices.
 - (4) Development of a comprehensive substance abuse prevention plan among state prevention partners.
 - (5) State prevention system activities, use of resources, and outcomes are reported to community stakeholders on a regular basis.

- n. 2014 Prevention Workforce and Retention (Community-Level)
 - (1) Prevention is supported by community agencies.
 - (2) Perception of agency value of employees is positive.
 - (3) Agency sustainability of prevention workforce is consistent.
 - (4) Prevention workforce preparedness to complete job responsibilities is present.
 - (5) Overall enjoyment with prevention roles/responsibilities is present.
 - (6) Overall feeling that the role of prevention is making a difference in communities.
- o. 2014 Funding Allocation (ADMH)
 - (1) Alabama's substance abuse prevention system is positioned to eradicate historic funding in Alabama's prevention system and substitute a data-driven process focusing on population/need.
 - (2) Alabama's prevention system has a formal funding allocation model to address resource allocation.
 - (3) Measures are developed for delivery of prevention strategies.
 - (4) Established incentives for prevention providers.
 - (5) All sixty-seven (67) counties within the State of Alabama have access to prevention services/funding.
 - (6) In addition to the components of the assessment tools, Alabama consistently employs the SPF process within all aspects of prevention services to include Assessment, Planning, Capacity, Implementation, Evaluation, Sustainability and Cultural Competence.

5. At the same time, weaknesses have also been identified in the state's substance abuse service delivery system which hinder optimum operations and effectiveness. These include:
- a. Treatment Data Underutilization: Throughout the years, there has been very little utilization of available data by ADMH for substance abuse treatment service planning purposes.
 - b. Access to Care: There is no organized plan for a development of a continuum of substance abuse treatment services 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.

- c. **Provider Performance Standards:** At the present time, ADMH makes few requests of its treatment providers to meet performance standards.
- d. **Service Need:** ADMH serves less than 10% of the estimated need for substance abuse treatment in Alabama.
- e. **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.
- f. **Lack of Medicaid expansion** coupled with flat state and federal funding impedes the ability of the system to adequately respond to the emerging community through implementation of evidence-based practices.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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 SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

SECTION II: ALABAMA PLANNING STEPS

STEP TWO: IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM.

A. Assessment of Needs and Identification of Critical Gaps in Alabama's Public Substance Abuse Service Delivery System

The Alabama Department of Mental Health (ADMH) is currently challenged by many needs and critical gaps in its substance abuse service delivery system these challenges include:

- A statewide prescription drug and heroin epidemic;
- An explosion of cases of neonatal abstinence syndrome;
- Greater demands for substance abuse services;
- 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 and federal funding for substance abuse services;
- System erosion due to flat state funding;
- 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.

1. ASSESSMENT PROCESSES

The State's Epidemiological Outcomes Workgroup is an active participant in the identification of needs and gaps in Alabama's substance abuse service delivery system. 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 AEW'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 AEW 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 AEW, 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 AEW is chaired by ADMH's Epidemiologist and its Prevention Services Director. Through the AEW'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.

The information that follows establishes the basis for Alabama's Substance Abuse Block Grant (SABG) priorities for FY 2016 and FY 2017. 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 Licit and Illicit Drugs in Alabama;
- Vulnerable/Underserved Populations; and
- System Issues.

The following data sources were utilized in this review and analysis process:

a. ADMH Behavioral Health 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:

- Adults (ages 19 and older);
- Children;
- Adolescents;
- Pregnant women;
- Parents with dependent children;
- Intravenous drug users (IVDUs);
- Persons with or at risk for HIV/AIDS;
- Persons with tuberculosis or other communicable diseases;
- Persons with disabilities;
- Racial and ethnic minorities;
- Foreign born individuals;
- LBGTQ populations (Lesbian, Bisexual, Gay, Transgender, Questioning);
- Military personnel;
- Veterans;
- Persons living below the Federal Poverty Level of 133%; and
- 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.

b. Alabama Department of Public Health 2015 Community Health Assessment

In 2014, leadership at the Alabama Department of Public Health (ADPH) developed a team of 19 members who represented a wide array of topic areas and that included data experts for many of those fields. This team, the Domain 1 Work Group, led efforts to conduct the Community Health Assessment (CHA) for the state of Alabama.

Due to the guidance from the University of Alabama (UAB) Project Team, the Domain 1 Work Group determined that the Health Issue Focused Approach was the best model to use for Alabama. The UAB Project Team provided organizational and technical support for the process. The following section will detail how the Domain 1 Work Group used the Health Focused Approach in the development of the CHA.

The Community Health Assessment Developmental Process

Step 1: Conducted a statewide online and paper copy survey of individual health care consumers. Fifty-eight known health care concerns were listed with space included for other concerns to be indicated. Respondents ranked the ten leading health care concerns in order of importance. This survey was available in English and Spanish.

This was done from November 2013 through March 2014 with over 6,000 usable responses being received from all demographic components of Alabama's population. Survey responses were monitored to assure that all components of Alabama's population were adequately represented. These 58 concerns and other concerns identified through this survey were later merged with related conditions to produce 22 major conditions and ranked by seriousness as reported through the survey.

Step 2: Conducted a statewide online and paper survey of Alabama organizations (health care and non-health care). This survey was identical to the survey of individuals described in Step 1 and was conducted during the same time frame. Over 500 Alabama organizations reflecting great diversity in mission and size participated in this survey. These 58 concerns and other concerns identified through this survey were later merged with related conditions to produce 22 major conditions and ranked by seriousness as reported through the survey.

Step 3: Each of the 11 Public Health Areas (PHAs) conducted their own public forums, surveys, etc., to identify their ten leading health concerns. The Domain 1 Work Group used personal knowledge and the listings of the top ten health care concerns identified in each of the 11 PHAs to merge related conditions into 22 major health care concerns ranked in order of severity.

Step 4: A selected group representing major interests in Alabama were identified and asked to participate in an online survey of the 22 major concerns by ranking these in order of importance to their special interest and to note other concerns that were not included among the leading 22 concerns. Special interests contacted for inclusion in this survey included: economic development, education, large employers, small hospitals, medium sized hospitals, large hospitals, public transportation, elderly residents, children/youth, the environment, the business community, manufacturing, local government, Medicaid, private health insurance, rural health interests, Native American interests, minority populations interests, Hispanic interests, emergency medical services, the Cooperative Extension System, charity clinics, local health care coalitions, health care technology, health care societies, health care institutes, the child death review program, emergency management, injury prevention, military health care, the hospital association, Federally Qualified Health Clinics, health care education, women's health, men's health, mental health care, poison control, faith based initiatives, and welfare agencies. Of the 41 entities contacted, 28 provided the requested information.

Step 5: The Domain 1 Work Group compared the major health care concerns listing developed in each of the first four steps and noted that the results from each step agreed on the top 13 concerns. The listing developed in Step 4 had the same 13 concerns included among its top 15 concerns. For this reason, the initial goal of identifying the 10 leading health care concerns was altered to include the 13 leading concerns. The Domain 1 Work Group then identified specific indicators for each of these 13 concerns that could be used to establish a baseline and to monitor progress on each major concern.

Step 6: A statewide webinar was presented on May 21, 2014; and a statewide satellite webcast was presented on July 17, 2014, to present the 13 leading health care concerns and the proposed indicators to be used in monitoring progress on each concern. Comments and suggestions concerning the selected indicators were encouraged. A special presentation of this same material was made to Medicaid officials with comments and suggestions being encouraged. This presentation was again made at a statewide meeting of special stakeholders that was held by the Domain 5 Work Group (responsible for developing the Statewide Community Health Improvement Plan) on August 20, 2014, with comments and suggestions being encouraged. Suggestions made through these presentations resulted in some changes to selected indicators.

Step 7: The final statewide CHA includes detailed data and information on each major concern and associated indicators, a comparative ranking of counties for each concern and indicator (where possible), and existing assets and resources that may be available to assist in intervention. An additional Web page will be developed to present data and information on the 13 leading concerns and on other health care concerns and issues that were not initially selected. Data and other information included on this website will be updated continuously as soon as new data becomes available. This ongoing process will involve stakeholders in the CHA Focus Group.

c. 2015 Alabama Health Care Improvement Task Force Substance Abuse Quality Improvement Survey.

In 2015 Governor Robert Bentley established the Alabama Health Care Improvement Task Force, which included both a mental health and substance abuse subject matter expert from the Alabama Department of Mental Health. The Task Force was charged with responsibility for providing Governor Bentley with recommendations of ways to improve the health of Alabamians. Recommendations could take the form of regulatory or statutory changes, with initial recommendations due before the start of the 2016 regular session of the Alabama Legislature.

The Task Force's Quality of Care Subcommittee (QCS), quickly recognized the major impact alcohol and other drug addiction has on the health of Alabamians and the difficulty of improving health care in this State without addressing this devastating illness. As a result, one of the goals adopted by the QCS is as follows:

To improve access to and the quality of prevention and treatment services for substance use disorders throughout the State of Alabama.

ADMH's substance abuse representative on the QCS developed a survey to assess the community's ideas for strategies which support attainment of this goal, while addressing the real-life needs of the state's residents. The survey

was disseminated via a Survey Monkey and resulted in over 300 responses. Respondents are detailed in TABLE 1 below.

TABLE 1

Respondents	%
An Employee of a Substance Abuse Program	22.88
A Nurse	15.03
A Primary Care Provider	8.17
A Family Member/Significant Other of A person in Recovery from a Substance Use Disorder	7.84
A Person in Recovery from a Substance Use Disorder	7.19
An Educator	4.58
A Social Worker	2.29
A Law Enforcement Officer	1.96
A Case Manager	1.63
A Person Currently Receiving Treatment for a Substance Use Disorder	.65
An Attorney	.65
Other	26.80
Nurse Practitioner	10.97
State Employees	7.31
Physician	4.87
Other	76.85

d. Other data sources utilized by ADMH to establish needs and gaps in Alabama’s service delivery system are as follows:

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)

2. IDENTIFICATION OF NEEDS

In the Alabama Department of Public Health's 2015 Community Health Assessment (CHA), Alabamians identified mental health and substance abuse as the second greatest current health concern in the State. Access to care was the greatest current health concern in Alabama. As identified by the AEW, the following is a compilation of key data (consequences and consumption patterns) for alcohol, tobacco, and other drugs in Alabama which support the findings of the CHA:

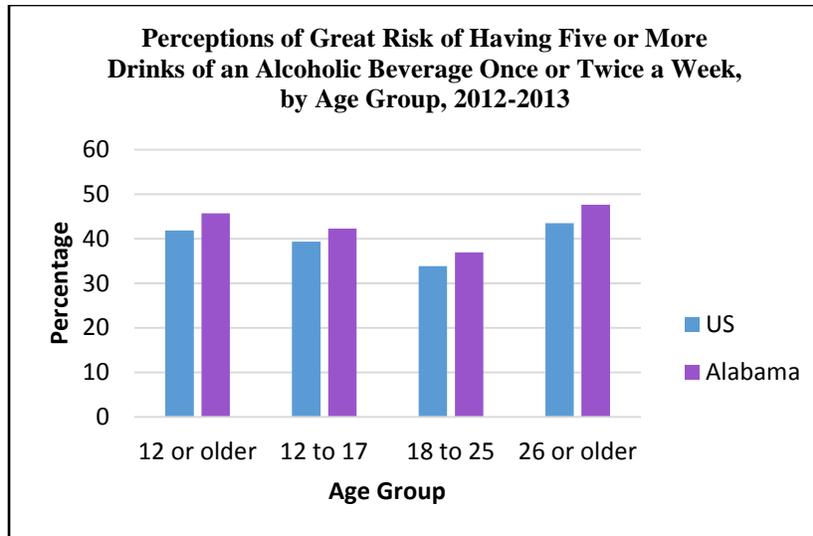
a. Alcohol

Alcohol is the single most used substance in Alabama and also in combination with other substance, followed by marijuana, prescription drugs not prescribed to the user, opiates, inhalants, methamphetamines and other drugs including cocaine, heroin, and spice. Alcohol is both the highest most diagnosed abused substance and the most treated, but 58% of those diagnosed are not being treated for the condition per the ADMH Needs Assessment's consumer survey.

In 2012, there were 26,852 people arrested for alcohol violations: 44 percent 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). Liver disease and cirrhosis deaths account for 577 deaths in Alabama in 2013 (ADPH).

Among youth 12-20 years old in Alabama, 19.6% reported consuming alcohol during the past month and 13% reported binge drinking. Among Alabamians in 2012-2013, 11.7% of persons aged 12-17 reported alcohol use in the past month compared to 12.3% of persons in the US. Also, 6.6% of person 12-17 reported binge alcohol use in the past month (NSDUH, 2012-2013).

Among person 12 or older in Alabama, 45.7% perceive a great risk in having 5 or more drinks of alcoholic beverages once or twice a week.



Source: NSDUH

The average age of first alcohol use was 12.6. Based on the 2013 YRBS, 20.6% of high school youth drank alcohol for the first time before age 13 years. Alabama female high school youth (17.4%) were more likely to report first using alcohol before age 13 compared with US female high school youth (16.6%) in 2013. For Alabama high school youth, 35% reported having at least one drink of alcohol on a least one day during the 30 days before the survey (YRBS, 2013).

b. Tobacco

According to the Behavioral Risk Factor Surveillance System (BRFSS), 21.5% of adults are current cigarette smokers with 25.1% of males currently smoking and 18.2% of females currently smoking in 2013. In the 2011 Alabama (PRAMS) Pregnancy Risk Assessment Monitoring System Surveillance Report, 2.2% of mothers reported they continued to smoke during pregnancy.

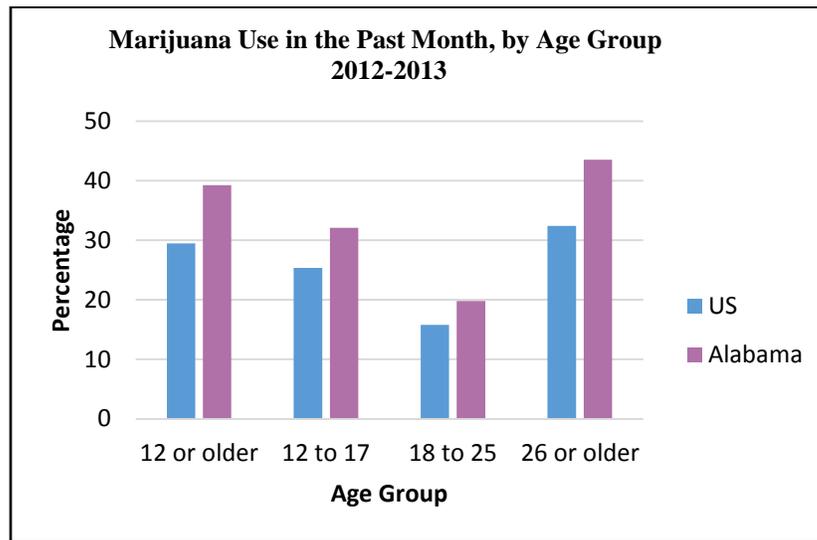
The 2010 Youth Tobacco Survey, administered to Alabama middle school and high school students every two years, shows a decline in smoking among youth. From 2000 to 2010, the prevalence of smoking decreased by 38% (from 30.2% to 18.6% among high school students and by 63% (from 19.1% to 7%) among middle 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%).

c. 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 to marijuana growers. This contributes heavily to the large quantities of marijuana produced in the state (ADTA). Marijuana is the second diagnosed and treated substance abused with 64% of those diagnosed being untreated per the ADMH Behavioral Health Needs Assessment’s consumer survey.

In the 2012-2013 NSDUH, 5% of individuals age 12 and older reported marijuana use in the past month compared to 7.40% in the US. According to ASAIS, 5,636 individuals sought treatment at state-operated or funded institutions for abuse of marijuana as primary substance in 2012 compared to 6,597 individuals in 2011 (14 percent decrease). Perceptions of great risk of smoking marijuana once a month is 39.3% for individuals age 12 and older (NSDUH 2012-2013).



Source: NSDUH

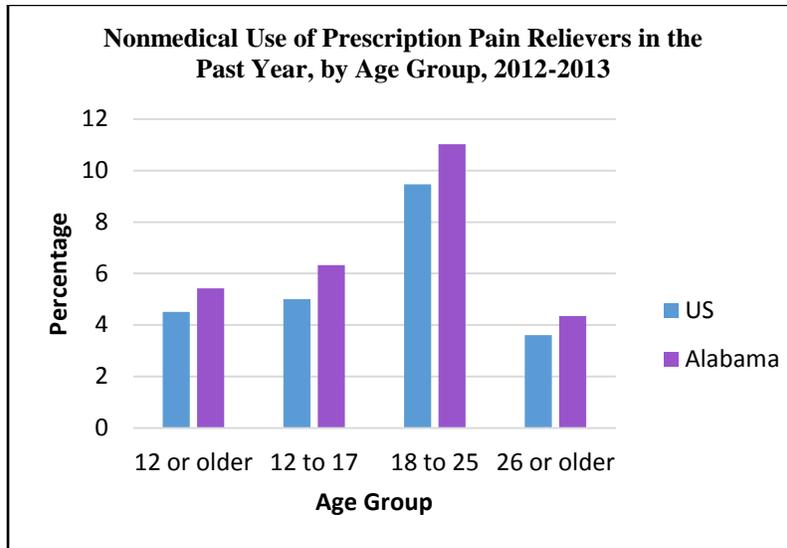
d. Prescription Drugs

Prescription drug abuse ranks third for 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 use of prescription drugs. (ADMH Behavioral Health 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 PDMP, hydrocodone bit/acetaminophen is the top dispensed controlled substance in Alabama. (ADTA)

In Alabama, 5.4% of persons aged 12 or older reported nonmedical use of prescription pain relievers in the past year compared to 4.5% in the US (NSDUH,

2012-2013). In 2013, 19.7% of high school youth had taken prescription drugs one or more times without a doctor's prescription. Males (21.2%) were significantly more likely to ever take prescription drugs one or more times without a doctor's prescription than females (17.9%). (YRBS, 2013)

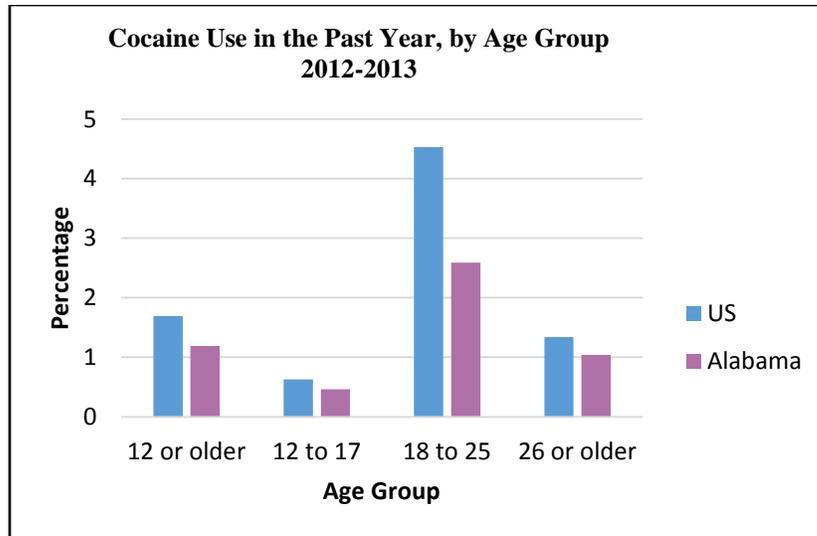


Source: NSDUH

e. Cocaine

Cocaine continues to be a 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. In the Uniform Crime Report, 21,693 violent crimes (449.9 violent crimes per 100,000 inhabitants) were reported in 2011 which is an increase from 20,174 violent crimes (420.1 violent crimes per 100,000 inhabitants) in 2010. Also, 168,878 property crimes (3502.2 property crimes per 100,000 inhabitants) were reported in 2012 which is a decrease from 173,190 property crimes (3606.1 per 100,000 inhabitants) in 2011.

In the 2012-2013 NSDUH, 1.2% of individuals age 12 and older reported cocaine use in the past month compared to 1.7% in the US. According to the Alabama substance Abuse Information System (ASAIS), 2,295 individuals sought treatment at state-operated or funded institutions for abuse of cocaine/crack as primary substance in 2012 compared to 2,653 individuals in 2011 (13 percent decrease).



Source: NSDUH

f. 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 retrieved from ASAIS, there were 319 treatment admissions for heroin as the primary substance in 2011 in comparison to 861 in 2014. In 2013, as according to the Youth Risk and Behavior Survey, 5.3% of high school youth had used heroin at least once. Males (5.9%) were significantly more likely to use heroin at least once than females (3.8%).

Based on the ADTA, heroin is increasingly becoming an alternate drug of choice for hydrocodone users. Areas in and around Birmingham have experienced an increase in heroin related deaths resulting from overdoses. Heroin is readily available in the Jefferson and Shelby County areas. Heroin has become so popular, that cocaine/other drug distributors are now selling heroin. The resurgence of heroin is a major factor in overdose deaths due to the high purity of the drug.

g. Inhalants

Per the ADMH Behavioral Health Needs Assessment 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 Behavioral Health Needs Assessment). Based on ASAIS, there were 16 treatment admissions for inhalants as the primary substance in 2011 vs. 12 in 2012.

h. 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).

The production of methamphetamine is a major drug threat, contributing to the commission of violent and property crimes. In the Uniform Crime Report, 21,693 violent crimes (449.9 violent crimes per 100,000 inhabitants) were reported in 2011 which is an increase from 20,174 violent crimes (420.1 violent crimes per 100,000 inhabitants) in 2011. Also, 168,878 property crimes (3502.2 property crimes per 100,000 inhabitants) were reported in 2012 which is a decrease from 173,190 property crimes (3606.1 per 100,000 inhabitants) in 2011. Methamphetamine generates violent crime and affects public safety, public health, and environmental concerns during its production and distribution.

i. 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 ADTH.

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.

In 2012 Alabama State Senate Bill 208 and House Bill 158, often referred to as the “Spice Bills”, were passed. Both laws regulate synthetic marijuana and other similar substances. Yet, from March 15 through April 20, 2015 Alabama hospitals reported a total of 462 patients seen who had experienced symptoms after smoking or ingesting synthetic cannabinoids. Of these, 96 patients were hospitalized and 2 deaths occurred. This outbreak of spice overdoses prompted the release of health advisories from both ADMH and the Alabama Department of Public Health.

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 methylenedioxypropylvalerone (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).

3. IDENTIFICATION OF GAPS

Alabama not only has significant needs in relation to the consumption and consequences of drugs by its residents, but also has access and service delivery gaps in regard to populations in need of services.

a. High Risk Youth

The potential for problematic alcohol and/or other drug use increases as the number of risk factors experienced, as illustrated in **TABLE 2**, 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.

TABLE 2

RISK/PROTECTIVE FACTOR CHART		
DOMAIN	RISK FACTOR	PROTECTIVE FACTOR
Individual	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Family history of high-risk behavior • Family management problems • Family conflict • Parental attitudes and involvement in the problem behavior 	<ul style="list-style-type: none"> • Bonding (positive attachments) • Healthy beliefs and clear standards for behavior • High parental expectations • A sense of basic trust • Positive family dynamics
School	<ul style="list-style-type: none"> • Early and persistent antisocial 	<ul style="list-style-type: none"> • Opportunities for pro-social

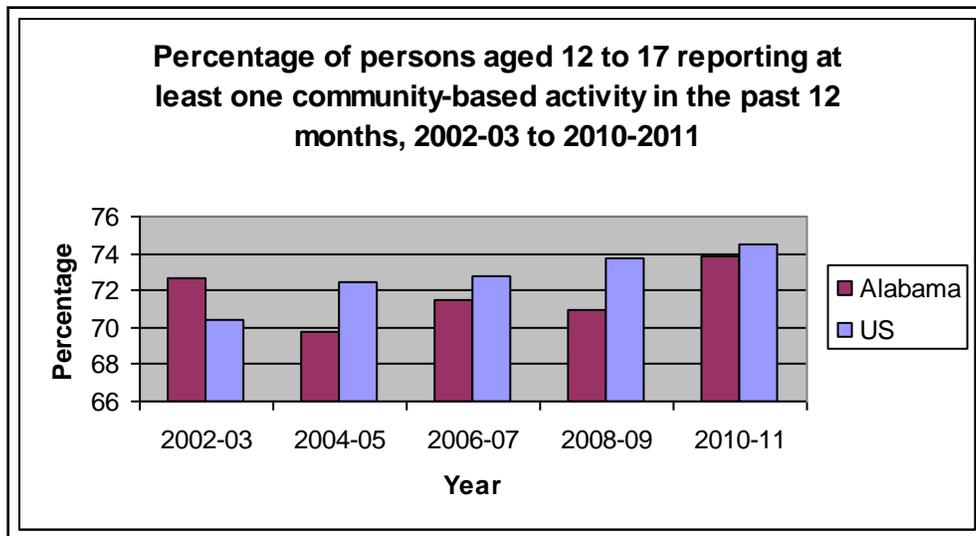
	behavior <ul style="list-style-type: none"> • Academic failure beginning in elementary school • Low commitment to school 	involvement <ul style="list-style-type: none"> • Rewards/recognition for pro-social involvement • Healthy beliefs and clear standards for behavior • Caring and support from teachers and staff • Positive instructional climate
Community	<ul style="list-style-type: none"> • Availability of drugs • Community laws, norms favorable toward drug use • Extreme economic and social deprivation • Transition and mobility • Low neighborhood attachment and community disorganization 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug-use messages in the media 	<ul style="list-style-type: none"> • 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

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 2013, 8,809 children were victims of abuse or neglect in Alabama.
- Of these children, 3,383 were neglected, 4,473 were physically abused, and 1,793 were sexually abused.
- In 2013, 32 children in Alabama died as a result of abuse or neglect, up from 11 in 2011 and 21 in 2012.

As reported in the 2014 Annie E. Casey Kids Count Profile:

- In 2012, 27% of Alabama’s children lived in poverty, with 13% living in families with incomes less than 50 percent of the federal poverty level.
- In 2012, 35% of the state’s children had parents who lacked secure employment.
- In 2012, 25% of the state high school students did not graduate on time.
- In 2012-2013, approximately 24,000 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 decreasing the likelihood of substance abuse includes parental involvement, involvement in activities, and religious beliefs influence.

b. Underage Drinkers

Although underage drinking is illegal in the state, 14.6% of all alcohol sold in Alabama is consumed by underage drinkers. In 2011, 9th –12th Graders in Alabama reported the following information in regard to underage drinking:

- Alcohol use prior to age 13 in 2011 - 24%
- Had at least one drink of alcohol on at least 1 day during the past 30 days - 36%
- Had five or more drinks of alcohol in a row within a couple of hours on at least 1day during the past 30 days - 21%
- Usually obtained the alcohol they drank by someone giving it to them - 39%
- 67% had at least one drink of alcohol on one day during their life.

Underage drinking cost the citizens of Alabama \$1.0 billion in 2010, which for each youth in the state is a cost of \$2,222 per year. Work lost costs and medical costs account for 39% (\$393M) of the total cost related to underage drinking. By problem, youth violence (homicide, suicide, aggravated assault) represent the largest costs for Alabama, followed by youth traffic crashes. Other problems that factor into the total

cost of underage drinking include poisonings and psychoses (\$8.6M), fetal alcohol syndrome among mothers age 15-20 (\$23.4M), and youth alcohol treatment (\$17.6M).

c. 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.

TABLE 3

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 ADMH Behavioral Health Needs Assessment 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 in **TABLE 4** below:

TABLE 4

Focus Group	Findings
Asian/ Pacific Islanders	Barriers to Care included: <ul style="list-style-type: none"> ▪ 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: <ol style="list-style-type: none"> 1. A linguistically and culturally aligned medical provider 2. Advertise behavioral health services by word of mouth.
Hispanics	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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.

d. 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

e. Intravenous Drug Users

Intravenous 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. Alabama has seen an explosion of drug overdoses since 2010. The use of opioids throughout our state is rapidly escalating and creating major public health concerns.

News stories and headlines from across the state clearly illustrate our current situation in regard to heroin and prescription drug use:

- *Multistate Heroin Sting Nets 8 on Federal Charges in the Shoals.*
- *Heroin and Cocaine Bust in Baldwin County.*
- *Lethal injection: Student Heroin Use increases.*
- *Alabama Police Find Heroin in Toddler's Diaper, Arrest Father.*
- *Birmingham's Heroin Problems Demand Solutions Right Now.*

- *Heroin Popularity on the Rise in Alabama.*
- *Has Alabama's Heroin Epidemic Reached the River Region?*
- *Heroin deaths jumped 140 percent in Jefferson County in 2014.*
- *Physicians in Alabama -- the state with the highest number of narcotic painkiller prescriptions -- issued nearly three times as many of those prescriptions as doctors in Hawaii -- the lowest prescribing state, according to researchers with the Centers for Disease Control and Prevention.*
- *Alabama Drug Abuse Task Force Panelists Say We're not Winning War on Drugs.*

To address these problems, a number of state and local efforts are in progress which include the following:

- The U.S. Attorney in Alabama's Northern District has joined forces with the Alabama Department of Public Health and the University of Alabama in creation of an organized effort to combat the epidemic use of heroin and prescription drug misuse in North Alabama. The campaign, "Pills to Needles – The Pathway to Rising Heroin Deaths," has brought together stakeholders from various professional disciplines, law enforcement, the faith-based community, as well as, families with personal experience of the addiction's devastation to create a strategic plan for addressing this issue. This includes efforts not only to provide more rigorous attack on the supply, but also efforts to promote awareness, prevention, treatment, and strategies to reduce drug overdose deaths.
- The U.S. Attorney's Office for the Middle District of Alabama recently convened a workgroup to address concerns over heroin, prescription drugs, and Spice use in the Middle District. Participants included state health and education agencies along with law enforcement personnel.
- The statutorily created Alabama Drug Abuse Task Force went live with its ZeroAddiction campaign on May 20, 2015. The campaign consists of a website, zeroaddiction.org, as well as television commercials. Prescription drug misuse is the focus of this campaign with the website providing access to educational information, as well as, links to substance abuse prevention and treatment resources.
- HB 208, a proposed Naloxone access statute, was introduced and passed during the 2015 Alabama State Legislative session. HB 208 will:
 - Authorize a physician or dentist to prescribe an opioid antagonist to an individual at risk of experiencing an opiate-related overdose or to an

individual who is in a position to assist another individual at risk of experiencing an opiate-related overdose;

- Provide immunity to a physician or dentist who prescribes an opioid antagonist and to an individual who administers an opioid antagonist; and
- Provide immunity from prosecution for possession or consumption of alcohol for an individual under the age of 21 or a misdemeanor controlled substance offense by any individual who seeks medical assistance for another individual under certain circumstances.

Admissions to Alabama’s public substance abuse treatment system by individuals who identified heroin as their primary drug of choice increased by 48% between October 2014 and May 2015 in comparison to the period between October 2013 and May 2014. For the very first time in FY 2014 admissions to treatment for opioid addiction exceeded admission for alcohol. Yet, outreach to IDUs by publicly funded programs lags behind the need, as do access to appropriate service modalities and use of evidence-based practices appropriate for treatment of this population.

f. 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.

Four hundred seventy-nine (479) women have been arrested since enactment of the state’s chemical endangerment law in 2006. Intended to protect children exposed to methamphetamine 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.” Alabama’s chemical endangerment law has been called the most sweeping measure deployed against pregnant women in the U.S.

In addition to the upward trend of arresting women for chemical endangerment of children, the number of cases of Neonatal Abstinence Syndrome (NAS) cases is also on the rise in Alabama. NAS covered by Medicaid in Alabama more than doubled from 170 cases in 2010 to 345 in 2013, according to research by Casey Wylie with the division of Quality Analytics. The true number of NAS cases in Alabama may be much higher. A 2008 study by the Alabama Maternal Drug Task Force found evidence of drug use in almost 13 percent of urine samples collected from 500

pregnant women. That could mean that more than 8,000 women in Alabama use drugs during pregnancy every year, according to the study.

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. Yet, 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 Time of Admission ADMH Funded Substance Abuse Treatment Programs	2009	2010	2011	2012	2013	2014
	281	262	267	275	219	245

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.

g. 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 contract providers are required to implement written policies and procedures for the provision of TB services. Directly or through arrangements with other public or nonprofit private entities, providers must make available TB services to include:

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

Initial screening for identification of high risk individuals is accomplished through questions integrated into the ADMH placement assessment used by all contractual providers. However, this screening process provides little guidance for appropriate follow-up of positive responses. As part of the placement assessment process, the

potential for positive responses to be overlooked during the actual intake process also exists.

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 reported in 2009. There has been a steady decline of new TB cases in Alabama since 2007. ADPH reports there were 133 new TB cases in 2014. Alabama's 2014 TB infection rate of 2.8 cases per 100,000 persons is less than the U.S. rate of 2.96 per 100,000

h. Individuals at Risk for HIV

According to the **2013 State of Alabama HIV Surveillance Report:**

- At the end of 2013, 14,019 Alabama residents were known to be living with HIV and 6,362 (45%) of these had progressed to Stage 3 (AIDS) infection.
- 650 newly diagnosed HIV infections were reported among Alabama residents in 2013. This number is an underestimate as it does not account for individuals unaware of their status.
- There are persons living with HIV in every county in Alabama and the number continues to increase. In 2013, more HIV cases were diagnosed in Jefferson County than any other county while the rate of HIV per 100,000 residents was greatest in Montgomery County.
- African Americans continue to be disproportionately affected by HIV in Alabama. Although African Americans comprise only 27% of the population, 71% of newly diagnosed HIV infections occurred in African Americans during 2013. African American males were 6.8 times as likely to be diagnosed with HIV as White males while the rate of HIV in African American females was 11.4 times that of White females.
- Alabama is experiencing a downward shift in the age distribution of newly diagnosed HIV infections, as adolescents and young adults (13-29 years) have emerged as the most affected age group.
- While male-to-male sexual activity continues to be the predominant mode of exposure for HIV infection, heterosexual contact is the second most common mode of exposure.
- African American males reporting sex with another male represent the majority of newly diagnosed HIV infections occurring among adolescents and young adults aged 15 to 29 years.

- More than three quarters (78%) of newly diagnosed HIV infections during 2013 were linked to care within 90 days of diagnosis. However, Alabama’s estimated unmet need is 41%, as 5,775 of the 14,019 persons living with HIV as of December 31, 2013 did not access care during 2013.

Alabama is experiencing an HIV epidemic of moderate magnitude when compared to the experience of other states, according to the Alabama Department of Public Health. Yet, its 2013 Stage 3 (AIDS) rate of 13.3 (11.1) per 100,000 population establishes Alabama as a designated state for delivery HIV early intervention services in FY 2016. With an estimated 1 in 6 people living with HIV in Alabama unaware of their infection, suggesting 16,262 Alabama residents may be infected with HIV, substance abuse treatment programs are in a prime position to intervene on the spread of this illness, as well as, prevent the development of new cases of the disease.

TABLE 5

Top Five Alabama Counties with the Highest Frequency of Newly Diagnosed HIV Cases, Alabama 2009 – 2013										
County	2009		2010		2011		2012		2013	
	No.	Rate								
Jefferson	198	30.1	194	29.5	208	31.6	194	29.5	174	26.4
Madison	39	11.6	36	10.7	46	13.5	44	12.8	40	11.5
Mobile	109	26.4	91	22.0	97	23.5	88	21.3	94	22.7
Montgomery	85	37.0	77	33.5	79	34.1	70	30.5	72	31.8
Tuscaloosa	25	12.8	31	15.9	27	13.7	32	16.1	47	23.4
Statewide	706	14.8	693	14.5	711	14.8	678	14.1	650	13.4

In 2013, injecting drug use and men having sex with men in conjunction with injecting drug use accounted for 6.6% of newly diagnosed HIV cases by mode of exposure in Alabama. With injecting drug use rapidly increasing in the state, the potential exists for this mode of HIV exposure also increase.

4. SYSTEM GAPS

a. Prevention

Data was collected from prevention providers concerning service gaps and barriers at the community-level prevention system as a part of the prevention system needs assessment conducted in 2013-2014. Data was collected in the following areas: 2013 Coalition Readiness (SPF-SIG), 2014 Prevention Workforce and Retention (Community-Level) and 2014 Funding Allocation (ADMH). One hundred thirty-five (135) community respondents, representative of twenty (20) communities currently being served by nine sub recipients responded to the survey regarding coalition readiness. Forty-nine (49) survey were collected by the current prevention workforce regarding workforce development. Information gathered from state and national sources provided preliminary data from which the needs assessment took direction to measure the most effective and efficient funding mechanism to Alabama’s prevention funding process. Counties were analyzed based on population and need. Service needs/gaps identified from each aforementioned area are as follows:

(1) 2013 Coalition Readiness (SPF-SIG)

- (a) There is a lack of community certainty that the state prevention system is contributing significantly to coalition mission and goals. Currently, the state prevention system contributes funding to two coalitions. Additional coalitions are funded through the SPF-SIG project.
- (b) There is a lack of collaboration among the state prevention system partners. Alabama has a collaborative prevention infrastructure that many individuals are not aware of or are uncertain as to its existence and/or function.

(2) 2014 Prevention Workforce and Retention (Community-Level)

- (a) There is a state-level need for increased prevention workforce development. Identified gaps in the area of T/TA 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.
- (b) Workforce perception that salary compensation is not comparable to the work required.
- (c) Workforce perception that there is a lack of advancement opportunities within organization.

(3) 2014 Funding Allocation (ADMH)

During the 2011 Alabama Substance Abuse Prevention and Synar System Review, the Substance Abuse and Mental Health Services Administration's (SAMSHA) Center for Substance Abuse Prevention (CSAP) found the following challenges, potential enhancements, and areas for strengthening Alabama's prevention system, thus, prompting the 2014 assessment of the funding process.

- Stabilize and strengthen the State's prevention system—including funding and other resources;
- Leverage resources to build the capacity of providers;
- Prioritize current high needs areas and emerging issues when making funding decisions;
- Need to demonstrate significant improvements in reducing the problems and consequences related to substance abuse;
- Expand the reach of prevention funds. The SSA's ability to achieve its desired goal of positive population-level change and reduce high substance use rates would be enhanced by an analysis of how the reach of prevention funds could be broadened;

(4) Data Gap

Alabama does not have a current state-wide depository for substance abuse data specific to the state. Instead, Substance Abuse Prevention Planning & Epidemiology Tool (SAPPET) is the primary resource utilized to access substance use data. SAPPET is an interactive, web-based data monitoring system supported by the SAMHSA and the CSAP. Although SAPPET is a useful instrument in locating substance use and/or abuse information for Alabama, gaps in this data are a significant problem. State agencies at this time do not submit data to SAPPET, but there is the option for them to do so.

Alabama has other challenges to contend with concerning data capacity. There are limitations to available data sources that 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.

b. Prevention, Treatment, and Recovery Support

A 2015 survey developed by the ADMH for Governor Robert Bentley’s Health Care Task Force asked respondents to identify the most important strategies that should be implemented in Alabama to improve the public’s access to services for prevention and/or treatment of substance use disorders. Categorical responses were as given in **TABLE 6**.

TABLE 6

Access	% Responses	# Responses
Capacity	33.2	88
Funding	15.09	40
System Infrastructure	14.72	39
Education	13.21	35
Treatment Services	8.30	22
Insurance	6.04	16
Performance Improvement	3.02	8
Prevention Services	2.26	6
Recovery Support	1.89	5
Other	1.51	4
Workforce	.75	2

Within the above listed categories, the top 5 predominant themes for improving service access were:

(1) Capacity:

- More treatment services needed
- Particular concern for rural area services
- Particular concern for affordable services/services for people without the ability to pay
- Transportation

(2) Funding:

- More funding needed to adequately support existing resources and improve access in underserved areas.
- Funding needed to purchase services for individuals who have no insurance or ability to pay for care.
- Free substance abuse treatment

(3) Infrastructure:

- Expand Medicaid
- Allow CRNPs to practice to the full scope of their training and education
- Establish guidelines and procedures to monitor the prescribing practices of HCPs
- Minimize state intrusion in regard to the regulation of SA programs
- Make treatment services available in lieu of incarceration

(4) Education:

- More education needed for the general public, physicians, school age children
- More advertising of available resources

(5) Treatment Services: Particular concern for:

- More detox services
- Access to medication assisted treatment
- Integrated care

The same survey asked respondents to identify the most important strategies that should be implemented in Alabama to improve the quality of services for prevention and/or treatment of substance use disorders. Categorical responses were as given in **TABLE 7**.

TABLE 7

Priority #2	% Responses	# Responses
Treatment Services	17.07	42
Performance Improvement	15.85	39
Workforce	13.01	32
System Infrastructure	12.60	31
Funding	9.35	23
Training	8.54	21
Capacity	6.50	16
Education	5.28	13
Prevention	4.47	11
Recovery Support	4.47	11
Insurance	2.85	7

Within the above listed categories, the top 5 predominant themes for improving service quality were:

(6) Treatment Services

- Integration of addiction and health care services

- Access to medication assisted services
- Evidence-based practices

(7) Performance Improvement

- More regulation of Methadone treatment and physicians prescribing pain meds.
- Certification of all treatment providers
- Publically available performance outcomes
- Quality benchmarks

(8) Workforce

- More workers needed
- Incentives to work in mental/health substance abuse
- Incentives to work in rural areas
- Increase number of peer workers
- Increase scope of practice for nurse practitioners

(9) System Infrastructure

- Consistent prenatal care for addicted mothers
- More relaxed and easier to understand standards of care

(10) Funding

- Increase funding for all services

B. ADMH 2014 Substance Abuse 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 16 - FY17 SABG. These priorities are representative of some of the state’s most critical gaps and needs, and provide ADMH with the opportunity to enhance the lives and well-being of thousands of Alabamians impacted by the use of alcohol 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. INTRAVENOUS 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 IDUs. 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.

In addition, ADMH provider organizations have been slow to implement evidence-based treatment strategies appropriate for use with this population. Except for Opioid Treatment Programs, there is very little use of medication assisted treatment within the State's public substance abuse service delivery system.

3. INDIVIDUALS WITH OR AT RISK FOR TUBERCULOSIS

Unmet Need/Gap: Although all certified substance abuse programs "screen" for TB, the quality of those screens and resulting client follow-up varies from program to program. To support efforts to appropriately identify individuals at risk for or who have tuberculosis, a standardized screening process is needed. In addition, to support monitoring of TB services, data reflecting services provided should be sent to ADMH.

4. PREGNANT AND PARENTING WOMEN

Unmet Need / Gap: In 2013 there were 58,162 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 and parenting 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.

5. HIV EARLY INTERVENTION SERVICES

Unmet Need / Gap: With the resurgence of heroin in the state, injecting drug use is on the rise in Alabama. Injecting drug use paves the pathway for HIV. The availability of HIV early intervention services for participants in the state's public service delivery system will aid in thwarting a surge of the state's HIV infection rate and save lives.

6. DEVELOPMENT OF PEER SERVICES

Unmet Need / Gap: The value of peers to the addictions workforce has been greatly ignored in the public service delivery system. ADMH currently lacks the infrastructure needed to insure the routine utilization of these vital workers within the programs it funds. Actions are needed to develop this infrastructure and promote the use of peers as part of the routine care for individuals who have substance use disorders.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Alabama is not in need of technical assistance in this area at this time.

Footnotes:

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client program, provider, and/or other levels).

The Alabama Substance Abuse Information System (ASAIS) went live in June of 2008. The web-based hosted management information system captures information on all clients who receive substance abuse services from the 64 ADMH-contract providers of substance abuse prevention and treatment services in the state of Alabama.

This system captures provider characteristics, including levels of care and services delivered, addresses, points of contact, etc. It also collects client enrollments, demographics and characteristics. The Treatment Episode Data Set (TEDS), National Outcome Measures, and ADMH specific performance improvement measures are collected at the time of client assessment, admission and discharge. This occurs through direct entry into the web-based system or through a secure web-based upload, depending upon the sophistication of the provider's management information system. To facilitate this process, each client is assigned a unique ID at the time of screening that follows their care throughout the system regardless of provider. Provider NPI numbers, as well as, unique vendor numbers assigned by ASAIS enable the system to track service delivery by program. System modifications are currently in process to enable client level data to be tracked at the individual practitioner level.

Client-level data is collected that includes information on the date of service, type of service, and service quantity through a standard 837 that can be submitted into ASAIS at any time during the fiscal year by the service providers. ASAIS serves as the payment system for State, SABG, and Medicaid substance abuse services. All claims submitted to the system are then validated against 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 SABG grant funds upon receipt of the Medicaid determination.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

ASAIS is specific to substance abuse services provided by the Alabama Department of Mental Health.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

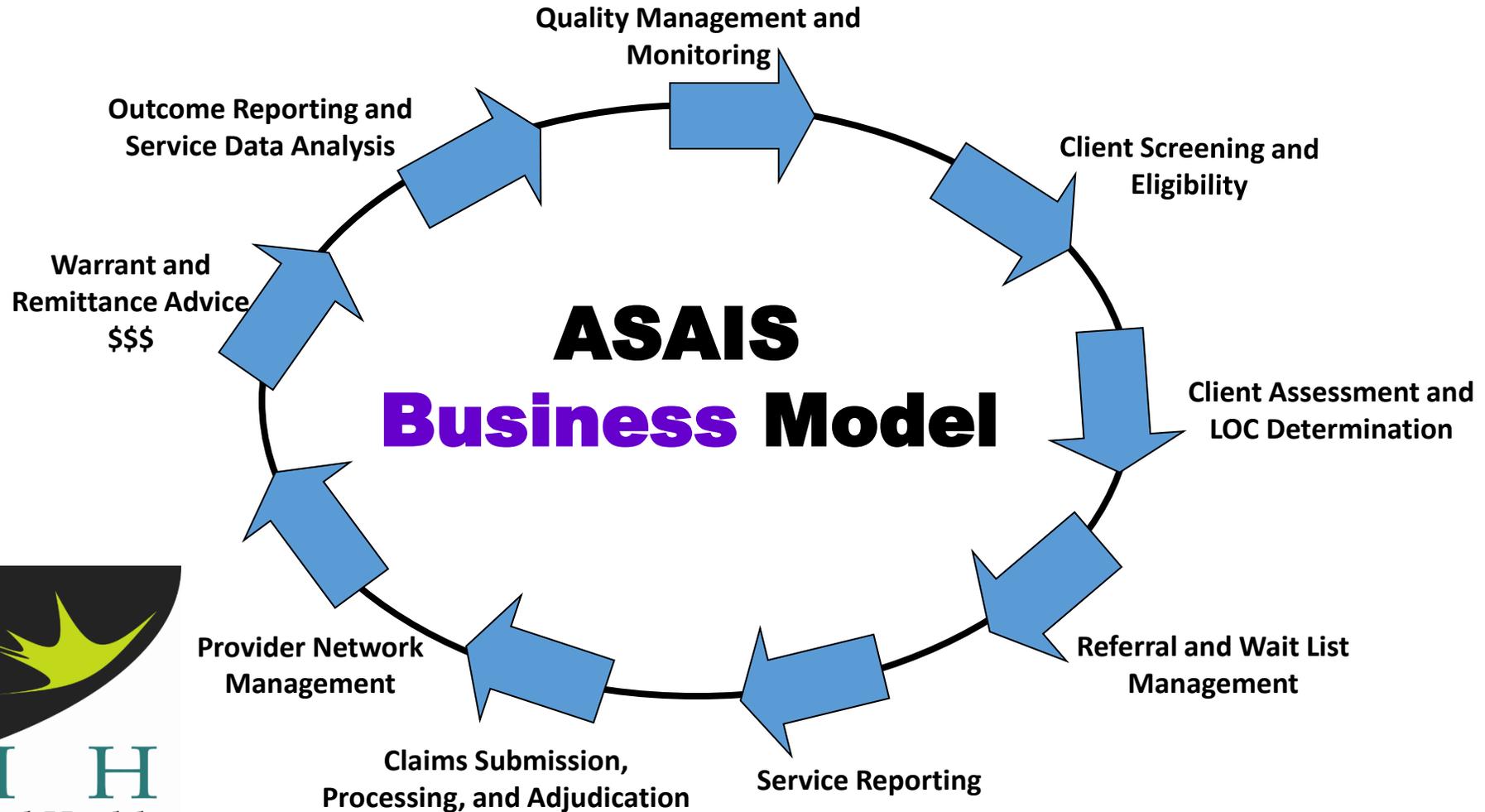
Yes.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

ALABAMA SUBSTANCE ABUSE INFORMATION SYSTEM (ASAIS)

A hosted web-based management information system designed to assist ADMH in the efficient and effective delivery of quality substance abuse prevention and treatment services



Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Underage Drinking
Priority Type: SAP
Population(s): PP

Goal of the priority area:

A comprehensive approach across prevention strategies will be taken to prevent the onset of and reduce underage drinking.

Objective:

Promote the prevention of underage drinking and young adult problem drinking.

Strategies to attain the objective:

- a) Maintenance of underage drinking as a priority for prevention services.
- b) Utilizing the Prevention Activity Sheet and state information system (ASAIS), track prevention activities targeting underage drinking.
- c) Disseminate underage drinking information.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of providers identifying underage drinking as a priority for prevention strategies.
Baseline Measurement: In SFY15, thirty-three (33%) providers identified underage drinking as a priority for prevention strategies.
First-year target/outcome measurement: By end of SFY16, 40% of providers will identify underage drinking as a priority for prevention strategies.
Second-year target/outcome measurement: By end of SFY17, 50% of providers will identify underage drinking as a priority for prevention strategies.

Data Source:

Selection of priority on the prevention plan. Back-up data reported from the state's information system (ASAIS).

Description of Data:

Priority selection section on the prevention plan will indicate where underage drinking was selected for the focus of prevention priority and prevention strategies. On the Prevention Activity Sheet (which is keyed into ASAIS), the selection of underage drinking as a priority of the focus of the prevention activities delivered.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 2
Priority Area: Pregnant Women
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Improve accessibility to substance abuse treatment for pregnant women in Alabama.

Objective:

Increase public awareness of substance abuse treatment services available to pregnant women in Alabama.

Strategies to attain the objective:

- a) Develop public awareness information about pregnant women and substance use disorders and the help available throughout the State.
- b) Disseminate public awareness information to various groups with relevance to pregnant women who have substance use disorders.
- c) Seek and secure speaking engagements with community groups that have relevance to pregnant women who have substance use disorders.
- d) Meet with state and local law enforcement officials in regard to referrals to treatment as an alternative to incarceration for pregnant women.
- e) Eliminate all intake fees for pregnant women at ADMH funded treatment programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Establishment of posters, brochures, public service announcements, and electronic media specific to access to care for pregnant women.

Baseline Measurement: As of September 30, 2016, no public awareness information has been developed by ADMH.

First-year target/outcome measurement: By September 30, 2016, brochures, posters, and public service announcements will exist as developed by ADMH.

Second-year target/outcome measurement: By September 30, 2017, brochures, posters, public service announcements, and electronic media will exist as developed by ADMH.

Data Source:

The existence of public awareness information.

Description of Data:

ADMH developed posters, brochures, public service announcements, and electronic media specific to access to care for pregnant women.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Indicator #: 2

Indicator: The number of outlets to which ADMH has distributed public awareness information.

Baseline Measurement: In FY 2015, ADMH distributed public awareness information to two outlets.

First-year target/outcome measurement: In FY 2016, ADMH will distribute public awareness information to 10 outlets.

Second-year target/outcome measurement: In FY 2016, ADMH will distribute public awareness information to twenty-five (25) outlets.

Data Source:

Records maintained by ADMH of public awareness information distribution.

Description of Data:

- Records detailing:
- a) Staff disseminating the information
 - b) Information distributed (type, amount, etc.)
 - c) Entity receiving the information
 - d) Date of distribution.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Indicator #: 3

Indicator: The number of speaking engagements held with community organizations and and meetings held with law enforcement officials.

Baseline Measurement: In FY 2015 there were was one (1) meeting held with community organizations and none held with law enforcement officials.

First-year target/outcome measurement: Five (5) meeting will be held with community organizations andthree (3) held with law enforcement officials.

Second-year target/outcome measurement: Ten (10) meetings wilwith community organizations and six (6) held with law enforcement officials.

Data Source:

Meeting attendance rosters.

Description of Data:

Records will be maintained which will provide:

- a) Meeting date
- b) Topic
- c) Group addressed
- d) Attendees
- e) ADMH presenter or meeting convener and other ADMH staff in attendance.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Indicator #: 4

Indicator: ADMH contract modifications to prohibit admission fees for pregnant women.

Baseline Measurement: In FY 2015 there were no contract stipulations in regard to admission fees for pregnant women.

First-year target/outcome measurement: In FY 2016 language will be added to each ADMH treatment services contract prohibiting providers from charging admission fees to pregnant women.

Second-year target/outcome measurement: in FY 2017, FY 2016 contract language prohibiting providers from charging admission fees to pregnant women will be maintined in substance abuuse treatment services contracts.

Data Source:

ADMH treatment services contracts.

Description of Data:

Contract language.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 3

Priority Area: Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Improve accessibility to substance abuse treatment services for women who have dependent children.

Objective:

Increase the number of substance abuse treatment resources for women who have dependent children.

Strategies to attain the objective:

- a) Identify potential new community organizations that may be amenable to partnering with ADMH for the provision of services for women who have dependent children, as County health departments, FQHC's licensed independent practitioners, etc.
- b) Establish criteria for contracting and service requirements for both women and their children.
- c) Modify ADMH's administrative code to support service requirements.
- d) Issue new service contracts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: New services will be available to serve pregnant women and women with dependent children.

Baseline Measurement: As of September 30, 2015, there are two(2) treatment provider organizations authorized to provide substance abuse treatment services for women with dependent children as specified by federal regulations.

First-year target/outcome measurement: In FY 2016, four (4) treatment providers will be authorized to provide treatment services for women who have dependent children as specified by federal regulations.

Second-year target/outcome measurement: In FY 2017, eight (8) treatment providers will be authorized to provide treatment services for women who have dependent children as specified by federal regulations.

Data Source:

Executed contracts for delivery of the specified service.

Description of Data:

Contract language identifying contractor, target population, and services to be provided.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 4

Priority Area: Persons at Risk of Contracting TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Ensure the ongoing availability of TB services, as specified in 45 CFR 96.127 for all individuals admitted to ADMH funded substance abuse treatment programs.

Objective:

Standardize the process of TB screening and related services in all ADMH certified programs.

Strategies to attain the objective:

- a) Adopt and deploy in AS AIS at least one CPT code to track the provision of TB services.
- b) Develop a payment rate for TB screening.
- c) Develop/adopt and require adherence to an ADMH TB screening tool.
- d) Modify ADMH contracts and its contract billing manual to require reporting of client-level TB service data.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Contract provider compliance with client level data report of TB service delivery

Baseline Measurement: As of September 30, 2015, no providers submit client level data to ADMH for TB screening and related services.

First-year target/outcome measurement: By September 30, 2016, 50% of ADMH contract providers will be submitting client level data to ADMH for TB screening and related services.

Second-year target/outcome measurement: By September 30, 2017, 100% of ADMH contract providers will be submitting client level data to ADMH for TB screening and related services.

Data Source:

ASAIS: Alabama Substance Abuse Information System

Description of Data:

CPT codes reported and billed through ASAIS documenting the provision of TB services.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 5

Priority Area: Individuals at Risk for HIV

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:

Ensure the availability of HIV early intervention services in select substance abuse treatment programs in Alabama.

Objective:

Establish HIV early intervention programs in each substance abuse treatment program located within the top five counties in Alabama with the highest frequency of newly diagnosed HIV cases.

Strategies to attain the objective:

- a) Develop and disseminate RFP for HIV early intervention services in designated areas.
- b) Develop serve codes and modify contract billing manuals to accommodate billing for HIV early intervention services.
- c) Review proposals, select providers, and develop service contracts.
- d) Monitor service delivery in accordance with requirements of federal regulations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of ADMH funded HIV Early Intervention Services (EIS) in operation in the top five counties with the highest frequency of newly diagnosed HIV cases.

Baseline Measurement: There are currently no ADMH funded HIV EIS in operation in Alabama.

First-year target/outcome measurement: By September 30, 2016, two of the five counties will have functioning HIV EIS at all substance abuse treatment programs located within those counties.

Second-year target/outcome measurement: By September 30, 2017, all five counties will have functioning HIV EIS at all substance abuse treatment programs located within those counties.

Data Source:

- 1) Provider Contracts
- 2) ADMH's Substance Abuse Services Management Information System (ASAIS)

Description of Data:

- 1) Contracts specifying the delivery of HIV EIS in specified counties.
- 2) Client level service data entered into ASAIS by contract providers.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 6
Priority Area: Intravenous Drug Users
Priority Type: SAT

Population(s):

Goal of the priority area:

To increase the number of IVDUs who are receiving substance abuse treatment

Objective:

Maintain the range of treatment services offered along the continuum of care and increase access to that care.

Strategies to attain the objective:

- 1) Intensify work with agencies to promote increase outreach efforts for IVDUs.
- 2) Monitor submitted TEDS data.
- 3) Monitor enrollments through the state's electronic reporting system.
- 4) Expand medication assisted treatment in underserved areas in the state.
- 5) Implement the revised placement assessment to facility more efficient access to care for IVDUs.
- 6) Provide training on evidence-based practices for treatment of IDUs.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of IVDUs served in Alabama's public substance abuse service delivery system.
Baseline Measurement: The baseline will be established on October 1, 2015, after collection of all data for SFY 2015.
First-year target/outcome measurement: Admissions will increase from baseline by 3%
Second-year target/outcome measurement: Increase from FY 2016 level by 5 %

Data Source:

ADMH's Substance Abuse Services Information System (ASAIS).

Description of Data:

Client level admission data entered by providers into ASAIS.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 7
Priority Area: Recovery Support Services for Individuals in or Seeking Recovery
Priority Type: SAT
Population(s): Other (Recovery Support)

Goal of the priority area:

Increase the availability of certified peer support specialists in Alabama to assist persons in recovery from substance use disorders.

Objective:

Establish an ADMH approved substance peer certification credential.

Strategies to attain the objective:

- a) Develop standards for substance abuse peer specialist services in Alabama.
- b) Complete the development of a certification training manual for substance abuse peer specialist.

- c) Train and certify substance abuse peer support specialist.
- d) Develop payment mechanisms to support the utilization of peer workers within ADMH's provider community.
- e) Monitor the utilization of peer workers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of ADMH trained and credentialed peer support support workers available to work with individuals who have substance use disorders.

Baseline Measurement: As of September 30, 2015, there are no ADMH trained and credentialed substance abuse peer support workers in Alabama.

First-year target/outcome measurement: By September 30, 2016, there will be 50 ADMH trained and credentialed substance abuse peer support workers in Alabama.

Second-year target/outcome measurement: By September 30, 2017, there will be 100 ADMH trained and credentialed substance abuse peer support workers in Alabama.

Data Source:

- 1) Alabama Administrative Code.
- 2) ADMH peer support training manual.
- 3) ADMH peer support training records.

Description of Data:

- 1) ADMH peer support worker credentialing rules filed in the Alabama Administrative Code
- 2) Training records with documented participant signatures, dates of training, and training content.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect this outcome measure.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	\$32,404,091		\$17,500,000	\$0	\$24,421,690	\$0	\$1,472,916
a. Pregnant Women and Women with Dependent Children*	\$4,063,644		\$1,000,000	\$0	\$0	\$0	\$0
b. All Other	\$28,340,447		\$16,500,000	\$0	\$24,421,690	\$0	\$1,472,916
2. Substance Abuse Primary Prevention	\$9,176,380		\$0	\$4,464,270	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$2,007,332		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$2,294,095		\$0	\$0	\$2,269,174	\$0	\$0
13. Total	\$45,881,898	\$0	\$17,500,000	\$4,464,270	\$26,690,864	\$0	\$1,472,916

* Prevention other than primary prevention

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$9,176,380
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$2,400,000
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$2,000,000
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$3,500,000
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$2,000,000
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$2,000,000
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$11,004,091
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$9,500,000
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$41,580,471

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$16,058,664
2 . Substance Abuse Primary Prevention	\$4,588,190
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	\$1,147,047
5 . Administration (SSA Level Only)	\$1,147,048
6. Total	\$22,940,949

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$147,379
	Selective	
	Indicated	
	Unspecified	
	Total	\$147,379
Education	Universal	\$64,003
	Selective	\$110,257
	Indicated	\$27,111
	Unspecified	
	Total	\$201,371
Alternatives	Universal	\$399,806
	Selective	\$8,609
	Indicated	\$23,521
	Unspecified	
	Total	\$431,936
Problem Identification and Referral	Universal	\$46,001
	Selective	\$93,005
	Indicated	\$94,272
	Unspecified	
	Total	\$233,278

Community-Based Process	Universal	\$369,677
	Selective	\$6,806
	Indicated	
	Unspecified	
	Total	\$376,483
Environmental	Universal	\$3,172,009
	Selective	\$25,734
	Indicated	
	Unspecified	
	Total	\$3,197,743
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		\$4,588,190
Total SABG Award*		\$22,940,949
Planned Primary Prevention Percentage		20.00 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$2,921,294	
Universal Indirect	\$1,277,581	
Selective	\$244,411	
Indicated	\$144,904	
Column Total	\$4,588,190	
Total SABG Award*	\$22,940,949	
Planned Primary Prevention Percentage	20.00 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$0	\$25,000	\$25,000
2. Quality Assurance	\$0	\$0	\$10,000	\$10,000
3. Training (Post-Employment)	\$0	\$0	\$50,000	\$50,000
4. Education (Pre-Employment)	\$0	\$0	\$0	
5. Program Development	\$0	\$0	\$100,000	\$100,000
6. Research and Evaluation	\$0	\$100,000	\$0	\$100,000
7. Information Systems	\$0	\$0	\$300,000	\$300,000
8. Total		\$100,000	\$485,000	\$585,000

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the 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?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses>; Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

⁴³ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

⁴⁸ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area at this time.

Footnotes:

Environmental Factors and Plan

1. Health Care System and Integration

Narrative Question:

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

- Healthcare Home/Physical Health
- Engagement Services
 - (1) Assessment
 - (2) Specialized Evaluations
 - (3) Consumer/family Education
- Outpatient Services
 - (1) Evidence-based Therapies
 - (2) Group Therapy
 - (3) Family Therapy
 - (4) Multifamily Therapy
- Medication Services
 - (1) Medication Management
 - (2) Pharmacotherapy
- Community Support
 - (1) Skill Building
- Other Supports
 - (1) Transportation
- Intensive Support Services
 - (1) Substance Abuse Intensive Outpatient

It is important to note that although the above services will be available through Medicaid, Alabama is a non-expansion state with the most rigid Medicaid requirements in the country.

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

ADMH does not have such a plan and is not aware of the availability of such.

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

No specific responsibility has been assigned to this task by the Alabama Insurance Commission.

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

No appeal has been made to the SSA for such involvement.

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

Coverage offered in the state's EHB package will only be available to a very small percentage of the SSA's clientele, as most are uninsured. Thus, at this time, the State is seeking to preserve its safety net benefit package.

6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?

- 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. The 1115 Waiver application was submitted to the Center for Medicare and Medicaid Services (CMS) on May 30, 2014. Although Alabama Medicaid is still in discussions with CMS regarding the 1115 Waiver application, implementation of full-risk Regional Care Organizations is anticipated to begin no later than October 1, 2016. At this time mental/behavioral health services, with the exception of substance use disorder treatment, will be included under the RCOs. The current plan is to roll substance use disorder treatment services into the RCO model beginning October 1, 2018.
 - 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.
 - ADMH participates in the Quality Assurance Committee which was formed by Alabama Medicaid to draft quality measures aimed at assuring that the quality of care provided to Alabama Medicaid recipients is not diminished under the RCOs. The group approved 42 measures, all but one of which is nationally recognized and validated. This will allow Alabama to compare its performance with other states and national benchmarks. The measures not only include metrics related to diabetes, asthma and well-child care, but mental and behavioral health, care coordination and if care is provided in the most appropriate location.
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

The SSA is currently participating in a NIATx systems integration initiative to enhance collaborative relationships as described above.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

ADMH 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 has expanded provider requirements in regard to smoking in residential facilities which serve women with dependent children. The following language was incorporated into the 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.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

Substance Use Disorder agencies certified by the Alabama Department of Mental Health are responsible to screen, assess, and address smoking among the persons they serve. The substance use placement assessment, which is required for admission into substance use disorder treatment programs certified by the Alabama Department of Mental Health, includes assessment of tobacco use. The ADMH 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.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- Regular screening with a carbon monoxide (CO) monitor

No

- Smoking cessation classes

The ADMH Administrative Code 580-9-44 includes requirements that smoking cessation classes are among core services which must be offered by agencies certified at Level I (Outpatient), Level II.1 (Intensive Outpatient) and Level II.5 (Partial Hospitalization).

- Quit Helplines/Peer supports

Yes as provided by the Alabama Department of Public Health

- Others:

ADMH Administrative Code requirements cited in items 8 and 9, above

11. The behavioral health providers screen and refer for:

- Prevention and wellness education;
- The ADMH Administrative Code 580-9-44 requires that Health Education be offered as one of the treatment strategies under:

Level I - Outpatient Treatment
 Level II.1 - Intensive Outpatient Treatment
 Level II.5 – Partial Hospitalization Treatment
 Level III.01 – Transitional Residential Program
 Level III.1 – Clinically Managed Low Intensity Residential Treatment
 Level III.3 – Clinically Managed Medium Intensity Residential Treatment – Adults
 Level III.5 – Clinically Managed Medium Intensity Residential Treatment – Adolescents
 Level III.5 – Clinically Managed High Intensity Residential Treatment – Adults
 Level III.7 – Medically Monitored Intensive Residential Treatment – Adults
 Level III.7 – Medically Monitored High Intensity Residential Treatment – Adolescents
 Level I-O – Opioid Maintenance Therapy

- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- The Placement Assessment which is required for admission into substance use disorder treatment screens for biomedical conditions and complications under Dimension 2 of the Assessment.
- The ADMH Administrative Code 580-9-44 requires that programs ensure the availability of, and provider referrals as needed, for medical services, including assessment under:
 - Level 0.5 (Early Intervention)
 - Level III.1 – Clinically Managed Low Intensity Residential Treatment
- The ADMH Administrative Code 580-9-44 requires that primary medical care, prenatal care and primary pediatric care for children be available under:
 - Level I – Outpatient Treatment - Women and Dependent Children
 - Level II.1 - Intensive Outpatient Treatment - Women and Dependent Children
 - Level II.5 – Partial Hospitalization Treatment - Women and Dependent Children
 - Level III.1 – Clinically Managed Low Intensity Residential Treatment – Women and Dependent Children
- The ADMH Administrative Code 580-9-44 requires completion of a comprehensive medical history and physical examination of the client at admission to:
 - Level I-D – Ambulatory Detoxification without Extending On-Site Monitoring
 - Level II-D – Ambulatory Detoxification without Extending On-Site Monitoring
 - Level III.2-D – Clinically Managed Residential Detoxification
 - Level III.7-D – Medically Monitored Residential Detoxification
- The ADMH Administrative Code 580-9-44 requires that medical and somatic services be available under:
 - Level II-D – Ambulatory Detoxification without Extending On-Site Monitoring
 - Level III.2-D – Clinically Managed Residential Detoxification
 - Level III.3 – Clinically Managed Medium Intensity Residential Treatment – Adults
 - Level III.5 – Clinically Managed Medium Intensity Residential Treatment – Adolescents

Level III.5 – Clinically Managed High Intensity Residential Treatment – Adults
Level III.7 – Medically Monitored Intensive Residential Treatment – Adults
Level III.7 – Medically Monitored High Intensity Residential Treatment – Adolescents
Level III.7-D – Medically Monitored Residential Detoxification

- The ADMH Administrative Code 580-9-44 requires that clients who have not had a physical examination with the last twelve (12) months be scheduled a physical examination within two (2) weeks of admission under:
 - Level III.3 – Clinically Managed Medium Intensity Residential Treatment - Adults
 - Level III.5 – Clinically Managed Medium Intensity Residential Treatment - Adolescents
 - Level III.5 – Clinically Managed High Intensity Residential Treatment - Adults

- The ADMH Administrative Code 580-9-44 requires that pregnant clients who are not receiving routine prenatal care shall be seen by a physician within two (2) weeks of admission under:
 - Level III.3 – Clinically Managed Medium Intensity Residential Treatment - Adults
 - Level III.5 – Clinically Managed Medium Intensity Residential Treatment - Adolescents
 - Level III.5 – Clinically Managed High Intensity Residential Treatment – Adults
 - Level III.7 – Medically Monitored Intensive Residential Treatment – Adults
 - Level III.7 – Medically Monitored High Intensity Residential Treatment – Adolescents

- The ADMH Administrative Code 580-9-44 requires the availability of a physician or physician extender to assess each client in person within twenty-four (24) hours of admission and thereafter as medically necessary under:
 - Level III.7 – Medically Monitored Intensive Residential Treatment – Adults
 - Level III.7 – Medically Monitored High Intensity Residential Treatment – Adolescents

- The ADMH Administrative Code 580-9-44 requires that before an entity admits an individual to a Level I-O program, the program’s medical director, or a physician or physician extender properly authorized by the medical directors, shall conduct and document the findings of a medical examination. Also required, within fourteen (14) days of admission, is a complete medical examination, including a complete medical history, TB skin test or X-ray, screening tests for STDs, and other laboratory tests as clinically indicated.
 - Recovery supports

- The Placement Assessment which is required for admission into substance use disorder treatment explores each individual’s recovery and living environment under Dimension 6 of the Assessment.

- The ADMH Administrative Code 580-9-44 requires that Recovery Support Services shall, directly or by referral, be offered as one of the core services under:
 - Level I – Outpatient Treatment
 - Level II.1 - Intensive Outpatient Treatment

Level II.5 – Partial Hospitalization Treatment
Level III.01 – Transitional Residential Program
Level III.1 – Clinically Managed Low Intensity Residential Treatment
Level III.3 – Clinically Managed Medium Intensity Residential Treatment - Adults
Level III.5 – Clinically Managed Medium Intensity Residential Treatment - Adolescents
Level III.5 – Clinically Managed High Intensity Residential Treatment - Adults
Level III.7 – Medically Monitored Intensive Residential Treatment – Adults
Level III.7 – Medically Monitored High Intensity Residential Treatment – Adolescents
Level I-O – Opioid Maintenance Therapy

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. 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, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and 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. 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area at this time.

Footnotes:

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, 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. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

Alabama's plan includes the following strategies:

1. Create a cultural competence advisory group of ADMH staff, provider organizations, and members of diverse cultural groups and institutions.
 2. Conduct a data comparison study that will identify and map current substance abuse service locations and levels of care in relation to Alabama county health indicators, and population demographics.
 3. Assess the staff and service capacity of the public substance abuse system to serve the identified groups.
 4. Assess the policies and procedures of provider organizations to address the needs of cultural groups.
 5. Develop practice strategies and standards to support improved service outcomes of diverse cultural groups.
 6. Conduct trainings to improve competence skill sets for the public workforce.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?

Yes. 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. ADMH's 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.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

ADMH's contracts for substance abuse services stipulate the requirement for collaboration with the ADMH Office of Deaf Services (ODS) for language assistance services. The contractors are required to inform ODS when a client who is deaf/hard of hearing presents for services and shall coordinate provision of interpreter services with ODS. In addition, ODS shall be involved in treatment planning for clients who are deaf/hard of hearing through consultation with the Contractor's staff and/or participation in treatment planning conferences. ADMH, also, provides, assistance for its contractor's in securing interpreter services for clients who are not deaf/hard of hearing, but speak languages other than English.

5. Is there state support for cultural and linguistic competency training for providers

Yes. ADMH is an active provider of cultural and linguistic training.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is requested to support ADMH's efforts to make value-based purchasing decisions.

Footnotes:

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

Prevention Services

The state has an EBP Workgroup that has representatives from all four mental health regions. The role of the Workgroup is to advise stakeholders on the use of evidence-based practices, explore various evidence-based resources, guide the formal process of selecting/approving evidence-based curricula which includes evidence of effectiveness, conceptual fit, practical fit, ability to implement with fidelity, cultural fit, the likelihood of sustainability, and identify potential research opportunities and make recommendations. In addition, the inclusion of an evaluation plan to assess the efficiency of the program activities reporting system designed to facilitate and track both statewide and grantee-level implementation for its Block Grant (BG) funded prevention service providers is utilized.

Treatment Services

There is no one entity responsible for conveying evidence-based practices to SA treatment providers. This information is communicated to assigned providers by ADMH's program managers.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

All prevention providers are required to utilize evidence-based programs/practices within their approved strategies in order to receive funding. This is not required of treatment programs, although the use of evidence-based practices is a treatment certification requirement.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

Yes.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

Prevention: Whereas we do not internally provide a rigorous evaluation process to assess emerging and promising practices, each provider is required to ensure program fidelity and documentation and consult with program developer(s) as needed as set forth by Department of Mental Health, Substance Abuse Services Division, Administrative Code, Chapter 580-9-47, Prevention Standards.

Treatment: An evaluation process is not used to assess emerging and promising practices.

5. Which value based purchasing strategies do you use in your state:

- a. Leadership support, including investment of human and financial resources.
No.
- b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
Yes
- c. Use of financial incentives to drive quality.
Yes
- d. Provider involvement in planning value-based purchasing.
No
- e. Gained consensus on the use of accurate and reliable measures of quality.
Yes
- f. Quality measures focus on consumer outcomes rather than care processes.
Yes
- g. Development of strategies to educate consumers and empower them to select quality services.
Yes
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
No
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.
Prevention: Yes; Treatment No

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Not applicable to substance abuse services.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to substance abuse services.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

The State of Alabama is interested in development of vouchers as a treatment and recovery support service reimbursement option. Technical assistance is requested in this area.

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area at this time.

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

A formal program integrity plan is currently under development by ADMH.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Yes. Federal requirements are conveyed through ADMH's the contracts executed with providers. The contract, including exhibits to the contract, between ADMH and each service provider, contains numerous references to specific sections of the Code of Federal Regulations (CFR) as well as to numerous federal laws. Contract language indicates that, by signing the contract, the provider understands, and agrees to follow, the provisions relative to the CFR and federal laws.

Requirements referenced in the contract include, but are not limited to: Federal immigration laws; employee background checks; nondiscrimination; confidentiality/HIPAA; lobbying activities; debarment/suspension/exclusion from participation in federal assistance programs; environmental smoke; federal cost principles for determining allowable costs and uniform administrative requirements (OMB Circulars); tuberculosis services; pregnant women; intravenous drug abusers; pregnant women and women with dependent children; primary prevention; continuing education; service coordination; needs assessment; independent peer review; treatment access; restrictions on the expenditure of the grant; payment schedule; and charitable choice.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds 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 cited findings of noncompliance.

- e. Client level encounter/use/performance analysis data; and

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. Describe payment methods, used to ensure the disbursement of 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. 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 does the state ensure block grant funds and state dollars are used for the four purposes?

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 services for individuals who are uninsured and for services that are not covered by private insurance and/or Medicaid.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ 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.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds 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 and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is needed to assist the state in development of a relationship with the state's federally recognized tribe.

Footnotes:

Environmental Factors and Plan

8. Tribes

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.

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. Unsuccessful attempts have been made to establish and implement a relationship that would 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.

ADMH is dedicated to continue efforts in establishing and implementing a relationship with the Poarch Creek Indian Tribe but guidance and technical assistance will be needed to achieve this endeavor.

2. Describe current activities between the state, tribes and tribal populations.

None.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does 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)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area.

Footnotes:

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

1) **Please indicate if the state has an active SEOW.**

In the state of Alabama, the SEOW is named the Alabama Epidemiological Outcomes Workgroup (AEOW). The AEOW operates under the authority of the ADMH as established by Alabama Acts 1965, No. 881, Section 22-50-2, and in conformance with Executive Order Number 23 signed by the Governor of Alabama. The AEOW was established in 2006 and since an active participation has remained. The AEOW meets face-to-face on a quarterly basis, and via conference call or a special-called session by the Epidemiologist, if needed. The AEOW, in keeping with the Strategic Prevention Framework (SPF), has focused efforts on a systematic assessment of statewide need in order to assure wise use of limited resources. The AEOW provides ongoing surveillance assessment, analysis, monitoring and dissemination of alcohol, tobacco, and other drugs (ATOD) consumption patterns and consequences in the State. In addition to monitoring ATOD consumption and consequence patterns in Alabama, the AEOW has made it a goal to build epidemiological capacity among state and local prevention professionals to ensure use of accurate data in planning, programming, and prioritization. The AEOW will continue to monitor the alcohol consumption and consequence indicators on a statewide basis with annual updates to the Epi Profile, and assist funded communities in carrying out their local needs assessment activities. The workgroup has proven to be an invaluable resource, particularly with addressing state data needs/gaps, relevancy of data and epidemiological input. The AEOW is made up of individuals from various agencies which collect data associated with substance abuse/use and consequences. All members of the group are familiar with data, data quality issues and data interpretation. The partnerships are essential to the data-driven decision making process and for the process of developing a state epidemiological profile.

If so, please describe:

- **The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);**

The AEOW collects and analyzes data related to alcohol, tobacco, and other drugs (ATOD) consumption patterns, consequences and intervening variable in Alabama in order to provide ongoing surveillance assessment, analysis, monitoring and dissemination. Below is a list of constructs that are collected based on the availability and validity of the data sources. The AEOW further collects data on the list of consumption, consequence, and intervening variable constructs by examining them across four dimensions: magnitude, relative comparison, trends, and severity when available and valid.

Table __: Alcohol, Tobacco, Other Drugs Consumption and Consequence Constructs

	Alcohol	Tobacco	Other Drugs
Consequences	Abuse/Dependence • Alcohol-related Mortality • Motor Vehicle Crashes	• Tobacco-related Mortality	Abuse/Dependence • Drug-related Mortality • Crime • Treatment

	<ul style="list-style-type: none"> • Crime • Treatment • Treatment Gap 		<ul style="list-style-type: none"> • Treatment Gap
Consumption	<ul style="list-style-type: none"> • Current Use • Current Binge Drinking • Current Heavy Drinking • Drinking & Driving • Total Sales 	<ul style="list-style-type: none"> • Age of Initial Use • Current Use • Lifetime Use • Tobacco Use During Pregnancy • Total Sales 	<ul style="list-style-type: none"> • Current Use • Lifetime Use • Past year use
Intervening variables (Including Risk/Protective Factors)	<ul style="list-style-type: none"> • Riding with Drinking Driver • Alcohol use during pregnancy • Age of initial use • Perception of risk • Compliance Checks 	<ul style="list-style-type: none"> • Tobacco Use during Pregnancy • Age of Initial Use • Friends use 	<ul style="list-style-type: none"> • Age of initial use • Lifetime Use • School property use • Perception of risk

- **The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and**

The constructs stated above were further analyzed into subgroup analyses which provides more informative information when conducting a data-driven process. Data on demographic characteristics were collected and summarized. The primary population that were collected, analyzed, and presented when possible based on the availability and validity of data sources were age groups (youth, young adults, older adults), grade level (9th-12th grade), gender, racial and ethnic minorities, mental health region, county (rural and urban areas).

The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

The national and state data sources are used to collect ATOD consumption, consequences, and intervening variable data. As data gaps are identified and filled more data sources are utilized. Below is a list of the data sources currently used:

National Data Sources

- Alcohol Related Disease Impact
- Behavioral Risk Factor Surveillance System

- CDC Wonder
- Fatality Analysis Reporting System
- National Survey on Drug Use and Health
- National Vital Statistics System Mortality
- Sales Data from the Alcohol Epidemiologic Data System
- Treatment Episode Data Set
- Uniform Crime Reporting Program
- United States Cancer Statistics
- Youth Risk Behavior Survey

State Data Sources

- Alabama Criminal Justice Information Center
- ADMH Alabama Substance Abuse Information System
- University of Alabama, Center for Advanced Public Safety
- Gulf Coast High Intensity Drug Area
- Pregnancy Risk Assessment Monitoring System
- Alabama Youth Tobacco Survey

2) Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

In an effort to address the state’s substance abuse prevention needs, a hybrid funding allocation approach utilizing county population and need determination by multiple factors is the determined approach. The purpose for this approach is typified in the following targets for change. Alabama’s substance abuse prevention system seeks to:

- eradicate historic funding in Alabama’s prevention system;
- designate a funding allocation model for the state prevention system;
- develop measures for delivery of prevention strategies;
- establish incentives for prevention providers; and
- fund prevention services throughout all counties in the state of Alabama.

Assessment provides a clearer understanding of substance use and factors related to substance use in Alabama’s counties in order to best address their problems. The establishment and identification of state and national data sources will enhance substance abuse prevention efforts across the state. Information gathered from state and national sources provided preliminary data from which the needs assessment took direction. The approach selected utilizes existing 310 Catchment Areas with considerations of population for each catchment area. Alabama consists of sixty-seven (67) counties which comprise twenty-two (22) 310 catchment areas. The twenty-two (22) catchment areas are compiled as seen below:

Table ___: Alabama 310 Catchment Areas

Catchment	Counties
M - 1	Lauderdale, Colbert, Franklin
M - 2	Limestone, Lawrence, Morgan
M - 3	Madison

M - 4	Fayette, Lamar, Marion, Walker, Winston
M - 5	Jefferson, Blount, St. Clair
M - 6	DeKalb, Cherokee, Etowah
M - 7	Calhoun, Cleburne
M - 8	Bibb, Pickens, Tuscaloosa
M - 9	Talladega, Clay, Randolph, Coosa
M - 10	Choctaw, Greene, Hale, Marengo, Sumter
M - 11	Chilton, Shelby
M - 12	Chambers, Lee, Tallapoosa, Russell
M - 13	Dallas, Perry, Wilcox
M - 14	Montgomery, Autauga, Elmore, Lowndes
M - 15	Macon, Pike, Bullock
M - 16	Mobile, Washington
M - 17	Clarke, Conecuh, Escambia, Monroe
M - 18	Butler, Coffee, Covington, Crenshaw
M - 19	Dale , Geneva, Henry, Barbour, Houston
M - 20	Jackson, Marshall
M - 21	Baldwin
M - 22	Cullman

The 310 catchment areas were proportion based on the population and the five need indicators which included a minimum allocation for each area plus an additional amount determined by identified need/population allocation. The first component used in the allocation of funding was population. Population statistics are often used in determining federal and state program funding allocations. The formula, such as using total population, population for specific age groups or setting aside a portion of funding based off population, varies from program to program depending on the objectives of the program. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, Population Estimates is used. The second component used in the allocation of funding was need. The first step of assessing the counties in Alabama was to determine the criteria for inclusion for need. To help determine need in relation to substance abuse the OP looked at substance abuse indicators as well as social and economic indicators within a county. The process for choosing indicators was determined by:

- Availability of indicators on the county level
- Relative Importance
- Current and Updated periodically

Based off the criteria, the following indicators (and data source) were selected to assess epidemiological need:

- Alcohol and/or Drug Related Motor Vehicle Crashes (University of Alabama, Center for Advanced Public Safety)
- Substance Abuse Treatment Admission (Alabama Department of Mental Health, Alabama Substance Abuse Information System)
- Graduation Rates (Alabama State Department of Education, Accountability Reporting System)

- Poverty (US Census, Small Area Income and Poverty Estimates)
- Suicides (Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System)

Once each indicator was selected and data collected, the second step was to standardize the indicators by calculating z-scores for each indicator. Z-score is an individual test score expressed as the deviation from the mean score of the group in units of standard deviation (Merriam-Webster.com). Z-score allows for standardization of each indicator to the county average for the state.

Note while each indicator has a negative effect on substance use in a county, an increase in graduation rates has a positive effect. When calculated graduation rate z-score, the process was reversed by multiplying it scores by a negative one so higher scores reflect a negative effect. Finally, after the z-scores for each measure was calculated, the z-score was multiplied by its respective weight then added together in order to develop a composite score (need score) for each county. The overall need score is a weighted composite of five indicators: Alcohol and/or Drug Related Motor Vehicle Crashes (30%), Substance Abuse Treatment Admissions (30%), Suicide (20%), Graduation Rates (10%), and Poverty Rates (10%). The weights added together equal 100%. Each indicator was assigned weights based off the following criteria:

- Relation to substance abuse
- Relation to substance abuse prevention priorities

The overall goal for using needs assessment data to allocate funds is to see a decrease in substance abuse within catchment areas through effective prevention efforts.

- 3) How does the state intend to build 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 to 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 be capable 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. The Office of Prevention 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 measure the 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 currently 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 was recently awarded the Partnerships For Success (PFS) grant. This sustainability effort has afforded the Office of Prevention retention of SPF-SIG Consultants and most recently, the inauguration of a college intern was utilized within our system. Current efforts are being employed to retain collegiate coordination/collaboration to increase prevention capacity on the front end (existing college student) and back end (post graduation) for the state.

- 4) Please describe if the state has statewide licensing or certification program, formal mechanism to provide training, formal mechanism to assess community readiness...
 - a) The state does not have a licensing or certification program for the substance abuse prevention workforce however there is a longstanding coordinated effort with the Alabama Alcohol & Drug Abuse Association (AADAA) for licensures and certifications. AADAA is a non-profit organization that certifies Alcohol and Drug Counselors, Prevention Specialists, Criminal Justice Professionals and Clinical Supervisors. In addition, DMH prevention standards requires all direct service providers complete a minimum of 20 hours of

continuing education relevant to the prevention of mental health and substance use disorders annually.

- b) A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce and the impact of the Strategic Prevention Framework (SPF) has increased throughout the prevention provider network and now includes SPF-focused training and technical assistance to all providers, communities, and coalitions. Training and technical assistance is delivered from CAPT, DMH prevention staff, and the state-level prevention consultants. The substance abuse prevention workforce also utilizes the annual statewide training opportunity forums to include the Alabama School of Alcohol and other Drug Studies (ASADS); Alabama Alcohol and Drug Abuse Prevention Conference (AADAA) and the Gulf Coast Conference.
 - c) There is an established systems review process in place to assess the prevention provider network's ability and readiness to implement prevention strategies. Through the systematic review of each provider's prevention plan, community readiness is assessed by the following identified point of references:
Is there an integration of the community's culture, resources, and level of readiness to effectively address the issue; Is their cooperation among systems and individuals; Is there existing capacity for prevention; Is there community investment/buy-in; Is the strategy measurable; Are adaptations and/or the expectations of adaptations considered; Is there a sustainability plan? In addition, communities and coalitions are direct benefactors from the face-to-face training and technical assistance that is garnered through each step of the SPF process which includes networking and strategizing with their colleagues. Further efforts will continue to improve existing success by providing extensive community-level training and technical assistance to assess community readiness, identify outcomes, and prioritize the most effective interventions with the expansion of local sustainability plans.
- 5) How does the state use data on substance abuse use consumption patterns, consequences of use, risk and protective factors to identify the types of primary prevention services that are needed?

The Alabama Epidemiological Outcomes Workgroup (AEOW) developed a State Epidemiological Profile (Epi Profile), which includes community level data, to inform the 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 the US, and severity. The data found in the Epi Profile helped the AEOW to determine the types of primary prevention services by identifying target populations and the priority problems.

The AEOW reviewed possible national and state data sources to include or exclude in the Epi Profile. The AEOW members conducted a data quality screening process to identify those data sources that would be appropriate for use in this assessment. This is largely due to the AEOW being comprised of members who are employees from different state agencies including Alabama Department of Youth Services, Alabama Department of Public Health, and Alabama Department of Public Safety which gives access to those departments collecting data pertaining to substance abuse. After the data sources were found, they were considered eligible for inclusion in the Epi Profile based on 5 criteria was conducted: Availability, Validity, Consistency, and Periodic Collection over at least three to five past years.

Once the Epi profile is compiled, the AEW 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 AEW.

Additionally, the ADMH receives specific alcohol and tobacco compliance data from the ABC. The data is provided to prevention agencies in order for them to better target areas that are noncompliant which give underage drinker easy access to retail sources. Lastly, 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 will be driven by cultural competency, local data and demographics of the specific target population as well as considering risk/protective factors and contributing conditions (e.g. local policies, practices, community culture or population shifts) in its relationship to the planning process. Prevention providers will formulate an effective plan for evidence based programs, practices and policies. A mix of strategies will be optimal for comprehensive approach to prevention.

- 6) Does the state have a strategic plan that address substance abuse prevention that was developed within the last five years?

Yes. The Office of Prevention (OOP) developed a strategic planning process that enables it to carry out its mission, vision, and achieve its goals. The process is aligned closely with the office goals and deliverables process and results in a three year strategic plan that is updated annually. Beyond the annual planning process, a formal review is conducted quarterly for leadership and staff to provide status updates on the goals, objectives, and actions undertaken to accomplish the plan. Recommendations and revisions are made as needed.

The statewide strategic prevention plan was created as a need and in response to a Center for Substance Abuse Prevention (CSAP) Core Technical Review potential enhancement recommendation. Specifically the state was 'encouraged to continue to develop the infrastructure plan' and to "create a comprehensive state strategic plan." The purpose of the plan is to communicate goals, action steps, distinguish responsibility, targets and metrics to guide the prevention system. The plan seeks to assist the enhancement of the prevention system in its leadership, capacity and processes. The plan incorporates: system organization; workforce development and capacity building; implementation; evaluation; prevention funding allocation model that emphasizes the primary prevention set-aside of the SABG and Syнар.

- 7) Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Alabama has identified an Evidence-based Practices (EBP) Workgroup through the SPF to identify needs and appropriate interventions for the communities. The EBP Workgroup will expand its efforts and surveillance to all aspects of prevention, to include SABG. The EBP Workgroup is comprised of substance abuse prevention experts with backgrounds in community-level

prevention, academic research, and governmental administration. The EBP Workgroup has been trained in understanding the core concepts related to selecting an EBP. The key elements are to understand the two main types of prevention strategies; Reinforce the understanding of contributing factors, intervening variables, and risk and protective factors; How to apply “good fit” components to EBPs and; Understand the Alabama EBP Approval Process.

The Evidence-Based Practice Approval Process determines the legitimacy of selected EBPs. A step-by-step guide, to include an EBP Test Fit Form to determine level of appropriateness. An actual flowchart has been developed to illustrate the EBP approval process. A requirement of the prevention plan is the approval of the EBP, which is necessary for funding allocation.

Funded communities will then expand on the assessment to identify additional community-level data and what the data indicates by identifying the risk and causal factors in their communities that can be targeted for prevention activities/strategies. Providers are required to develop a prevention plan for the awarded area(s) to include sustainability, collaborative, and coordinated substance abuse prevention efforts. The prevention plans follow the strategic prevention framework which includes assessment of substances use consumption patterns, consequences of use and risk/protective factors in the awarded area. Their selected primary prevention services or strategies must align with the assessment of the area and ensure duplication of services is nonexistent.

- 8) Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies...

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.

9. What methods were used to ensure the SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

All subcontractors for SABG prevention services are required to identify all collaborative partners including other funding sources. In addition, monitoring of SABG prevention services are conducted through certification visits from the Office of Prevention via the 45 Code of Federal Regulations.

10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?

A comprehensive and sustainable data infrastructure to support the state's substance abuse prevention system includes two components:

- An efficient program activities reporting system designed to facilitate and track both statewide and grantee-level implementation for its Block Grant (BG) funded prevention service providers
- The use of standardized surveys to be used across the state for generating population-based measures of targeted substance abuse outcomes and key intervening variables at either the regional or county level

In addition, it is desirable that both data infrastructure components be compatible with the requirements of other initiatives that fund local substance abuse prevention services in Alabama (e.g., Partnerships for Success {PFS})

On the state-level, the key question to answer is "Is new funding allocation model being implemented as planned?" In order to answer this question, the state will use data from current data sources (RFP, Alabama Substance Abuse Information System (ASAIS) data, and annual monitoring reports). On the grantee-level, the key questions to answer are a) "What strategies are implemented by the grantees and how successful are they in completing the planned activities for each?" b) "How well and/or how completely are grantees implementing planned activities (or pre-determined core activities) of each strategy they implement?" and c) "What is grantees' capacity to implement SPF model and is it increasing over time?" In order to answer these questions, the state will use current data sources (ASAIS data and annual monitoring reports) and potential new data sources (sub-grantee capacity assessment tool).

Process data that is available for collection related to the key questions from the data sources stated above, as referenced in the prevention activity sheets, include number of participates

served by race, ethnicity, age group, and other populations such as LGBTQ, homeless, students in college, military families, high risk youth, and youth in tribal communities. Also, the state intends to look at community type (rural or urban) and community size. In addition, a Performance Feedback Survey is administered to measure participant satisfaction.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this 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, National Survey of Drug Use and Health, Fatality Analysis Reporting System, Uniform Crime Reporting, and National Center for Education Statistics. While state data sources included, but are not limited to, 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 (ASAS). 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 the 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.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, 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, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and 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 to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance needed in this area at this time.

Footnotes:

Alabama's Performance Improvement plan and operational procedures uploaded to this section.

Substance Abuse Services

Performance Improvement Subcommittee (SASPI) Operational Procedures

The SASPI Subcommittee, operating under the structure and authority of the MHSA PI Committee, monitors and manages performance improvement activities specific to the provision of services for prevention, treatment, and recovery support of substance use disorders. The Subcommittee develops and implements performance improvement strategies which incorporate the goals and objectives of the MHSA PI Program and the core concepts of Continuous Quality Improvement/Total Quality management (CQI/TQM). Through its development of an annual SASPI Plan, the Subcommittee identifies, evaluates, and monitors critical performance measures that describe the health of the state's addiction system. The SASPI Plan provides the organizational structure which supports accomplishment of the following objectives:

- Ensure there is an ongoing process to provide meaningful opportunity for input on operation and improvement of the ADMH SA Performance Improvement system from patients in recovery, family members of patients, providers, patient groups, advocacy organizations, and advocates.
- Assist in the identification and/or development of performance indicators for certified contract substance abuse programs that measure accomplishment of, or positive contribution to, selected aspects of the ADMH's mission and values for the MHSA Services Division.
- 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.
 - Providing services and supports that uphold values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, resilience, accessibility, choice and compassion.
 - 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 patients.
 - Ensuring SA Block Grant program integrity.
 - Ensuring compliance with Medicaid and all other regulatory requirements.
- 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.
- Provide a mechanism for sharing of ideas and information relative to Performance Improvement strategies and "best practices."
- Utilize feedback from patients, families, practitioners, employees, payers, the community, accrediting agencies and other stakeholders to trigger assessments aimed at improving services.

- 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.
- 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.
- 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.
- Seek ongoing involvement and periodic evaluation of the SASPI Program from stakeholders, Community Program Executive Directors, and ADMH MHSA Division personnel.
- Encourage participation and commitment of all levels of leadership and all levels of MH/SA community program staff in performance improvement initiatives.
- Provide information, consultation, training, and technical assistance at the provider level regarding performance improvement topics, issues, methods and requirements.
- Develop an annual SA Performance Improvement work plan that outlines responsibilities and actions proposed for accomplishment of the above stated objectives.

The SA PI Subcommittee will be organized and function in a manner to facilitate accomplishment of the stated objectives, to promote teamwork, and to fully engage all members in ADMH SA quality management processes. The SASPI Subcommittee shall meet on an as needed basis and may be requested to work on additional PI related activities by the PI Committee and/or the MHSAS Director of PI. Membership of the MHSPI Subcommittee consists of:

- MHSA Director of Performance Improvement (or staff designee), Chairperson
- SA Family Representatives (one family member of an Adult Consumer and one family member of a Child/Adolescent Consumer) (2)
- SA Consumer Representatives (two SA Consumers) (2)
- Substance Abuse Community Program Executive Director
- Substance Abuse Community Program PI Director
- Substance Abuse Medication Assistance Treatment Program PI Director
- Direct Care Clinician from a Substance Abuse Community Program
- Direct Care Clinician from a Substance Abuse Medication Assistance Treatment Program
- MHSA Executive Assistant
- MHSA Director of SA Prevention Services
- MHSA Director of SA Treatment Services
- MHSA Director of SA Development and Training
- MHSA Epidemiologist
- MHSA Director of Certification
- MHSA Director Office of Deaf Services
- ADAP Representative

- ADMH Advocacy Office Representative
- Other approved representatives as indicated

Specific responsibilities of the SASPI Subcommittee include:

- Assisting in the development of performance improvement priorities and strategies to support the Stated objectives;
- Establishing a cohesive and focused annual work plan that directs time, effort, and resources;
- Establishing a specific formal approach for addressing each performance improvement activity;
- Identifying performance measures, indicators and benchmarks;
- Developing and/or adopting data collection tools and related procedures to insure proper measurement of selected indicators;
- Reviewing and analyzing the results of performance improvement activities;
- Developing reports of PI findings and recommendations for improvements relative to findings; and
- Submission of reports to the MHSA PI Committee as directed for appropriate review, publication and/or dissemination.

SA COMMUNITY QUALITY MEASURES

In addition to **Patient Safety Measures**, the SA PI Subcommittee will utilize the Agency for HealthCare Research and Quality *Domains of Measurement* to assess the health of the state’s public addiction services system (<http://managementhelp.org/quality/total-quality-management.htm>):

I. Clinical Quality Measures:

Measures used to assess the performance of individual clinicians, clinical delivery teams, delivery organizations, or health insurance plans in the provision of care to their patients or enrollees, which are supported by evidence demonstrating that they indicate better or worse care.

- **Process:** A health care-related activity performed for, on behalf of, or by a patient. Process measures are supported by evidence that the clinical process—that is the focus of the measure—has led to improved outcomes.
- **Access:** The attainment of timely and appropriate health care by patients or enrollees of a health care organization or clinician. Access measures are supported by evidence that an association exists between the measure and the outcomes of or satisfaction with care.
- **Outcome:** A health state of a patient resulting from health care. Outcome measures are supported by evidence that the measure has been used to detect the impact of one or more clinical interventions.
- **Structure:** A feature of a health care organization or clinician related to the capacity to provide high quality health care. Structure measures are supported by evidence that an association exists

between the measure and one of the other clinical quality measure domains. These measures can focus on either health care organizations or individual clinicians.

- **Patient Experience:** A patient's or enrollee's report of observations of and participation in health care, or assessment of any resulting change in their health. Patient experience measures are supported by evidence that an association exists between the measure and patients' values and preferences, or one of the other clinical quality domains. These measures may consist of rates or mean scores from patient surveys.

Related Health Care Delivery Measures:

Measures used to assess the non-quality aspects of performance of individual clinicians, clinical delivery teams, delivery organizations, or health insurance plans in the provision of care to their patients or enrollees. These measures are not supported by evidence demonstrating that they indicate better or worse care.

- **User-Enrollee Health State:** A user-enrollee health state is the health status of a group of persons identified by enrollment in a health plan or through use of clinical services.
- **Management:** A feature of a health care organization related to the administration and oversight of facilities, organizations, teams, professionals, and staff that deliver health services to individuals or populations. Management measures assess administrative activities that are important to health care but are not part of the direct interaction between individual patients and health care professionals.
- **Use of Services:** Use of services is the provision of a service to, on behalf of, or by a group of persons identified by enrollment in a health plan or through use of clinical services. Use of service measures can assess encounters, tests, or interventions that are not supported by evidence for the appropriateness of the service for the specified individuals.
- **Cost:** Costs of care are the monetary or resource units expended by a health care organization or clinician to deliver health care to individuals or populations. Cost measures are computed from data in monetary or resource units. Costs may be reported directly (i.e., actual costs) or estimated based on the volume of resource units provided and the charges for those units.

Clinical Efficiency Measures:

Measures that may be used to assess efficiency directly (e.g., by comparing a measure of quality to a measure of resource use) or indirectly (e.g., by measuring the frequency with which health care processes are implemented that have been demonstrated by evidence to be efficient).

- **Efficiency:** A measure of the relationship between a specific level of quality of health care provided and the resources used to provide that care.

Population Health Quality Measures:

Measures applied to groups of persons identified by geographic location, organizational affiliation or non-clinical characteristics, in order to assess public health programs, community influences on health, or population-level health characteristics that may not be directly attributable to the care delivery

system. These measures are supported by evidence demonstrating that they indicate better or worse performance of population health activities.

- **Population Process:** A public health-related practice or service performed for, on behalf of, or by a population.
- **Population Access:** The timely and appropriate receipt of a public health intervention by a population.
- **Population Outcome:** A health state of a population resulting from a public health intervention.
- **Population Structure:** A feature of a public health program related to its capacity to provide high quality public health services to a population.
- **Population Experience:** The report of the members of a population concerning observations of and participation in public health programs.

Related Population Health Measures:

Measures applied to groups of persons identified by geographic location, organizational affiliation or non-clinical characteristics, in order to assess non-quality aspects of public health programs, community influences on health, or population-level health characteristics that may not be directly attributable to the care delivery system. These measures are not supported by evidence demonstrating a link to better or worse performance of population health activities.

- **Population Health State:** The health status of a population.
- **Population Management:** A feature of a public health system that is relevant to the system's administration, oversight, or staff.
- **Population Use of Services:** The provision of services to, on behalf of, or use by a population.
- **Population Cost:** The monetary or resource units expended to deliver public health interventions to a population. Cost measures are computed from data in monetary or resource units.
- **Population Health Knowledge:** The awareness and understanding of health-related information such as risk factors, prevention strategies, or treatment recommendations.
- **Social Determinants of Health:** Characteristics of a population related to social position or economic status, such as age, gender, or poverty status, that evidence has shown to be related to health states.
- **Environment:** The conditions outside of the health care delivery system that may influence the health of a population.

Population Efficiency Measures:

Measures that may be used to assess efficiency directly (e.g., by comparing a measure of quality to a measure of resource use) or indirectly (e.g., by measuring the frequency with which population health processes are implemented that have been demonstrated by evidence to be efficient).

- **Population Efficiency:** Efficiency of population health is the amount of resources used to attain a specific level of quality on measures related to maintaining or improving the health of a population.

Through the use of valid and reliable data, the SASPI Subcommittee will implement procedures to continuously measure, monitor and improve indicators in the following domains:

Domain	Measure/Indicator (During the Measurement Year)	Measure Source
Access	Number and Percentage of Individuals who initiated treatment who had two or more additional services with a diagnosis of ADD within 30 days of the initial visit.	NQMC 8241:
Access	Number and percentage of SA providers who admit patients to SA treatment at hours outside of traditional 8 to 5 office hours	ADMH
Use of Services	Number of individuals receiving a substance use disorders prevention, treatment, or recovery support service.	NQMC 8281:
Process	Percent of patients who receive a prescription for FDA approved medication for treatment of an alcohol or drug use disorder.	NQMC:008839
Process	Percent of patient visits and admissions where preferred written language for health care is screened and recorded.	NQMC:005610
Process	Percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.	NQMC:005609
Process	Language services: the percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.	NQMC:005614
Process	Percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.	NQMC:005611
Process	Number and percent of programs that offer and have available pharmacotherapy for alcohol addiction that is directly linked with psychosocial treatment and support.	NQF: Consensus Standards
Process	Number and percent of patients who receive empirically validated psychosocial interventions.	NQF: Consensus Standards
Process	Number and percent of programs that offer and have available pharmacotherapy for Opioid addiction that is directly linked with psychosocial treatment and support.	NQF: Consensus Standards
Process	Percent of patients receiving a tobacco use assessment	NBHF; NQF: 0028
Process	Percent of admissions who receive tobacco cessation intervention	NBHF; NQF: 0028
Process	Percent of admissions who receive tobacco cessation medication	ADMH
Process	Percent of patients who receive risky behavior assessment or counseling by age 13	NBHF; NQF# 1406

Process	Percent of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	NBHF; NQF 0418
Process	Number of programs providing long-term, coordinated management of substance use disorders.	NQF: Consensus Standards
Process	Number of Medicaid maternity care providers utilizing SBIRT	ADMH/Medicaid
Outcome	Reduction in/no change in frequency of substance use during past thirty days	TX NOM – Abstinence
Outcome	Increase in/no change in number of employed or in school at date of last service vs first service	TX NOM – Employment/Education
Outcome	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service	TX NOM – Crime and Criminal Justice
Outcome	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service	TX NOM - Stability in Housing
Access	Unduplicated count of persons served	TX NOM – Access Capacity
Access	Penetration Rate: Number of patents served compared to those in need	TX NOM – Access Capacity
Use of Services	Average length of stay from date of first service to date of last service by level of care	TX NOM – Retention
Outcome	Percentage of patient admissions participating in self-help programs 30 days prior to treatment admission in comparison to participation at discharge	TX NOM– Social Connectedness
Cost	Cost of treatment services:	TX NOM – Cost Effectiveness
	○ Per person by level of care	
	○ By level of care in relation to treatment budget	
	○ By level of care per region	
	○ By level of care per contractor	
Patient Experience	Number of patients responding to perception of care surveys	TX NOM– Perception of Care
Patient Experience	Responses to perception of care surveys – Percentage of clients reporting:	TX NOM– Perception of Care
	○ Staff here are supportive and encourage my participation in treatment activities that will benefit my recovery.	
	○ Staff treat me with dignity and respect	
	○ I am free to complain without fear of retaliation.	
	○ I was given information about my rights.	
	○ Staff encourage me to take responsibility for how I live my life.	
	○ Staff respect my wishes about who is and who is not to be given information about my treatment.	
	○ Staff respect my religious/spiritual beliefs	
	○ Staff speak to me in a way that I understand	

	<ul style="list-style-type: none"> ○ Staff helped me obtain the information I needed so that I could take charge of managing my disease of addiction. 	
	<ul style="list-style-type: none"> ○ Staff acknowledge and honor my cultural/ethnic background 	
	<ul style="list-style-type: none"> ○ I am encouraged to use community support groups (AA, NA, CA, Dual, crisis phone lines, etc.). 	
	<ul style="list-style-type: none"> ○ The location of services was convenient (parking, public transportation, distance). 	
	<ul style="list-style-type: none"> ○ Staff returned my call(s) in 24 hours. 	
	<ul style="list-style-type: none"> ○ Services were available at times that were good for me. 	
	<ul style="list-style-type: none"> ○ The people I went to for services spent enough time with me. 	
	<ul style="list-style-type: none"> ○ My counselor is knowledgeable about recovery. 	
	<ul style="list-style-type: none"> ○ I talk freely, openly, and honestly with my counselor. 	
	<ul style="list-style-type: none"> ○ I participated in the development of my individualized service plan. 	
	<ul style="list-style-type: none"> ○ I like the services that I am receiving at the treatment program. 	
	<ul style="list-style-type: none"> ○ If I had other choices, I would still get services from this agency. 	
	<ul style="list-style-type: none"> ○ I would recommend this agency to a friend or family member. 	
	<ul style="list-style-type: none"> ○ As a result of the treatment or services I am receiving, I see that using alcohol and/or other drugs is a problem for me. 	
	<ul style="list-style-type: none"> ○ I feel comfortable here 	
	<ul style="list-style-type: none"> ○ The building is clean and comfortably furnished 	
	<ul style="list-style-type: none"> ○ The building is in good repair 	
	<ul style="list-style-type: none"> ○ The grounds are well maintained 	
	<ul style="list-style-type: none"> ○ I am satisfied with my room 	
	<ul style="list-style-type: none"> ○ I have enough privacy in my room 	
	<ul style="list-style-type: none"> ○ My belongings are safe here 	
	<ul style="list-style-type: none"> ○ I can find places to talk with my visitors in private 	
	<ul style="list-style-type: none"> ○ I get enough to eat during mealtime 	
	<ul style="list-style-type: none"> ○ I get to eat the food I need for my health 	
	<ul style="list-style-type: none"> ○ I have access to snacks and drinks whenever I want them 	
Use of Services	Rate of readmission to treatment by level of care	ADMH
Use of Services	Percent of program discharges by discharge type	ADMH
Access	Percent of patients admitted to the level of care assessed as needed	ADMH
Access	Percent of patients served who have co-occurring substance use and mental disorders	ADMH
Structure	Evidence-based treatment programs provided	TX NOM – Use of Evidence-Based Programs

Population Outcome	Rates of thirty-day substance use (non-use/reduction in use)	PRV NOM – Abstinence
Population Outcome	Rates of perceived risk/harm of use	PRV NOM – Abstinence
Population Health Status	Ranking of patients’ age at first use	PRV NOM – Abstinence
Population Health Knowledge	Percent of individuals who express disapproval/attitude relative to AOD use	PRV NOM – Abstinence
Social Determinants of Health	Percentage of ATOD suspensions and expulsions by county	PRV NOM - Employment / Education
Social Determinants of Health	Percentage of school attendance and enrollment by county	PRV NOM – Employment/ Education
Social Determinants of Health	Percentage of workplace AOD use and perception of workplace policy	PRV NOM – Employment/ Education
Social Determinants of Health	Percentage of alcohol and drug-related crime	PRV NOM – Crime and Criminal Justice
Social Determinants of Health	Number of alcohol-related car crashes and injuries	PRV NOM – Crime and Criminal Justice
Use of Services	Number of persons served in prevention programs by age, gender, race, and ethnicity	PRV – NOM Access/Capacity
Population Experience	Percentage of family communication around drug use	PRV NOM – Social Connectedness
Cost	Services provided within cost bands for universal, selected, and indicated programs	PRV NOM – Cost Effectiveness
Structure	Number of evidence-based programs and strategies employed	PRV NOM – Use of Evidence-Based Programs
Population Experience	Percentage of youth seeing, reading, watching, or listening to a prevention message	PRV NOM – Retention
Management	Number and nature of program deficiencies identified during peer reviews	SABG
Access	Percent of pregnant women served	SABG
Access	Number of IV Drug users served	SABG
Use of Services	Number of patients receiving Tuberculosis services	SABG
Access	Number of children of mothers in treatment served	SABG
Structure	Number and nature of provider continuing education activities made available by MH/SA	SABG
Management	Number of continuing education participants	SABG
Patient Safety	Number of reported and substantiated allegations of abuse/neglect.	ADMH Critical Incident: Allegations Of Abuse/ Neglect

Patient Safety	Number of reported incidents of non-consensual contact.	ADMH Critical Incident: Non-Consensual Sexual Contact
Patient Safety	Number of client deaths reported (from known or unknown causes) 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.	ADMH Critical Incident: Client Death
Patient Safety	Number of adult elopements reported for patients 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.	ADMH Critical Incident: Elopement of Patients from Residential Programs Under a Commitment Order/on a Temp Visit/ Locked Unit
Patient Safety	Number of elopements for any child/adolescent patient.	ADMH Critical Incident: Elopement of a Child/ Adolescent
Patient Safety	Number of hospitalizations for medical and/or psychiatric reasons reported for clients on crisis units, child/adolescent programs and other locked units/program.	ADMH Critical Incident: Hospitalization of a Client from Locked Residential Unit/Program
Patient Safety	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.	ADMH Critical Incident: Major Client Injury
Patient Safety	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	ADMH Critical Incident: Medication Errors
Patient Safety	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	ADMH Critical Incident: Suicide Attempts
Patient Safety	Number of suicides reported for patients in the provider's non-residential caseload	ADMH Critical Incident: Suicide Of Client in a Provider's Non-Residential Caseload
Patient Safety	Number of seclusions and restraints reported by community providers	ADMH Critical Incident: Seclusion/Restraint
Patient Safety	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.	ADMH Critical Incident: Unplanned Relocation

Patient Safety	The number of times that media is involved in unplanned manner regardless of location	ADMH Critical Incident: Media Event
Management	Number of times that any violation of the confidentiality or privacy of protected client information occurs relative to the <i>Alcohol and Other Drug Confidentiality Rule</i> within 42 C.F.R Part 2 and Part 8, or the <i>Health Insurance Portability and Accountability Act Privacy Rule</i> , within 45 C.F.R. Parts 160 and 164.	ADMH Critical Incident: Confidentiality/ Privacy Breach
Patient Safety	Number of times events occur involving client(s) and/or staff that necessitates the intervention of law enforcement officials	ADMH: Critical Incident: Legal/Criminal Activity
Management	Program certification review scores ranked by level of care	ADMH
Management	Percentage of program certification deficiencies by level of care	ADMH
Management	Percentage of providers in compliance with contract compliance requirements:	ADMH
	○ Audits submitted on time	
	○ Audit findings resolved as specified	
	○ Current program description provided on time	
	○ ASAIS waiting list utilization	
Management	Number and nature of SA patient complaints received by MH/SA personnel	ADMH
Management	Percent of clinical staff with certification credentials	ADMH
Management	Percent of contract providers with Electronic Health Records	ADMH

II. IMPLEMENTATION OF QUALITY STRATEGIES

III. The SA PI Subcommittee will utilize a variety of tools to support its performance improvement efforts:

- Problem identification, assessment and resolution may incorporate one or more of the following formal models as the organizational structure for specific quality improvement activities:
 - RCI - Rapid Cycle Improvement
 - PDSA – Plan, Do, Study, Act
 - FADE – Focus, Analyze, Develop, Execute, Evaluate (Organizational Dynamics Institute, Wakefield, MA)
- Data collection tools may include, but are not limited to:
 - Patient records
 - ASAIS
 - Customer surveys
 - Employee feedback
 - Demographic datasets
 - Public Health datasets
 - SAMHSA datasets
 - Claims

- Audit findings
- Activity logs
- Observational studies
- Interviews
- Special studies
- Peer review reports
- Regulatory review reports
- Tools used to assist in process and data analysis may include, but are not limited to:
 - Root cause analysis
 - Benchmarking
 - Flow-charting
 - Cause and effect diagrams
 - Run charts
 - Pareto charts
 - Control charts



ALABAMA DEPARTMENT OF MENTAL HEALTH

**DIVISION OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES**

PERFORMANCE IMPROVEMENT PLAN

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I. INTRODUCTION

Guided by the mission, vision and values of the Alabama Department of Mental Health (ADMH), the purpose of this plan is to provide a framework for operation of the Division of Mental Health and Substance Abuse Services (MHSAS) Performance Improvement (PI) Program. This plan is applicable to the state facilities and all community programs operated, contracted, and/or certified by the ADMH and is based on the Department's commitment to provide a system of care and support that is consumer-driven, evidence-based, recovery-focused, outcome-oriented, easily accessible, and promotes a productive and meaningful life in the community for everyone.

The MHSAS PI program is designed to ensure an established planned, systematic, organization-wide approach to process design and performance measurement, analysis and improvement for the department's objectives for community and inpatient services. Community and inpatient services and supports should encompass and reflect the ADMH's values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, accessibility, choice and compassion. Performance measure data should provide information that can be utilized by stakeholders to make informed decisions about care, resources, safety, and PI initiatives. Each Mental Health (MH) state facility and certified or contracted MH and Substance Abuse (SA) community program shall have a site specific PI Plan and program based on written guidelines that incorporate the ADMH's commitment to a consumer/family-driven system that fosters continuous quality improvement in all aspects of service delivery.

II. MISSION

The Mission of the ADMH is "Leading Alabama's efforts to enhance the health and well-being of individuals, families and communities impacted by mental illnesses, developmental disabilities and substance use disorders".

III. GOALS AND OBJECTIVES OF THE MHSAS PI PROGRAM

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

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

2. To assist in the identification and/or development of performance indicators that measure accomplishment or positive contribution to selected aspects of the ADMH's mission and values for the MHSAS Division.
3. To assess the MHSAS Division's success in providing a system of care and support that is consumer-driven, evidence-based, recovery-focused, outcome-oriented and easily accessible, promotes choice and self-determination, and contributes to the achievement of a life in the community for everyone.
4. To assess the MHSAS Division's success in providing services and supports that uphold the ADMH values of respect, collaboration, professional competency, diversity, accountability, inclusion, hope, resilience, accessibility, choice and compassion.
5. To assess the MHSAS Division's success in providing services and supports in a culture that fosters safety as a priority for everyone. This includes effective mechanisms for evaluating the culture of safety and quality on an ongoing basis and requirements for identifying, reporting, investigating, reviewing, and preventing critical incidents involving consumers.
6. To assess the MHSAS Division's success in complying with applicable standards for accreditation and certification.
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 seek comparison data from national databases, national reporting, the literature and other similar organizations to gauge and benchmark the performance of ADMH services as compared within the state, regionally and nationally as applicable.
9. To 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 organizations to trigger assessments aimed at improving services.
11. To facilitate the development of recommendations and actions including, but not limited to, changes in policies and procedures and standards of practice, when trends, problems or opportunities to improve care are identified.
12. To proactively assess and facilitate the identification and implementation of strategies to enhance the quality of services and supports, to enhance consumer safety, and to reduce risk to consumers and staff members in the community and inpatient facilities.
13. To disseminate information to the appropriate committee(s), department(s), discipline(s) and/or state facility or community provider stakeholder(s) in response to

PI recommendations and/or regarding follow-up actions/improvement strategies taken in response to identified PI opportunities.

14. To ensure ongoing involvement and periodic evaluation of the PI Program from stakeholders, the Governing Body, Facility Directors, MHSA Division Executive Staff, Community Program Executive Directors, Medical/Clinical Committee and the Division's PI Committee.
15. To encourage participation and commitment of all levels of leadership and all levels of facility and community program staff in PI initiatives in the MHSAS Division.
16. To provide a mechanism for the development of joint inpatient and community activities designed to improve services for consumers at different levels of care.
17. To provide information, consultation and training at the provider and division/state level regarding PI topics, issues, methods and requirements.
18. To develop and approve a PI Plan that outlines the responsibilities and activities of the MHSAS PI Program as described above.

IV. STATEMENT OF AUTHORITY

The authority and responsibility for the MHSAS Division PI Program is vested by the Commissioner of ADMH and the Associate Commissioner for MHSAS Division who have delegated the authority for conducting the program to the MHSAS Director of PI. It is the responsibility of the Director of PI to administer and coordinate the functions of the program and to report on PI Measures and PI activities on a regular basis to the Division PI Committee.

FACILITIES:

In accordance with the Governing Body Bylaws, the Associate Commissioner for the MHSAS Division has delegated to each of the Facility Directors the responsibility to establish and maintain effective PI Programs in addition to participation in the MHSAS Division PI Program. The Facility PI Programs shall be organized and managed by the leadership of each facility, primarily through committee functions. The Facility PI Directors will submit periodic reports to the Office of PI via system level indicators and reporting. PI data and activities affecting the state facilities will also be reported to the Medical/Clinical Committee, Directors' Committee and the Governing Body.

CERTIFIED MENTAL HEALTH COMMUNITY PROGRAMS:

Certified Mental Health community providers, under the direction of the Executive Director, shall develop, implement, and maintain a PI System as specified in the *Alabama Department of Mental Health, Mental Illness Community Programs Administrative Code* (Chapter 580-2-9-.07). This Chapter requires that each "provider shall operate and

maintain a PI system that is designed to assess important processes and outcomes, to correct and follow-up on problems, to improve the quality of services provided, and to improve consumer and family satisfaction with services provided.” Section (i) further specifies that “the agency will participate in all required performance indicators and quality improvement reporting requirements as specified by the ADMH MHSAS PI Committee.” The community provider PI designee will submit periodic reports to the Office of PI for identified system level indicators and pursuant to published special incident and quality indicator reporting procedures.

CERTIFIED SUBSTANCE ABUSE (SA) COMMUNITY PROGRAMS:

Certified substance abuse community providers shall develop, implement, and maintain a PI System that is relevant to the level(s) of care and services provided, as specified in the *Alabama Department of Mental Health, Substance Abuse Services Administrative Code (Chapters 580-9-44-.11 and 580-9-47-.06)*, and incorporates the principles of CQI/TQM. Each Community provider will designate an individual to serve as the agency’s ADMH liaison who will assume primary responsibility for submission of periodic reports to the Office of PI. Reports will include those which address identified system level quality indicators, those pursuant to published special incident reporting procedures, and others as specified by ADMH in its efforts to ensure that services provided by substance abuse community providers are safe, accessible, effective, patient-centered, efficient, and equitable.

V. COMMITTEE STRUCTURE

Composition of PI Committee

- The MHSAS PI Committee members are appointed by the Commissioner and the MHSAS Associate Commissioner and include representatives from the various stakeholder groups. The voting membership is designed to reflect the equal partnership between consumer/family stakeholders and provider stakeholders in achieving the objectives of the Committee. Committee membership will consist of the following stakeholder representatives: (Ex-Officio Members will not vote unless otherwise specified).
- 4 - Family Representatives (2 Mental Health; one family member of an Adult Consumer/one family member of a Child/Adolescent Consumer and 2 Substance Abuse; one family member of an Adult Consumer/one family member of a Child/Adolescent Consumer)
- 4 - Consumer Representatives (2 Mental Health; 2 Substance Abuse)
- 1 - Council of Community Mental Health Board Representatives
- 1 - Substance Abuse Executive Director
- 1 - UAB Adolescent Services Unit Representative
- 1 - Direct Care Clinician from a Mental Health Community Program
- 1 - Direct Care Clinician from a Substance Abuse Community Program

- 1 - Direct Care Clinician from a Substance Abuse Medication Assistance Treatment Program
- 1 - Direct Care Clinician from an ADMH Inpatient Facility
- 1 - ADMH Facility Director
- 1 - MHSA Director of MH Community Programs
- 1- MHSA Director of SA Development and Training
- 4 - ADMH Facility PI Directors/Designees
- 1 - Substance Abuse Program PI Director
- 1 - Substance Abuse Medication Assistance Treatment Program PI Director
- 1 - MH Community Program PI Director
- 1 - ADMH Advocacy Office Representative (ex-officio)
- 1 - MHSA Director of Performance Improvement (ex-officio), Chairperson*
- 1 - MHSA Executive Assistant (ex-officio)
- 1 - MHSA Director of Consumer Relations (ex-officio)
- 1 - MHSA Director of SA Prevention Services (ex-officio)
- 1 - MHSA Director of SA Treatment Services (ex-officio)
- 1 - MHSA Epidemiologist (ex-officio)
- 1 - MHSA Director of MHSAS Certification (ex-officio)
- 1 - MHSA Director Office of Deaf Services (ex-officio)
- 1 - ADAP Representative (ex-officio)

* *Chairperson will vote in tie situations only*

The Director of PI will be responsible for ensuring groups/agencies/stakeholders recommend a representative to be appointed to the PI Committee. Committee members are appointed for two years unless the member is filling in for a slot that was vacated. Terms of service generally begins during the February PI Committee meeting. The PI office will routinely review the roster of members during the preceding quarter to ensure reappointment letters are sent and/or that vacant slots are filled. All members are eligible for reappointment.

Inpatient Performance Improvement Subcommittee:

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

Mental Illness Services Performance Improvement Subcommittee (MISPI):

The MISPI Subcommittee, operating under the structure and authority of the MHSAS PI Committee, is responsible for small group work related to the development and refinement of MI community indicators and PI activities specific to the provision of services for mental illness. The MISPI Subcommittee shall meet on an as needed basis

and may be requested to work on additional PI related activities by the PI Committee and/or the MHSAS Director of Performance Improvement. Membership of the MISPI Subcommittee consists of:

- 1 - Director of MHSAS Performance Improvement (or staff designee), Chairperson
- 2 – MI Family Representatives (one family member of an Adult Consumer and one family member of a Child/Adolescent Consumer)
- 2 – MI Consumer Representatives (two MI Consumers)
- 1 – Council of Community Mental Health Board representative
- 1 – ADMH Facility Director
- 1 – Direct Care Clinician from an ADMH Inpatient Facility
- 1 – Direct Care Clinician from a Mental Health Community Program
- 4 – ADMH Facility PI Directors/Designees
- 1 – MI Community Program PI Director
- 1 – UAB Adolescent Services Unit Representative
- 1 – MHSAS Executive Assistant
- 1 – ADMH Advocacy Office Representative
- 1 – MHSAS Director of MI Community Programs
- 1 – MHSAS Director of Consumer Relations

- 1 – MHSAS Director of MHSAS Certification
- 1 – MHSAS Director Office of Deaf Services
- 1 – ADAP Representative
- Other approved representatives as indicated

Substance Abuse Services Performance Improvement Subcommittee (SASPI):

The SASPI Subcommittee, operating under the structure and authority of the MHSAS PI Committee, is responsible for small group work related to the development and refinement of SA community indicators and PI activities specific to the provision of services for prevention, treatment, and recovery support of substance use disorders. The SASPI Subcommittee shall meet on an as needed basis and may be requested to work on additional PI related activities by the PI Committee and/or the MHSAS Director of PI. Membership of the MHSPI Subcommittee consists of:

- 1 - MHSAS Director of Performance Improvement (or staff designee), Chairperson
- 2 – SA Family Representatives (one family member of an Adult Consumer and one family member of a Child/Adolescent Consumer)
- 2 – SA Consumer Representatives (two SA Consumers)
- 1 – Substance Abuse Executive Director
- 1 – Substance Abuse PI Director
- 1 – Substance Abuse Medication Assistance Treatment Program PI Director

- 1 – Direct Care Clinician from a Substance Abuse Community Program
- 1 – Direct Care Clinician from a Substance Abuse Medication Assistance Treatment Program
- 1 – MHSA Executive Assistant
- 1 – MHSA Director of SA Prevention Services
- 1 – MHSA Director of SA Treatment Services
- 1 – MHSA Director of SA Development and Training
- 1 – MHSA Epidemiologist
- 1 – MHSA Director of Certification
- 1 – MHSA Director Office of Deaf Services
- 1 – ADAP Representative
- 1 – ADMH Advocacy Office Representative
- Other approved representatives as indicated

Additional Subcommittee/Workgroups:

Additional subcommittees or workgroups of the MHSAS Division’s PI Committee may be appointed on either a permanent or temporary basis at the discretion of the MHSAS Division PI Director and MHSAS Associate Commissioner. In general, time limited subcommittees/workgroups may be appointed to study and provide recommendations to the MHSAS Division’s PI Committee concerning broad areas of divisional function affecting patient care or clinical practice and may include individuals outside of the MHSAS Division’s PI Committee who have particular expertise/experience in the area(s) under study.

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

The MHSAS Division Level PI functions shall be performed by the MHSAS Performance Improvement Office that is within the Office of the Associate Commissioner of the MHSAS Division. The MHSAS PI Office will be responsible for developing Division wide reports for the Committee’s review. The PI Committee will meet at least quarterly and review system findings for opportunities for improvement. Final Subcommittee reports and recommendations will be submitted to the PI Committee for review and approval. Final committee reports and recommendations will be submitted to the MHSAS Associate Commissioner through the PI Committee’s report to the MI Governing Body and related committees. Findings and recommendations regarding inpatient data are submitted to the Associate Commissioner and MI Governing Body. Findings and recommendations relevant to community data will be submitted to the Associate Commissioner and Commissioner and shared with pertinent stakeholders.

1. The MHSAS Division Performance Improvement Committee

The MHSAS PI Committee is a Division level advisory committee to the Associate Commissioner for MHSAS Division, the MI Governing Body, Directors’ Committee and the Medical/Clinical Committee on matters related to improvement of patient services

and patient outcomes. The MHSAS Division's PI Committee meets on a quarterly basis to review performance and a quorum is defined as the presence of a simple majority of the voting members of the Committee members exclusive of the Chairperson. Any business brought before the Committee may be passed by a simple majority of the members present. The Chairperson shall vote only in the event of a tie. The Chairperson shall be responsible for developing the meetings' agenda and distributing it to the Committee members prior to any scheduled meeting. The PI Office shall be responsible for sending data items to committee members in advance of the meeting.

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

The Director of PI is responsible for ensuring that any PI related recommendations to or from the PI Committee are communicated to the appropriate stakeholder committees including the Associate Commissioner for MHSAS, MH Directors' Committee, Medical/Clinical Committee, Governing Body, MISPI and SASPI Subcommittees, and/or relevant community provider stakeholder committees.

2. Directors' Committee

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

3. Medical/Clinical Committee

The Medical/Clinical Committee is a MHSAS Division level advisory committee to the Governing Body, the Directors' Committee, and the MHSAS Division's PI Committee on matters related to state facility patient care. The Committee is comprised of the Clinical Directors of each Facility operated by the MI Division, a Facility Directors' representative, a consumer representative, an Advocacy Services representative and the chairperson of each Medical/Clinical Professional staff subcommittee to include

Pharmacy, Psychology, Social Work, Nursing, Psychiatry, Medical Physician, Infection Control, Rehabilitation Services, and Health Information Management. The MHSAS Division Director of PI or designee and Director of Consumer Relations serve as ex-officio members. The MHSAS Division Director of PI or designee shall provide the Medical/Clinical Committee regular reports from the MHSAS Division PI activities. In the review of these reports, the Medical/Clinical Committee may provide recommendations to correct problems and/or improve care and services. These recommendations shall be communicated to the MHSAS Division's PI Committee by the MHSAS Division PI Director or designee. The PI Director shall then communicate recommendations to the Directors' Committee and, as appropriate, by the Governing Body for approval and/or action.

VII. COMMUNITY PROGRAMS RECOMMENDATIONS

Findings and recommendations regarding the community programs shall be made directly to the Associate Commissioner for MHSAS and/or to relevant committees. The MHSAS PI Committee should approve the addition of any new indicators or the removal of any current indicators that affect community providers, with the exception of indicators mandated by the MHSAS Division Associate Commissioner and/or the ADMH Commissioner or other regulatory/statutory requirements (i.e. *Alabama Department of Mental Health, Mental Illness Community Programs Administrative Code or the Alabama Department of Mental Health Substance Abuse Services Administrative Code*).

VIII. COMMUNICATION

The Associate Commissioner for MHSAS shall be kept aware of the activities of the MHSAS Division PI Program through committee meetings, meetings with and reports from the Director of PI, and MHSAS Division reports from P I activities. The ADMH Commissioner and other members of the Governing Body shall be kept informed of significant PI activities through reports provided by the MHSAS Division Director of PI and/or his designee in Governing Body meetings and other communications as indicated.

IX. CONFIDENTIALITY OF QUALITY ASSURANCE DATA

In order to participate, any individual appointed to the PI Committee as a full committee member, alternate member, ex-officio and/or a permanent or ad hoc workgroup or subcommittee member shall sign the MHSAS Confidentiality Statement(s) as applicable (see Appendix D). Confidential quality assurance data including any information defined by HIPAA as Protected Health Information (PHI) or by 42 CFR Part 2 as confidential alcohol and drug patient records shall not be disclosed by members in a manner that violates applicable law or violates the requirements for confidentiality as outlined in the PI Committee Confidentiality Statement. Failure to comply with confidentiality requirements may result in removal from the committee and exclusion from attending meetings. Members of committees and stakeholder groups reviewing reports from the MHSAS PI Committee as specified in Section VI shall also be required to sign the Confidentiality Statement.

X. PROGRAM EVALUATION

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

APPENDIX A

CURRENT ACTIVE INPATIENT INDICATORS & SOURCE OF DEFINITION*

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

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

ALCOHOL USE SCREENING – SUB-1: Indicator measures documentation of the adult patient’s alcohol use status within 3 days of admission using a validated screening questionnaire for unhealthy alcohol use.

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

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

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

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

DEFICIENCIES ACCREDITATION, LICENSURE OR CERTIFICATION: **Deficiencies** – Requirements (Joint Commission standards/elements of performance and/or CMS Conditions of Participation and/or standards, and/or Alabama Administrative Code Regulations) that, if not met, are likely to create an immediate threat or a threat over time that could increase the risk of safety and quality of patient care. **Accreditation** – The organization is in compliance with all standards at the time of an on-site survey or has successfully addressed all Requirements for Improvement of The Joint Commission or is in compliance with all standards at the time of an on-site survey or has successfully addressed “tags” from CMS. **Licensure** – A legal right that is granted by a government agency in compliance with a statute governing an occupation or the operation of an activity. **Certification** – Determined by The Joint Commission or CMS that an eligible program or service complies with applicable requirements.

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

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

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

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

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

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

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

NON-CONSENSUAL SEXUAL CONTACT: Indicator measures the number of reported incidents of non-consensual contact. Non-consensual sexual contact involves sexual contact between recipients involving a recipient who is coerced, is under sixteen (16) years of age, or

does not otherwise have the capacity to consent (Capacity may be either mental or physical, or the individual may be mentally incapacitated). (ADMH IMP)

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

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

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

NPSG 6: REDUCE THE HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS: Indicator measures the compliance with management of clinical alarm systems that have the most direct relationship to patient safety.

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B

CURRENT ACTIVE MI COMMUNITY INDICATORS

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

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

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

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

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

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

CONSUMER SATISFACTION YOUTH FAMILY (MHSIP): Indicator measures the results of the annual Mental Health Statistics Improvement Program (MHSIP) Youth Family Satisfaction Services (YSSF) Survey conducted by the MI Community programs. Using the nationally

recommended tool, the Youth Family Survey consists of 26 questions. The tool assesses consumer perception of care in the following seven domains: Access to Services, Satisfaction with Services, Participation in Treatment Planning, Outcomes of Services, Cultural Sensitivity as well as the Social Connectedness and Functioning Domains – which were added in 2006.

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

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

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

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

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

MEDIA EVENTS: This indicator measures the number of times that media is involved in unplanned manner, regardless of location.

MEDICATION ERRORS: Indicator measures the number of medication errors reported in 24-hour care settings, on the provider’s premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident manager. A medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. Additionally, a medication error occurs when the medication is not given for the right purpose or if there 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)

NON-CONSENSUAL SEXUAL CONTACT: Indicator measures the number of reports of non-consensual sexual contact in 24- hour care settings, on the provider’s premises, during an event supervised by the provider or in an apartment setting at which there is a provider resident

manager. Non-consensual sexual contact involves a client(s) who is forced or coerced, is under sixteen (16) years of age, or does not otherwise have the capacity to consent (Capacity may be either mental or physical, or the individual may be mentally incapacitated).

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

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

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

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

TRACKING RECEIPT OF CONTINUING CARE PLAN: Indicator measures the number of continuing care plans received from the state facilities by the next level of care provider, measures the timeliness of receipt, and measures the completeness of the care plan.

UNPLANNED RELOCATION: Indicator measures the number of unplanned relocations 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.

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

APPENDIX C

CURRENT ACTIVE SA COMMUNITY INDICATORS

Through the use of valid and reliable data, the PI Subcommittee will implement procedures to continuously measure, monitor and improve indicators in the following domains:

Domain	Measure/Indicator (During the Measurement Year)	Measure Source
Access	Number and Percentage of Individuals who initiated treatment who had two or more additional services with a diagnosis of ADD within 30 days of the initial visit.	NQMC 8241:
Access	Number and percentage of SA providers who admit patients to SA treatment at hours outside of traditional 8 to 5 office hours	ADMH
Use of Services	Number of individuals receiving a substance use disorders prevention, treatment, or recovery support service.	NQMC 8281:
Process	Percent of patients who receive a prescription for FDA approved medication for treatment of an alcohol or drug use disorder.	NQMC:008839
Process	Percent of patient visits and admissions where preferred written language for health care is screened and recorded.	NQMC:005610
Process	Percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.	NQMC:005609
Process	Language services: the percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.	NQMC:005614
Process	Percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.	NQMC:005611
Process	Number and percent of programs that offer and have available pharmacotherapy for alcohol addiction that is directly linked with psychosocial treatment and support.	NQF: Consensus Standards
Process	Number and percent of patients who receive empirically validated psychosocial interventions.	NQF: Consensus Standards
Process	Number and percent of programs that offer and have available pharmacotherapy for Opioid addiction that is directly linked with psychosocial treatment and support.	NQF: Consensus Standards
Process	Percent of patients receiving a tobacco use assessment	NBHF; NQF: 0028
Process	Percent of admissions who receive tobacco cessation intervention	NBHF; NQF: 0028

Process	Percent of admissions who receive tobacco cessation medication	ADMH
Process	Percent of patients who receive risky behavior assessment or counseling by age 13	NBHF; NQF# 1406
Process	Percent of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	NBHF; NQF 0418
Process	Number of programs providing long-term, coordinated management of substance use disorders.	NQF: Consensus Standards
Process	Number of Medicaid maternity care providers utilizing SBIRT	ADMH/Medicaid
Outcome	Reduction in/no change in frequency of substance use during past thirty days	TX NOM – Abstinence
Outcome	Increase in/no change in number of employed or in school at date of last service vs first service	TX NOM – Employment/Education
Outcome	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service	TX NOM – Crime and Criminal Justice
Outcome	Increase in/no change in number of patients in stable housing situation from date of first service to date of last service	TX NOM - Stability in Housing
Access	Unduplicated count of persons served	TX NOM – Access Capacity
Access	Penetration Rate: Number of patents served compared to those in need	TX NOM – Access Capacity
Use of Services	Average length of stay from date of first service to date of last service by level of care	TX NOM – Retention
Outcome	Percentage of patient admissions participating in self-help programs 30 days prior to treatment admission in comparison to participation at discharge	TX NOM– Social Connectedness
Cost	Cost of treatment services:	TX NOM – Cost Effectiveness
	○ Per person by level of care	
	○ By level of care in relation to treatment budget	
	○ By level of care per region	
Patient Experience	Number of patients responding to perception of care surveys	TX NOM– Perception of Care
	Responses to perception of care surveys – Percentage of clients reporting:	TX NOM– Perception of Care
Patient Experience	○ Staff here are supportive and encourage my participation in treatment activities that will benefit my recovery.	
	○ Staff treat me with dignity and respect	

	<input type="radio"/> I am free to complain without fear of retaliation.	
	<input type="radio"/> I was given information about my rights.	
	<input type="radio"/> Staff encourage me to take responsibility for how I live my life.	
	<input type="radio"/> Staff respect my wishes about who is and who is not to be given information about my treatment.	
	<input type="radio"/> Staff respect my religious/spiritual beliefs	
	<input type="radio"/> Staff speak to me in a way that I understand	
	<input type="radio"/> Staff helped me obtain the information I needed so that I could take charge of managing my disease of addiction.	
	<input type="radio"/> Staff acknowledge and honor my cultural/ethnic background	
	<input type="radio"/> I am encouraged to use community support groups (AA, NA, CA, Dual, crisis phone lines, etc.).	
	<input type="radio"/> The location of services was convenient (parking, public transportation, distance).	
	<input type="radio"/> Staff returned my call(s) in 24 hours.	
	<input type="radio"/> Services were available at times that were good for me.	
	<input type="radio"/> The people I went to for services spent enough time with me.	
	<input type="radio"/> My counselor is knowledgeable about recovery.	
	<input type="radio"/> I talk freely, openly, and honestly with my counselor.	
	<input type="radio"/> I participated in the development of my individualized service plan.	
	<input type="radio"/> I like the services that I am receiving at the treatment program.	
	<input type="radio"/> If I had other choices, I would still get services from this agency.	
	<input type="radio"/> I would recommend this agency to a friend or family member.	
	<input type="radio"/> As a result of the treatment or services I am receiving, I see that using alcohol and/or other drugs is a problem for me.	
	<input type="radio"/> I feel comfortable here	
	<input type="radio"/> The building is clean and comfortably furnished	
	<input type="radio"/> The building is in good repair	
	<input type="radio"/> The grounds are well maintained	
	<input type="radio"/> I am satisfied with my room	
	<input type="radio"/> I have enough privacy in my room	
	<input type="radio"/> My belongings are safe here	
	<input type="radio"/> I can find places to talk with my visitors in private	
	<input type="radio"/> I get enough to eat during mealtime	

	○ I get to eat the food I need for my health	
	○ I have access to snacks and drinks whenever I want them	
Use of Services	Rate of readmission to treatment by level of care	ADMH
Use of Services	Percent of program discharges by discharge type	ADMH
Access	Percent of patients admitted to the level of care assessed as needed	ADMH
Access	Percent of patients served who have co-occurring substance use and mental disorders	ADMH
Structure	Evidence-based treatment programs provided	TX NOM – Use of Evidence-Based Programs
Population Outcome	Rates of thirty-day substance use (non-use/reduction in use)	PRV NOM – Abstinence
Population Outcome	Rates of perceived risk/harm of use	PRV NOM – Abstinence
Population Health Status	Ranking of patients’ age at first use	PRV NOM – Abstinence
Population Health Knowledge	Percent of individuals who express disapproval/attitude relative to AOD use	PRV NOM – Abstinence
Social Determinants of Health	Percentage of ATOD suspensions and expulsions by county	PRV NOM - Employment / Education
Social Determinants of Health	Percentage of school attendance and enrollment by county	PRV NOM – Employment/ Education
Social Determinants of Health	Percentage of workplace AOD use and perception of workplace policy	PRV NOM – Employment/ Education
Social Determinants of Health	Percentage of alcohol and drug-related crime	PRV NOM – Crime and Criminal Justice
Social Determinants of Health	Number of alcohol-related car crashes and injuries	PRV NOM – Crime and Criminal Justice
Use of Services	Number of persons served in prevention programs by age, gender, race, and ethnicity	PRV – NOM Access/Capacity
Population Experience	Percentage of family communication around drug use	PRV NOM – Social Connectedness
Cost	Services provided within cost bands for universal, selected, and indicated programs	PRV NOM – Cost Effectiveness
Structure	Number of evidence-based programs and strategies employed	PRV NOM – Use of Evidence-Based Programs
Population Experience	Percentage of youth seeing, reading, watching, or listening to a prevention message	PRV NOM – Retention

Management	Number and nature of program deficiencies identified during peer reviews	SABG
Access	Percent of pregnant women served	SABG
Access	Number of IV Drug users served	SABG
Use of Services	Number of patients receiving Tuberculosis services	SABG
Access	Number of children of mothers in treatment served	SABG
Structure	Number and nature of provider continuing education activities made available by MH/SA	SABG
Management	Number of continuing education participants	SABG
Patient Safety	Number of reported and substantiated allegations of abuse/neglect.	ADMH Critical Incident: Allegations Of Abuse/ Neglect
Patient Safety	Number of reported incidents of non-consensual sexual contact.	ADMH Critical Incident: Non-Consensual Sexual Contact
Patient Safety	Number of client deaths reported (from known or unknown causes) 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. Any death of a consumer in medication assisted treatment (methadone clinics).	ADMH Critical Incident: Client Death
Patient Safety	Number of adult elopements reported for patients 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.	ADMH Critical Incident: Elopement of Patients from Residential Programs Under a Commitment Order/on a Temp Visit/ Locked Unit
Patient Safety	Number of elopements for any child/adolescent patient.	ADMH Critical Incident: Elopement of a Child/ Adolescent
Patient Safety	Number of hospitalizations for medical and/or psychiatric reasons reported for clients on crisis units, child/adolescent programs, other locked units/program, and SA Residential Programs.	ADMH Critical Incident: Hospitalization of a Client from Locked Residential Unit/Program
Patient Safety	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.	ADMH Critical Incident: Major Client Injury

Patient Safety	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	ADMH Critical Incident: Medication Errors
Patient Safety	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	ADMH Critical Incident: Suicide Attempts
Patient Safety	Number of suicides reported for patients in the provider's non-residential caseload	ADMH Critical Incident: Suicide Of Client in a Provider's Non-Residential Caseload
Patient Safety	Number of seclusions and restraints reported by community providers	ADMH Critical Incident: Seclusion/Restraint
Patient Safety	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.	ADMH Critical Incident: Unplanned Relocation
Patient Safety	The number of times that media is involved in unplanned manner regardless of location	ADMH Critical Incident: Media Event
Management	Number of times that any violation of the confidentiality or privacy of protected client information occurs relative to the <i>Alcohol and Other Drug Confidentiality Rule</i> within 42 C.F.R Part 2 and Part 8, or the <i>Health Insurance Portability and Accountability Act Privacy Rule</i> , within 45 C.F.R. Parts 160 and 164.	ADMH Critical Incident: Confidentiality/ Privacy Breach
Patient Safety	Number of times events occur involving client(s) and/or staff that necessitates the intervention of law enforcement officials	ADMH: Critical Incident: Legal/Criminal Activity
Management	Program certification review scores ranked by level of care	ADMH
Management	Percentage of program certification deficiencies by level of care	ADMH
Management	Percentage of providers in compliance with contract compliance requirements:	ADMH
	○ Audits submitted on time	
	○ Audit findings resolved as specified	
	○ Current program description provided on time	
	○ ASAIS waiting list utilization	
	○ Compliance plans established	

Management	Number and nature of SA patient complaints received by MH/SA personnel	ADMH
Management	Percent of clinical staff with certification credentials	ADMH
Management	Percent of contract providers with Electronic Health Records	ADMH

○

APPENDIX D

CONFIDENTIALITY AGREEMENT

Division of Mental Health and Substance Abuse Services: Governing Body Members and Governing Body Committee/Subcommittee Members

CONFIDENTIALITY AGREEMENT

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

- I agree that I will hold all such information as confidential and shall not disclose it to anyone outside of the Governing Body Committee/subcommittee structure or other authorized employees or agents of the Alabama Department of Mental Health such as those involved in facility or division level performance improvement processes.
- Although individual client or staff member names are not disclosed within the context of the Committee or Subcommittee Meetings, there are occasions where specific details of an event and/or performance monitoring indicator may provide sufficient information (alone or combined with other public sources of information (media, other regulatory agencies, etc.)), where one may be able to ascertain the identity of an individual client or staff member. Therefore, in the case of client information, there may also be information that meets the definition of Protected Health Information (PHI) and hence its confidentiality would also be regulated under the Federal Health Insurance Portability and Accountability Act (HIPAA) or confidential alcohol and drug patient records which are regulated under 42 CFR Part 2. I agree to uphold all such requirements for protected health information.
- In the case of employee/agent/or LIP performance issues, I recognize that any information regarding clinical competency or performance of individuals is likewise held in strictest confidence among those present during such proceedings and others authorized by the Associate Commissioner for Mental Health and Substance Abuse Services or designee.
- I likewise agree to hold any information that may reflect on the performance of an individual staff member(s) or agent(s) of a state psychiatric facility or certified community program as confidential for quality assurance purposes only.

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

1. Any data that could identify a specific client/patient or staff member of a certified community program and/or of a state psychiatric facility *(see below specific HIPAA provisions regarding PHI).
2. Any data that will identify a patient as a participant in a substance abuse community program.
3. Any data that would identify an individual provider's (certified community provider and/or state psychiatric facility) performance on any PI indicator/measure or monitor.
4. Any data that would identify NASMHPD Research Institute (NRI) National Mean numbers on any NRI performance indicators such as seclusion/restraint rates, elopement rates, etc. National mean data is copyrighted and any release of it outside of the Committee/Subcommittee could result in the cancellation of our participation in the system by NRI and/or possible sanctions related to breach of contract.

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

Please review and initial each statement to indicate agreement:

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

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

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

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

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

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

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

My signature below attests that I agree to hold all information described in this CONFIDENTIALITY AGREEMENT in confidence and I acknowledge that any intentional or

inadvertent release of confidential information will result in my removal from the committee/subcommittee.

Signature of Committee/Subcommittee Member

Date

Name(s) of Committee/Subcommittee(s) on which I serve (please identify all permanent and ad hoc committees, workgroups, subcommittees, etc. on which you serve).

**ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
PERFORMANCE IMPROVEMENT PLAN**

APPROVED BY MHSAS PI COMMITTEE:

Phillip Ward
Director, Office of Performance Improvement
Chairperson, MHSAS Division Performance Improvement Committee

Date

APPROVED BY ASSOCIATE COMMISSIONER MHSAS DIVISION:

Dr. Beverly Bell-Shambley
Associate Commissioner for MHSAS

Date

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance needed in this area.

Footnotes:

11- Trauma

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

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).

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.

- 2. Describe the state's policies that promote the provision of trauma informed care.

The Alabama Department of Mental Health promotes the strategies identified in "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach."

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.

- 3. How does the state promote the use of evidenced-based trauma-specific interventions across the lifespan?

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.

- 4. Does the state provide trainings 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 2014 and 2015 included Compassion Fatigue: Let the Healing Begin; Communication During Volatile Situations; Trauma, Spirituality, and Recovery; Culturally Attuning Substance Abuse Treatment; The Pain of Pleasure: The Neuroscience of Trauma; Treating Early Life Developmental Trauma; Cultural Competency: Understanding the Need to Provide Culture-Specific Treatment in Substance Use Disorders Programs; Recovering Your Family: Helping Families Help Themselves; Conflict Resolution; and Peer Support.

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.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

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 use 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.^{80 81} 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. 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 a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate 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. Are cross-trainings provided 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?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ 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.

⁸² 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, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area.

Footnotes:

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

No. Alabama remains a non-expansion state.

2. Are screening and services 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. Do the SMHA and SSA coordinate 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 writing 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. Are cross-trainings provided 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 provides funding for 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 law enforcement, as well as, 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. The school provides an excellent venue for cross training of behavioral health and criminal/juvenile justice involved personnel.

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.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area at this time.

Footnotes:

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity? Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

ADMH has not taken an active role in the development of communication plans to educate and raise awareness about MHPAEA.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

ADMH has not taken an active role in regard to the increasing consumer awareness about MHPAEA.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

ADMH has not taken an active role in regard to increasing awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance needed in this area.

Footnotes:

14. Medication Assisted Treatment

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

ADMH currently certifies twenty two Opioid Treatment Programs. Of those twenty two, nine receive funding either through Medicaid or state funding. An additional OTP is in the process of being approved for Medicaid.

ADMH has recently had technical assistance from SAMHSA in regards to their role as the State Opioid Treatment Authority. Part of the technical assistance was centered on how to become more adept at promoting the use of medication assisted treatment both to the public and within the substance use field of Alabama.

ADMH is also working closely with the contract Opioid Treatment Programs to strengthen their outreach programs. This includes ensuring that materials they use for marketing their programs is updated, their websites provide correct information and encouraging them to take advantage of social media tools.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

ADMH's administrative code requires that all programs to give priority access for treatment to the following individuals in the following order:

- Pregnant individuals who are pregnant with IV substance use disorders
- Pregnant individuals with substance use disorders
- All other individuals with substance use disorders
- Women with substance use disorders and dependent children
- All other individuals with substance use disorders

As part of site visits and compliance reviews, agencies' policies regarding priority access is reviewed. ADMH is expanding their use of the Performance Improvement department who are in the process of developing electronic reports which will help agencies and ADMH to monitor implementation of these policies.

ADMH is in the process of establishing quarterly meetings with all agencies, including abstinence based and Opioid Treatment programs. One of the goals of these meetings will be for the different treatment modalities to become more integrated in the care of the individuals of Alabama. The first meeting is scheduled for November of 2015.

Alabama currently has a moratorium on the establishment of new OTPs. ADMH has diligently worked to have this moratorium lifted and to establish a need methodology for new facilities. Part of the need methodology is that preference will be given to those applicants demonstrating the most comprehensive plan for treatment patients regardless of their ability to pay. It is anticipated that the official lifting of the moratorium will be on or around October 15, 2015.

ADMH is a sponsor of the Alabama School of Alcohol and Drug Studies. For the years of 2014 and 2015, classes were offered that focused on the need for medication assisted treatment (The White Horse Rides Again: The Return of Heroin) and understanding Opioid Treatment Programs (Stop Stigma Now: Breaking the Stigma of Methadone Treatment; The Pain of Pleasure-Opioid Use Disorders and Their Treatment).

The Alabama Alcohol and Drug Abuse Association is one of the boards that certifies professionals for work in the substance abuse field. They offer an education retreat each year. Classes offered this year included Heroin 2015: Medicated Assisted Treatment for Substance Abuse and The Rise of Opioid Use in Alabama and Safe Alternatives.

In addition, ADMH has made a concentrated effort to ensure that all contract providers follow a specific outreach policy as related to pregnant women and individuals with IV substance use disorders. The focus has been ensuring that agencies actually have a policy and procedure that they follow in regards to outreach. In the last year, there has been more emphasis on providing proof that the outreach policies and procedures are being implemented.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

All agencies are required to use ASAM criteria when determining what level of care an individual needs. All agencies can refer to OTP programs.

ADMH promotes the use of Alabama's Prescription Drug Monitoring Program (PDMP). All Opioid Treatment Programs are encouraged to use the PDMP as a regular part of their programs. The goals of the Alabama Prescription Drug Monitoring Program are 1) to provide a source of information for practitioners and pharmacists regarding the controlled substance usage of patient; 2) to reduce prescription drug abuse by providers and patients; 3) to reduce time and effort to explore leads and assess the merits of possible drug diversion cases; 4) and to educate physicians, pharmacists, policy makers, law enforcement, and the public regarding the diversion, abuse, and misuse of controlled substances.

The Alabama Board of Pharmacy has established practice standards regarding oversight of pharmacy services in Alabama's Opioid Treatment Programs. Some of those practice standards include:

- In clinic dosing will be under the supervision of the clinic's medical director. These individual doses will be prepared, stored, administered, documented and inventoried by the clinic's nursing staff under the direction of the medical director.
- All medication intended for take home units will be under the supervision of the facility pharmacist and will be considered by the Board to be similar to outpatient dispensing.
- All take home medications and single take home units will be stored in a safe to be kept within the medication pass area only. Only the pharmacist will have a key to the safe for take home doses.
- A pharmacist must be present when take home doses are prepared and when they are dispensed to the patient for future use.
- The pharmacist will be responsible for the inventory of the involved methadone and ensuring that a method exists for documenting each dose of medication being given to the patient for future use.

OTP's must have a written plan to reduce the possibility of diversion of controlled substances from legitimate treatment to illicit use. The diversion control plan has to include, at a minimum:

- A process for routine surveillance and monitoring of the internal and external treatment environment;
- A process for continuous examination of dosing and take home dispensing practices to identify weaknesses in the dispensing of medication that could lead to diversion problems;
- Procedures for clients who are dispensed three or more take home doses to receive a minimum of two call backs annually;
- A process to address identified diversion problems through corrective and preventive efforts.

OTP providers must participate in a Central Registry. Alabama uses Lighthouse Software Systems to administer the registry. The registry serves to track patients in order to prevent multiple enrollments of patients with more than one provider.

As part of ADMH's administrative code, agencies must provide written documentation in their policies and procedures that they will not deny admission or readmission of clients based exclusively on current maintenance on methadone.

ADMH also requires that OTP's provide certain core services. These core services include: medication management and administration, individual counseling, group counseling, family counseling, psychoeducation, assessment services and case management. All of these services must be documented in the client's clinical chart. All clients must receive a minimum of one documented clinical service per month.

All OTP's receive either annual or bi-annual site visits in which the above areas are verified. OTP's who receive any type of funding through the state receive an annual compliance review which covers both their contract requirements and areas of services.

In addition, ADMH is participating in SAMHSA's BRSS TACS Academy. The use of peers in OTP's is an area of focus. The BRSS TACS members are currently working on establishing a set of standards for the use of peers in agencies.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to substance abuse services application.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, 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.

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. 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?
4. 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? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is requested in regard to implementation a valid patient satisfaction survey process.

Footnotes:

Environmental Factors and Plan

16. Recovery

Narrative Question:

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

Alabama is currently developing the infrastructure, including a plan, to support implementation of a Recovery Oriented System of Care. To date the plan incorporates a definition of recovery and a set of guiding principles for ROSC. In addition, ADMH has acquired personnel to lead the State's ROSC efforts. The agency's Coordinator of Recovery Support Services is a self-identified person in recovery and serves as the team coordinator for Alabama's participation in the 2015 Bringing Recovery Support to Scale (BRSS TACS) Policy Academy. The State's participation in the Policy Academy has resulted in its development of a peer workforce development, training, and certification plan. This action plan incorporates a variety of peer services in the current system of care and the community.

In August, 2015, ADMH sponsored the State's 1st Annual Consumer Conference for people with substance use disorders who were currently in treatment, along with family members of people in recovery. In addition, the State also sponsored its own Policy Academy for treatment providers to assist them in development of the infrastructure needed to incorporate peer workers into their service delivery systems.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. ADMH's Administrative code incorporates rules within each ASAM level of care that require the availability of recovery support services for clients served in substance abuse treatment programs. There is no specific reference to the SABG.
3. 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?

Other than the rules stated above, there are no other policies in place within Alabama's state system that require peer-delivered services for special populations.

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

The State provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems. ADMH is currently a participant in the 2015 BRSS TACS Policy Academy focusing on Peer Workforce Development, Training, and Certification. ADMH has a plan to establish the infrastructure to support and sustain a workforce that routinely

utilizes trained and certified peer specialists in the provision of services for individuals, families, and communities impacted by substance use disorders and mental illnesses. Implementation of this plan has resulted in the following actions:

- A. ADMH has adopted defined specific peer services, core competencies, and categories of peer workers.
 - B. The peers on the BRSS TACS team developed the first draft of the certification training manual. The manual has 24 modules for a total of 40-hours of training. The manual is currently under review by all BRSS TACS team members.
 - C. Team members implemented the Alabama BRSS TACS Policy Academy for certified providers. Fifteen (15) certified providers attended a 3-day workshop and ten (10) providers submitted a plan to incorporate peer support services within their system by the deadline September 2, 2015. Team members are currently reviewing the plans. Chosen plans will be awarded a grant to assist with changing their infrastructure to include peer services.
 - D. ADMH/SA is currently developing certification standards for publication in Chapter 580 of the Alabama Department of Mental Health's (ADMH) Administrative Code for both substance use disorders and mental illness peer services that include common elements and specializations.
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

No.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

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 bi-monthly. The 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).

The ADMH BRSS TACS team consist of people in recovery, members of peer organizations, and family members. The Associate Commissioner for Mental Health and Substance Abuse Services has also established a consumer advisory groups that meets directly with her on a quarterly basis to discuss issues of relevance to them.

Family members are given the opportunity to participate in consumer satisfaction surveys at the agency and state level. The consumer satisfaction surveys provides 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.

7. Does the state support, 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. ADMH's Recovery Support Services Coordinator assists in planning and participates in activities held in support of Recovery Month. Some of the activities held this year included:

- a. Numerous showings of the movie, "**Anonymous People**" and panel discussions. The documentary is about the 23 million Americans in long term recovery refusing to stay in the shadows. ADMH hosted a viewing in its central office.
- b. **Sober Tailgate** on the campus of the University of Alabama as Alabama's Football team hosted Ole Mississippi. This free event included recovery stories, community booths, kids and adult contests, Alabama memorabilia, face painting, door prizes and giveaways, a visit by Big Al, popcorn, cotton candy, 3 screen digital truck for tailgating, Pepsi products and more.
- c. **Lipstick and Liquor:** A documentary and panel discussion on alcoholism among women. "Lipstick & Liquor" is a documentary film that explores the growing number of women in the suburbs that are abusing alcohol and becoming alcohol dependent. A panel discussion featuring women in recovery took place immediately following the film.
- d. **Legalizing Marijuana in Alabama.** Alabama State University. Implications in the African-American Community.
- e. **Coastal Alabama Recovery Awareness Walk/Run** This event includes a 1.5-3 mile walk/run. There were various behavioral health agencies on site to provide information. FREE food and activities for the children, including a fun zone with face painting and Moon Bounce. This was a fun filled activity for the entire family and all who support the Recovery Community in Coastal Alabama.
- f. **Birmingham Recovery Walk/Run** A family friendly event that offered recovery stories, guest speakers, free lunch, live music, proclamation presentation, moon walks, door prizes, face painting, and our recovery panel featuring recovery experts.
- g. **Recovery Prom** was an event for adults in recovery and others who support an alcohol and substance abuse free lifestyle.
- h. **10th Annual National Prescription Drug Take-Back Day** As with the previous nine Take-Back events, sites were set up throughout communities in Alabama so local

residents can return their unwanted, unneeded, or expired prescription drugs for safe disposal.

In addition, the Alabama BRSS TACS Policy Academy plans include new recovery-oriented services throughout the state including educational services for peer specialist and the first ADMH supported substance abuse drop-in center. ADMH is also developing a plan to certify recovery organizations and other self-help programs.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

ADMH/SA does not have a formal process to track the impact of consumer outreach activities.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

As used in the ASAM Placement Criteria “recovery” refers to the goal of helping a consumer to achieve overall health and well-being. As part of ADMH’s Administrative Code, Levels of Care, agencies are required to offer certain core services either directly or through referrals, including smoking cessation. Other well issues are yet to be addressed by the State.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

ADMH/SA does not currently have a plan to address housing. Several ADMH certified providers are offering transitional housing for clients who complete treatment that is less restrictive, and provides an independent living environment.

11. Describe how the state is supporting the employment and educational needs of individuals served.

ADMH/SA does not currently have a plan in place to address these issues.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to substance abuse services application.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support 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 more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious 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?
6. Has the state 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? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is not needed in this area at this time.

Footnotes:

18. Children and Adolescent Behavioral Health Services

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 ADMHSA Office of Treatment Services. The ADMHSA 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 SAPTBG 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 the SAPT block grant 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 to a host of uniform program standards, which is monitored through an onsite certification process.

ADMHSA 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 of level of care.

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 ADMHSA that individualized plans of care be established for all children and adolescents entering substance use disorder treatment. As part of Individual Services 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).

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.)?

- ADMHSA has established the Substance Abuse Adolescent Advisory Committee which is comprised of members from various child servicing agencies to include juvenile justice, substance abuse treatment providers, Medicaid representation, substance abuse prevention providers, and advocacy representation. The committee is looking for opportunities with both public/private entities to collaborate 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 MHSA 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.

In addition to the establishment of the Substance Abuse Adolescent Advisory Committee, the state has linkages with several committees whose focus is to provide greater access to quality services for youth and families in the state of Alabama. Those committees include: *Multiple Needs Case Review Committee*, which reviews referral for children in need of a more restrictive treatment environment; *State Children's Policy Council*, which is the coordinating body for the local counties Children's Policy Council; *Children's Justice Task Force*, which promotes the identification, assessment, and prosecution of child abuse; *State Perinatal Advisory Committee*, which advises the state health officer in the planning, organization, and evaluation of the state's perinatal program; *Fetal and Infant Mortality Review*, which is responsible for identifying critical community strengths and weaknesses as well as unique health and social issues associated with poor outcomes of pregnancy; *Statewide System Reform Program*, which is a collaboration of state agencies aiming to establish protocols to reach more families that find themselves at the crossroads of the justice system, mental health, and the child welfare system; and *Impaired Drivers Trust Fund Advisory Committee*, which facilitates a system of services for Alabamians with head and spinal cord injury.

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

- To improve the competencies and skills of providers and staff serving youth with substance abuse disorders, ADMHSA collaborates with other entities to sponsor the Alabama School for Alcohol and Drug Studies annually. During the 2015 conference the following seminars relating to youth were offered:
 1. Engaging Group Techniques with Resistant Adolescents, which provided participants with techniques to convert unwilling clients into willing participants who cooperate in counseling and achieve positive change.
 2. Families of Dysfunction, which provided participants with an in depth discussion of family systems, dysfunctional family operations, and the effect of dysfunction in the absence of a family member.
 3. Culturally Attuning Substance Abuse Treatment, 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 disorder.

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

- Alabama Substance Abuse Information System (AS AIS), is a web based management information system which collects all of the TEDS data from all certified contracted providers. The system is capable of running numerous reports and it is just a matter of setting up a data warehouse and knowing what information is available. ADMHSA realizes the magnitude of AS AIS and the role it will play in shaping the SA service delivery system.

Has the state 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? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

- ADMHSA has not identified a liaison for children to assist schools in assuring identified children are connected with available substance abuse treatment and recovery support services. ADMHSA does employ an Adolescent Substance Abuse Services Coordinator that has collaborated with several child and youth serving agencies in the state to address behavioral health needs. In addition, some of the certified adolescent providers in the state have linkages to their local school systems for adolescent substance abuse services.

What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

- Substance Abuse Services for children and adolescents in Alabama is designated for those ages 12-18. There is no formal process for transitioning children/adolescents, when an individual reaches maximum age to be served in the adolescent programs they are transferred to the adult programs.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is not needed in this area at this time.

Footnotes:

19. Pregnant Women and Women with Dependent Children

The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

- Contracted providers are responsible for methods of providing this information to pregnant women. Methods utilized include: Street outreach programs, public service announcements (radio or television), advertisements in local and regional print media, posters placed in targeted location and notification of availability of treatment to community based organizations, health care providers and social service agencies. ADMH staff ensures compliance with this during annual monitoring visits with contracted providers, where providers are expected to show evidence of compliance via written policies and procedures. If a provider cannot show evidence of compliance they are expected to submit an action plan to become compliant this plan would include copies of developed policies and procedures.

Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

- Contracted providers are contractually obligated to implement and maintain a written policy and procedure that states the pregnant women be provided treatment within 48 hours, contingent upon the availability of space. If space is not available, the Substance Abuse Services Division of the ADMHSA must be notified for placement in another program and interim services offered until placement is made.

Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

- Contracted providers are contractually obligated to implement and maintain a written policy and procedure that ensures interim services are provide to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services. These interim services include, but are not limited to:
 1. Counseling on the effects of alcohol and drug use on the fetus and referrals for prenatal care for pregnant women
 2. Counseling and education about HIV and Tuberculosis
 3. Risk of needle sharing
 4. Risk of transmission to sexual partners and infants
 5. Steps that can be taken to ensure that HIV and Tuberculosis does not occur
 6. Referral for HIV or Tuberculosis services if necessary

Discuss who within your state is responsible for monitoring the requirements in 1-3.

- The Office of Treatment Services is responsible for monitoring the requirements listed above in 1-3.

How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP.)

- Alabama has two (2) residential programs that offer ASAM levels 3.5, 3.3, and 3.1 to serve women and infants/children.
 - a. **How many of the programs offer medication assisted treatment for the pregnant women in their care?**
- None of the programs that serve women and infants/children offer medication assisted treatment. However the twenty-two (22) methadone clinics in the state, provide medication assisted treatment for the pregnant women in their care. The methadone clinics must also continue to make pregnant women in their care a priority and follow an individualized service plan to ensure continued progress towards improved functioning and healthy prenatal care.
 - b. **Are there geographic areas within the State that are not adequately served by the various levels of care and /or where pregnant women can receive MAT? If so, where are they?**
- ADMHSA treatment services covers four (4) regions, however there are two (2) areas in regions 3 and 4 where medication assisted treatment (MAT) is not available.

How may programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP)

- Alabama has two (2) residential programs that offer ASAM levels 3.5, 3.3, and 3.1 to serve women and infants/children.
 - a. **How many of the programs offer medication assisted treatment for the pregnant women in their care?**
- None of the programs that serve women and infants/children offer medication assisted treatment. However the twenty-two (22) methadone clinics in the state, provide medication assisted treatment for the pregnant women in their care. The methadone clinics must also continue to make pregnant women in their care a priority and follow an individualized service plan to ensure continued progress towards improved functioning and healthy prenatal care.
 - b. **Are there geographic areas within the State that are not adequately served by the various levels of care and /or where pregnant women can receive MAT? If so, where are they?**
- ADMHSA treatment services covers four (4) regions, however there are two (2) areas in regions 3 and 4 where medication assisted treatment (MAT) is not available.

Participant Directed Care (voucher program)

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

- The Alabama Department of Mental Health Substance Abuse does not have a plan at this time for Participant Directed Care (voucher program); subsequently, this section does not apply.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is needed in regard to an ADMH population specific suicide prevention plan.

Footnotes:

20. Suicide Prevention (Bev)

Instructions - 20. Suicide Prevention

SABG Instructions

20. Suicide Prevention

- In the FY 2016/2017 block grant application, SAMHSA asks states to:
 1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
 2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
 3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

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http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Alabama Suicide Prevention and Resource Coalition (ASPARC).

In 2001, the Commissioner of the Alabama Department of Mental Health and the State Health Officer of the Department of Public Health (ADPH) 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 (98) 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 were published in the peer reviewed Alabama Counseling Association Journal. This special edition is included in the attachments. At present ASPARC is planning for its annual meeting to be held on September 27, 2013. A save the date card is provided in the attached documents.

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.

For twelve (12) 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. A recent news report indicates the suicide rate in Alabama reached an all-time high of 14.9 suicides per 100,000 people in 2013, as reported by the Alabama Department of Public Health. This rate was higher than that of the U.S. rate. Thus, the DMH identified "Suicide Prevention" as a priority to in Section II of this Block Grant Application when the spike began in FY12. The Office of Prevention identified as a goal to prevent suicides and attempted suicides and continues to have this as a goal for prevention provider planning. To address this goal the following objective that is underway is to promote the prevention of attempted suicides and deaths by suicide among those at risk for suicide. The action steps that have been in progress to meet this goal and objectives are: participation and collaboration with the suicide prevention task force, educate the prevention system on suicide and effective practices and resources for the prevention of suicide; ensure prevention plans address suicide, and prevention and reduce suicides among populations at high risk. Having suicide as a target of focus for prevention strategy implementation allows prevention providers to address high risk and vulnerable populations for this public health issue. Nineteen percent of the prevention provider agencies addressed suicide in FY2015 through use of Alternatives, Community Based Processes, Education,

Environmental, and Information Dissemination strategies. One community example was the use of social media, community outreach events, town hall forums and public awareness campaigns to disseminate information on suicide to a six county catchment area. At the state level, the DMH has continued its relationship with the suicide prevention task force with board membership, active meeting participation, collaboration on the Garrett Lee Smith (GLS) grant, and attendance at suicide conference. DMH sponsored suicide gatekeeper training, QPR (question, persuade, refer) in April 2014 to the prevention provider network. In September 2014, during Suicide Awareness week, daily prevention messaging was disseminated to the statewide provider network on suicide. Suicide was indicated in the proposed approach for the Partnership for Success discretionary grant that was awarded to the state and slated to begin October 2016. Through this grant, the following aims are desired. Our agency plans to collaborate and coordinate efforts directly related to suicide with the University of West Alabama prior to the culmination of its GLS grant on 9/29/16 and a local prevention provider. Specifically, a representative from the university will be invited to become a member of the State Prevention Advisory Board. Continued workforce development opportunities will be coordinated throughout the state for clinical providers. Targeted technical assistance sessions on focusing strategies toward addressing suicide prevention will be coordinated and developed in collaboration with the local prevention and clinical providers to ensure prevention planning addresses suicide, as well as suicide screening and assessment, are occurring and individuals are referred for treatment. At the community level, PFS sub-recipients will be tasked with updating their existing needs assessments that were developed during the SPF-SIG. The updated needs assessment process will include suicide as a construct for assessment in addition to the existing substance related constructs (alcohol and/or drug related motor vehicle crashes, substance abuse treatment admission, graduation rates, poverty). The existing EBP Workgroup will work with PFS sub-recipients to provide T/TA to assist in the selection of evidence based policies, programs, and practices focused on suicide prevention.

ASPARC began revision of Alabama's 2004 Suicide Prevention Plan in June 2010 and the revisions were finalized in late 2011-2012 denoting a three year plan. A draft five year plan is currently under development and was begun in 2015. This plan is provided below.

The 2015 State Plan

The 5 Year Alabama State Plan for Suicide Prevention provides state-specific recommendations that include Strategic Directions, Objectives and Strategies that align with the 2012 National Strategy for Suicide Prevention. The strategies outlined in this plan can be supported by ADPH, ASPARC, the Alabama Chapter of the AFSP, crisis centers, and colleges and universities throughout the state.

Strategic Direction

- Healthy and Empowered Individuals, Families, and Communities
- Clinical and Community Preventive Services
- Treatment and Support Services
- Surveillance, Research, and Evaluation

Goals

- 1) Integrate and coordinate suicide prevention activities in multiple sectors and settings across the lifespan.
- 2) Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.
- 3) Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery
- 4) Promote responsible media reporting of suicide, and the safety of online content related to suicide.
- 5) Develop, implement, and monitor best practice-based programs that promote wellness and prevent suicide and related behaviors such as QPR and other best practice first responder training programs.
- 6) Promote strategies to reduce access to lethal means of suicide among individuals and groups with identified suicide risk.
- 7) Provide training to schools, community, clinical and behavioral health service providers on the prevention of suicide and related behaviors.
- 8) Promote suicide prevention as a core component of health care services.
- 9) Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. (8 and 9 seem the same to me).
- 10) Provide care and support to individuals affected by suicide deaths or suicide attempts, and implement community best-practice based postvention strategies to help prevent further suicides.
- 11) Increase the timeliness and usefulness of national, state, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.
- 12) Promote and support research on suicide prevention.
- 13) Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings across the lifespan

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Strategy 1.1.1: Increase the number of local, state, professional, and faith-based groups that integrate suicide prevention activities into their programs.

Strategy 1.1.2: Strengthen collaborations across state agencies to advance suicide prevention.

Strategy 1.1.3: Strengthen collaboration between public-private partnerships to advance suicide prevention.

Strategy 1.1.4: Actively and visibly promote suicide awareness, education and outreach within schools and on college and university campuses.

Strategy 1.1.5: Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.

Strategy 1.2.1: ADPH and ASPARC will coordinate three regional suicide prevention annual trainings to promote suicide prevention collaboration efforts throughout Alabama. (Sounds good but I'm not sure what this means).

Strategy 1.2.3: ADPH, ASPARC, AFSP, and other interested organizations will coordinate and convene stakeholder meetings to assess needs and resources, and update the state suicide prevention plan in 2020.

Strategy 1.2.3: ADPH, AFSP, and local crisis center partners will encourage Local Education Agencies (LEAs) and other relevant education agencies to adopt and maintain suicide prevention policies.

Strategy 1.2.4: ASPARC will promote outreach and education through the Alabama Comprehensive Suicide Prevention Online Resource Directory (<http://legacy.montevallo.edu/asparc/>).

Strategy 1.2.5: ADPH will promote suicide awareness within different media outlets around the state.

Objective 1.3: Sustain and strengthen collaborations across agencies and organizations to advance suicide prevention.

Strategy 1.3.1: ADPH and partners will educate local, state, professional, volunteer, and faith-based organizations about the importance (necessity?) of integrating suicide prevention activities into their programs.

Strategy 1.3.2: Strengthen and expand partnerships with agencies that serve individuals at higher risk of suicide.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

Strategy 1.4.1: Utilize the resources of the National Action Alliance for Suicide Prevention (<http://actionallianceforsuicideprevention.org/>), a public-private partnership dedicated to advancing the National Strategy for Suicide Prevention.

Strategy 1.4.2: ADPH, crisis centers, and ASPARC will partner with state hospitals to distribute handouts to local emergency departments addressing suicide-proofing your home, what happens after a suicide, etc.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

Strategy 1.5.1: Encourage businesses and employers to ensure that mental health services are included in health plans and encourage employees to use these services as needed.

Strategy 1.5.2: Encourage suicide screening questions on intake forms in primary care and other health care visits.

Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Strategy 2.1.1: Design suicide prevention, education, and awareness messages, each tailored to specific and diverse audiences that convey messages of help, hope, and resiliency.

<http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf> and

<http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/>

Strategy 2.1.2: Develop suicide prevention messages for teacher, administrators, students, and parents about resources available for referrals and mental health screenings.

Strategy 2.1.3: ASPARC and AFSP will identify and implement suicide prevention strategies for faith-based settings.

Strategy 2.1.4: AFSP will promote and support “community walks” as a way to increase suicide prevention and awareness.

Objective 2.2: Reach policymakers with dedicated communication efforts.

Strategy 2.2.1: AFSP will educate policymakers on effective suicide prevention efforts.

Strategy 2.2.2: AFSP will advocate for and support increased opportunities and funding initiatives for suicide prevention activities.

Strategy 2.2.3: ADPH will develop fact sheets for the public and at-risk groups about suicide, including talking points and data.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Strategy 2.3.1: Integrate new technologies in suicide prevention programs (such as?).

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Strategy 2.4.1: Increase public awareness of the role of the national and local crisis lines in providing services and support to individuals in crisis.

Strategy 2.4.2: Promote the use of new and emerging technologies such as tele-health, chat, and text services, websites, mobile applications, and online support groups for suicide prevention communications including follow-up communication for persons successfully intervened.

Strategy 2.4.3: Crisis centers will provide services and literature to families/significant others in discharge planning after a suicide attempt has occurred.

Strategy 2.4.4: Offer suicide prevention and awareness trainings to agencies working in the community. (SEEMS REDUNDANT)

Strategy 2.4.5: Crisis centers will provide training to local youth in the school setting. (Lifelines training curriculum from Hazelden)

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Strategy 3.1.1: ADPH will develop and disseminate media promoting means restriction, including safe medication storage and firearm safety.

Strategy 3.1.2: ADPH and partners will educate individuals and families on building strong, positive relationships with family and friends.

Strategy 3.1.3: Colleges and universities will integrate trainings to educate faculty, student services, and resident advisors about identifying students and other individuals on campus who are at risk for suicide.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders

Strategy 3.2.1: Promote and participate in community awareness campaigns to reduce stigma and to increase access.

Strategy 3.2.2: ASPARC and AFSP will present information about faith-based suicide prevention strategies to promote mental health, increase understanding of mental and substance use disorders, and eliminate barriers to help seeking individuals.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is real and possible for all.

Strategy 3.3.1: Develop a variety of age-appropriate materials to educate on mental health issues for children, teens, and adults.

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Strategy 4.1.1: ADPH and crisis centers will disseminate *Recommendations for Reporting on Suicide* to news and online organizations. <http://reportingonsuicide.org>

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Strategy 4.3.1: Update recommendations related to suicide prevention as new media tools come into widespread use.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Strategy 4.4.1: ADPH and crisis centers will distribute national guidelines to journalism and mass communications schools in Alabama.

Strategic Direction 2: Clinical and Community Preventive Services

Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

Strategy 5.1.1: ADPH, ASFP and ASPARC will engage stakeholders across the state to raise awareness and educate the community to promote wellness and prevent suicide.

Strategy 5.1.2: ASPARC will convene regular meetings for all state partners working to promote suicide prevention.

Strategy 5.1.3: Colleges and universities will promote and encourage suicide prevention efforts on campuses.

Strategy 5.1.4: ASPARC and crisis centers will **carry out** training of school staff (e.g., school nurses, school counselors, administration, bus drivers, social workers, school psychologists, resource officers) and faculty to increase knowledge of warning signs and suicide prevention efforts.

Strategy 5.1.5: ASPARC will annually update a link and listing of best practice-based suicide prevention programs in the Alabama Comprehensive Suicide Prevention Online Resource Directory (<http://legacy.montevallo.edu/asparc/>).

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors

Strategy 5.2.1: ADPH and partners will provide education, training, and resources **about** the signs and symptoms of suicide and suicidal behaviors **and how to take action** to obtain help.

Strategy 5.2.2: ADPH and partners will identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups.

Strategy 5.2.3: ASPARC will train employees and supervisors to recognize coworkers in distress and respond appropriately, using information available from the Action Alliance for Suicide Prevention web-page.

Strategy 5.2.4: Crisis centers, colleges, and universities will **make sure** that students at risk of suicide have access to mental health and counseling services and are encouraged to use those services.

Strategy 5.2.5: Crisis centers will provide suicide awareness and prevention training to school aged students. (e.g., Hazelden's Lifelines Curriculum)

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Strategy 5.3.1: ADPH and partners will provide education, training, and resources on the signs and symptoms of suicide and suicidal behaviors **to nonprofit, community, workplace, and faith-based programs along with how and where to go for help**

Strategy 5.3.2: ADPH and AFSP will identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups. (**SAME AS 5.22**)

Strategy 5.3.3: Crisis center, colleges, and universities will screen for mental health needs, including suicidal thought and behaviors and make referrals to treatment and community resources, as needed.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

Strategy 5.4.1: AFSP will educate the general public and policy makers about the need for adequate funding and leveraging of resources to increase access to and delivery of best practice-based programs.

Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Strategy 6.1.1: Disseminate information on means restriction to mental health providers, professional associations, and patients and their families <http://www.hsph.harvard.edu/means-matter/>.

Strategy 6.1.2: ASPARC will educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of **making increased** efforts to reduce access to lethal means among individuals at risk for suicide.

Strategy 6.1.4: Provide information and resources about the disposal of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at higher risk for suicide.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Strategy 6.2.1: Promote firearm safety for people who reside with a minor.

Strategy 6.2.2: AFSP will provide educational information about firearm safety and suicide prevention to gun retailers, shooting clubs and ranges, law enforcement, military personnel, and veteran groups.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Strategy 7.1.1: Provide education, training, and resources on the signs and symptoms of suicide and suicidal behaviors along with how and where to go for help.

Strategy 7.1.2: ADPH will promote the use of best practice gatekeeper programs.

Strategy 7.1.3: ADPH will provide technical assistance as needed to help LEAs develop suicide prevention plans.

Strategy 7.1.4: ASPARC and AFSP will identify suicide prevention strategies for faith-based settings, connecting with the National Action Alliance for Suicide Prevention's Faith Communities Task Force (<http://actionallianceforsuicideprevention.org/task-force/faith-communities>).

Strategy 7.1.5: Train employees and supervisors to recognize coworkers in distress and respond appropriately.

Strategy 7.1.6: ADPH, ASPARC, and crisis centers will train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services.

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Strategy 7.2.1: Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way.

Strategy 7.2.2: Provide primary care toolkits **for suicide prevention** to primary care providers. (<http://www.sprc.org/for-providers/primary-care-tool-kit>)

Strategy 7.2.3: Promote training in suicide prevention for social workers, nurses, and other health-related personnel.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions. This includes health professional graduate and continuing education.

Strategy 7.3.1: Integrate appropriate core suicide prevention competencies into relevant curricula (e.g., nursing, medicine, allied health, pharmacy, social work, education).

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Strategy 7.5.1: Educate relevant agencies about the use of emergency management guidelines/protocols to deal with crisis situations.

Strategic Direction 3: Treatment and Support

Goal 8: Promote suicide prevention as a core component of health care services.

Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

Strategy 8.1.1: Promote www.zerosuicide.com website in publications and communications about treatment and support services.

Strategy 8.1.2: Crisis centers and ASPARC will educate providers of health care and community support systems about adopting zero suicide as an aspirational goal, and promote the organizational readiness survey of the national action alliance for suicide.

<http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/OrganizationReadinessSurvey.pdf>

Objective 8.2: Develop and implement protocols for delivering services to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Strategy 8.2.1: ADPH will develop and maintain a list of support groups or self-help groups within the state.

Strategy 8.2.2: Crisis centers will support Crisis Chat programs which provide teens in difficult situations a way to anonymously receive support.

Objective 8.3: Promote and enable timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Strategy 8.3.1: Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines.

Strategy 8.3.2: Promote the availability of online support services and crisis outreach teams through ADPH and ASPARC websites and crisis center social media outlets.

Strategy 8.3.3: ADPH will develop protocols and improve collaboration among crisis centers, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Strategy 8.4.1: ASPARC and crisis centers will educate and improve follow-up communication and connection (e.g., phone, text) with dischargers after care.

Strategy 8.4.2: ADPH will identify mobile app technology to engage individuals in their treatment of care.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Strategy 8.6.1: ASPARC and ADPH will hold suicide prevention meetings to enhance linkages among providers of primary care, mental health, and substance abuse services and community-based programs, including peer support programs.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Objective 8.8: Develop collaborations between emergency department care and hospital staff when appropriate, and promote rapid follow-up after discharge.

Strategy 8.8.1: Crisis centers will improve follow-up measures after discharge, such as status inquiries and caring letters, postcards, texts, and letters.

Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

Strategy 9.1.1: Crisis centers will educate middle-school aged children about suicide, suicidal ideation or depression through age appropriate programs (e.g., Hazelden's Lifelines Curriculum)

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Strategy 9.2.1: ADPH and partners will educate students in training to become mental health, social services, or health care providers with respect to the identification and treatment of individuals at high risk for suicide.

Strategy 9.2.2: ADPH will increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocacy to receive optimal care.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Strategy 9.3.1: ADPH and partners will **carry out** suicide awareness, prevention, and education to demonstrate the effectiveness of preventative treatment.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Strategy 9.4.1: ADPH and crisis centers will engage family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge from an ED or inpatient unit through follow-up and educational materials.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders.

Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

Strategy 9.7.1: Implement best practice-based recommendations related for assessment and treatment of those identified with suicidal thoughts and behaviors. www.sprc.org/bpr and www.samhsa.gov.

Goal 10: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implantation of these guidelines at the state/territorial, tribal, and community levels.

Strategy 10.1.1: Encourage mental health services be offered to employees including grief counseling for individuals bereaved by suicide.

Strategy 10.1.2: ASPARC will identify, maintain, and distribute suicide awareness, prevention and outreach resources via their Resource Directory.

Strategy 10.1.3: Crisis centers and ASPARC will educate community members in suicide awareness and prevention programs (QPR).

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategy 10.5.1: Provide support to professional caregivers in communities and schools after a patient or a colleague dies by suicide.

Strategy 10.5.2: ADPH and ASPARC will maintain a list of bereavement groups and suicide peer support groups.

Strategic Direction 4: Surveillance, Research, and Evaluation

Goal 11: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

Strategy 11.3.1 ADPH will collaborate with The Department of Mental Health about improving capacity to routinely collect, analyze, and report on mental health, substance abuse, and suicide-related data.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors related risk factors, and exposure to suicide.

Strategy 11.4.1 ADPH will review and make recommendations to Alabama Youth Risk Behavior Surveillance System Survey and Behavioral Risk Factor System Survey to include additional questions that will provide additional suicide prevention data.

Goal 12: Promote and support research on suicide prevention.

Objective 12.1: Develop a national and regional suicide prevention research agenda with comprehensive input from multiple stakeholders

Strategy 12.1.1: Support suicide-related research, including research on the risk and protective factors for suicide among different groups.

Strategy 12.2.2: Form partnerships with higher education partners to promote and support suicide prevention research.

Objective 12.2: Disseminate the national suicide prevention research agenda.

Strategy 12.2.1: Encourage Alabama Research Institutions to apply for national grants and research opportunities on suicide prevention, intervention, and postvention.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Strategy 12.3.1: Encourage suicide researchers to publish suicide-related research findings to share with state and local suicide prevention coalitions, health care providers, and other relevant practitioners.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

Strategy 12.4.1: ASPARC will frequently update the Alabama Comprehensive Suicide Prevention Resource Directory (<http://legacy.montevallo.edu/asparc/>) with the most recent suicide-related research, toolkits, websites, databases, etc.

Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of grant-related suicide prevention interventions.

Strategy 13.1.1: Promote the evaluation of local and regional suicide prevention programs and practices and the synthesis and dissemination of findings.

Strategy 13.1.2: Promote workplace evaluation of effectiveness of workplace wellness initiatives aimed at reducing the risk of suicide.

Strategy 13.1.3: Support evaluation efforts to assess knowledge gains and increases in self-efficacy.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Strategy 13.2.1: Disseminate evidence for suicide prevention interventions.

Strategy 13.2.2: Encourage colleges and universities to share information on suicide prevention efforts.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states, territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Strategy 13.3.1: Collect data to plan and implement successful youth suicide prevention programs.

Strategy 13.3.2: Examine policies and procedures for universities with low suicide rates for effectiveness.

Strategy 13.3.3: Promote and share already existing national resources to address interventions.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Strategy 13.4.1: ADPH will assess the impact of the National Strategy for Suicide Prevention, outlined by the Alabama State Plan, in attaining the ultimate goal of Zero Suicide in Alabama

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs 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. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area at this time.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

One of ADMH's strengths is its historical collaboration with a number of state agencies relative to individuals who have or are impacted by substance use in Alabama. ADMH has identified the entities 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 specified.

State Prevention Advisory Board (SPAB)

ADMH established and provides management support for the State Prevention Advisory Board (SPAB). The SPAB is composed of twenty-five (25) diverse state stakeholders in the areas of prevention, treatment, education, health and/or enforcement. Alabama state department stakeholders are representative 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. Representation from the aforementioned agencies also comprises the composition of the SPAB, as well as, the AEW (Alabama Epidemiological Outcomes Workgroup).

The SPAB functions as an advisory board for prevention services in the state. The responsibilities of the SPAB include: a) overseeing the development and implementation of statewide prevention activities to include the SPF-SIG and PFS, b) working with AEW "EPI Workgroup" on setting priorities, c) collaborating with Evidence-Based Practice Workgroup (EBP) on selecting evidence-based interventions, d) reviewing the Strategic Plan, e) developing resources and allocation models for communities, f) developing timelines for completion of the Strategic Plan and g) monitoring community-level implementation of the SPF-SIG. Currently, the SPAB plays a large role in developing the state's prevention infrastructure and is the approving board of SPF-SIG/PFS operations. The SPAB has representation from all of the state agencies that play a role in substance abuse prevention. School and community-based organizations are represented on the SPAB as well. Bringing these key stakeholders together in an advisory role has already helped to increase communication and collaboration between prevention agencies, and it is anticipated that it will continue to serve this function.

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
Schaffer, Tonia	SAMHSA-Center for Substance Abuse Prevention	Federal Project Officer
Selase, Seyram, Chair	Agency for Substance Abuse Prevention (ASAP) Executive Director	Provide community level feedback, assist members in understanding of political processes, how to advocate, engage and collaborate within local

		political systems. Share successes, barriers and outcomes on community-level prevention service delivery.
Keith, Jamie, Vice Chair jkeith@acptp.org	Alabama Campaign to Prevent Teen Pregnancy (ACPTP) Executive Director	Provide latest research and statistics on Teen Pregnancy as it relates to substance abuse and misuse and provide recommendations on integrating programs and practices in reducing risky behaviors in youth prevention programming implementation.
Kimble, Bruce, Secretary	Alabama Alcohol and Drug Abuse Association (AADAA) President Elect	Provide recommendations for Prevention Professional certification standards, update on current trends in substance use, misuse and/or abuse, and provide clinical expertise related to the identifying of signs, symptoms and progressive stages of addiction to promote early intervention and prevention practice.
Butler, Dr. Erica	Alabama State Department of Education (ALSDE) School Safety and Crisis Management-Prevention and Support Services	Assist with navigation of ALSDE Website to access current data, provide updates on current trends and policies in school systems statewide to assist providers in selection of EB interventions and best practices relative to bullying, truancy, promoting positive behavior and positive school climates and etc.
Deavers, Penny	Southern Prevention Associates, LLC	Provide community level feedback and recommendations on allocation of resources promoting clearinghouses and recommendations for marketing and dissemination of materials related to ATOD. Share successes, barriers and outcomes on community-level prevention service delivery.
Douglass, Gerald	Retired Educator	Provide community level feedback, recommendations on working with local school systems, understanding family dynamics relating to teen/parent relationships and assist with recommending development of and dissemination of resources to providers relative to facilitation of groups and integrating cultural sensitivity in prevention program implementation.
Farmer, Virginia	Youth Educator-Ascension Day School	Provide community level feedback with specific regard to working with primary grade level youth and identifying early signs of risks factors and recommendations for early interventions with this targeted age group.
Garrison, Ruby	Big Lots Distribution Human Resource Manager	Provide community level feedback with specific regard to drug use/misuse in the workplace, organizational policies and practices and recommendations for implementation and enforcement of Employee Assistance Programs.
Hernandez, Jean	AIDS Alabama Latino Outreach Coordinator	Community Level Feedback with specific regard to immigrant populations as it relates to health disparities and access to services and care including cultural and language barriers and provide recommendations to improve such.
Hinton, Vincent	Alabama State University Counseling Faculty	Assist with the identification of common themes and trends among college-aged youth substance

		use/misuse and abuse and provide recommendations on new and emerging trends and initiative from a collegiate perspective as well as assist with providing recommendation on engaging college-aged youth in prevention activities and collaborating with universities to promote prevention efforts on campuses.
Jerkins, Ashton	Health Services Emergency Room Nurse Practitioner	Provide community level feedback from patients, family members and other healthcare workers with specific regard to overdose including prescription and illicit drug use; assist AEW in identifying relevant data sources of the aforementioned.
Leonard, Corporal Cedric	Law Enforcement-Montgomery County Sheriff's Office Administrative	Provide community level feedback, best practices and recommendations for collaborating and engaging with law enforcement, assist with access to local data sources and provide updates on policies regarding youth offender management regarding substance use and abuse.
Long-Cohen, Leigh	Homewood City Schools Intervention Coordinator	Provide K-12 level feedback and expertise on EB prevention practices utilized within K-12 school systems and provide recommendations and updates on theory and trends in youth social-emotional development and behavioral performance. Also, provide insight on promoting parental involvement in youth prevention activities.
McConico, Lt. Yolonda	National Guard Counter Drug Program	Provide information on trends in SA among military members and families, special initiatives for military personnel, and make recommendations on how to engage, collaborate and/or facilitate effective prevention programs for service members, veterans and/or their families.
Mitchell, Dr. Q'Shequilla	University of Alabama Department of Psychology & Education	Provide collegiate level feedback and perspectives on SA among college-aged youth, provide relevant updates on college-wide SA prevention initiatives and how to engage and/or recruit college-aged students in prevention activities.
ParkerMerriweather, Elana	ESAR-VHP/Minority/Special Populations and State Medical Reserve Corps Coordinator ADPH Center for Emergency Preparedness/Office of Minority Health	Provide information on state-wide issues and initiatives as it relates to a Public Health Model and the relationship of Substance Use and Health Disparities among substance users, SA risk factors associated with health disparities, recommendations for integrating cultural responsiveness and sensitivity into prevention delivery and assist in identification of key public health contacts and resources on new and emerging trends in SA from a public health perspective as well as engaging minority populations in prevention activities.
Pierre, Vandlynn	South Regional Clearinghouse- Drug Ed Council	Provide community level feedback and recommendations on allocation of resources promoting clearinghouses and recommendations for marketing and dissemination of materials related to ATOD. Share successes, barriers and outcomes on community-level prevention service delivery.
Pinkston, Honorable Patrick	Elmore County District Judge	Provide relevant information as it relates to substance abuse in the criminal justice system,

		including, but not limited to legalizing marijuana, punishment, substance to crime correlation, alternative sentencing and the impact on families and communities and make recommendations for early intervention and best practices in prevention service delivery.
Robinson-Cooper, Vickie	AL Department of Human Resources (DHR)	Provide community-level feedback and expertise on older adult population regarding family dynamics including SA risk factors associated with 2 nd time parenting/caregivers, geriatric population, income driven risk factors, dislocated workers and policies regarding assistance for individuals with substance abuse histories and/or criminal convictions involving illicit drugs.
Stapleton, Danita	Foster Care Family Preservation	Provide community level feedback with specific regard to risks factors associated with youth in foster care and best recommendations for developing and/or adapting prevention services for youth in foster care.
Tyre, Dr. Yulanda	Auburn University at Montgomery	Assist with training and development to improve and enhance prevention workforce, provide collegiate level feedback and provide recommendations on how to engage and collaborate with universities
TyTell, Dr. David	Alabama Department of Corrections (DOC) Chief Psychologist Office of Health Services	Provide information on understanding impact on the family of youth whose parents have substance abuse, mental health and/or co-occurring disorders, identifying early warning signs of behavioral health or substance abuse disorders and assist with recommendations of EBP's and best practices to promote early intervention and prevention services.
Vilamaa, Kris	Germane Solutions Director of Health Access	Provide recommendations on best data collection methods and survey tools relevant to our target populations to be able to make more accurate needs assessments and locate gaps in service delivery as well as assist with training on data analysis and presentation.
Wilcox, Delynne	Health Planning & Prevention Assistant Director University of Alabama Department of Health Promotion and Wellness	Provide collegiate-level feedback on student and staff perspectives and expertise regarding poor lifestyle choice and environmental influences in an effort to create healthier cultures and well-being in the workplace. Also, provide information and recommendation on new trends in SA among college-aged youth and university prevention efforts and initiatives.
Witherspoon, Shandra	Family Guidance Center	Community level feedback and expertise regarding risk factors associated with families impacted by poverty, lack of education, under employment, divorce, and or fragmentation. Provide information on community level programming initiatives relevant to reducing risky behaviors and promoting healthier lifestyles.

Alabama Epidemiological Outcomes Workgroup (AEOW)

The AEW provides ongoing surveillance assessment, analysis, monitoring and dissemination of ATOD consumption patterns and consequences in the State. Data collection and analysis is the charge of the Epidemiologist and State Evaluator who are members of the AEW and who both make regular reports to the Prevention Management Team and SPAB. The AEW has established a process for collecting and reporting ATOD data relevant to the prevention services system. Additionally, the AEW has established partnerships with state agencies to collect ATOD epidemiological information. The AEW will continue to monitor the alcohol, tobacco and other drug consumption and consequence indicators on a statewide basis with annual updates to the Epi Profile, and assist funded communities in carrying out their local needs assessment activities. The AEW will also collaborate with the State Evaluator on annual state evaluation activities, as appropriate. Additional activities include assistance with training regarding the use of data for planning and evaluation, and ongoing review of changes in data indicators to identify improvements or gaps that need to be addressed. The AEW meets every spring to review updated data and develop recommendations for presentation to the SPAB regarding emerging trends, new potential data indicators, gaps in indicators that are identified once communities begin their needs assessment and evaluation activities, and other data issues as identified.

Additionally, the AEW will continue to update the epidemiological data overtime. Through the partnerships with state agencies developed through the AEW, the epidemiologist is provided data from state agencies: Administrative of Courts (AOC), ALSDE, DPS, ACJIC, AOC, DHR, DYS, ADMH. The partnerships are essential to the data-driven decision making process and for the process of developing a state epidemiological profile. The partnerships, as well as the epidemiological profile, enhance the data capacity to monitor the effects substance abuse prevention funded programs on ATOD use in Alabama. With the collection and analysis of the data, electronic access to data is available by the posting of epidemiological profiles and related substance abuse data online. Having online access to this data assists with the facilitation of local and state level prevention needs assessment and planning.

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
Anderson, Ronada	Alabama Department of Public Health Hepatitis Coordinator	Provide updates on current trends in HIV prevalence and incidences based on ADPH research, surveillance, assessments and analysis and assist with identifying current and/or emerging SA risk factors among HIV/AIDS populations to include county and state-wide data.
Burks, Henry	Alabama Board of Pharmacy Chief Drug Inspector	Provide updates on prescription drug issues including policy changes on drug monitoring, physician obligations and assist in identifying data sources relevant to prescription drug use/misuse and/or abuse and population correlations.
Burleson, Erin	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Deavers, Penny	President Southern Prevention Associates, LLC	Provides updates from the perspective on the prevention providers.
Winningham, Janet	Alabama Department of Human Resources	Provides updates related to effects on children and services target to children.
Douglass, Charon	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community

		level and related to working directly with providers.
Means, Cesily	Governor's Office of Faith-Based and Community Initiatives Outreach Specialist	Provides updates related to community and services in the community.
Nightengale, Julie	Alabama Department of Public Health Epidemiologist	Assist with identifying correlating infectious disease such as STI's with SA risk factors, developing common themes and trends among youth in an effort to effectively select youth intervention models for prevention service delivery and activities. Also assist with identifying substance use rate data to show where rates are changing in the state.
Toney, Jim	Alabama State Department of Education	Provides updates on education on the elementary through high school level
Oakes, Robert	Alabama Department of Pardons and Paroles	Provides updates related to correction
Pendergast, Pat	Alabama Department of Youth Services Screening and Placement Coordinator	Assist with identifying relevant data on detained youth and provide recommendations on prioritizing youth prevention efforts based on risk factors associated specifically with detained youth.
Quinn, Michael	Department of Rehabilitation Program Coordinator	Provides updates on services related to children and adults with disabilities.
Reese, Sondra	Alabama Department of Public Health	Assist with updates related to Synar and chronic diseases
Shanks, Bill	ALEA Alabama Department of Public Safety	Assists with data on alcohol related motor vehicle crashes
Nelson, Loretta	AL Department of Revenue	Provides updates on others funding outside of the Dept. of Mental Health are distributed to other organization for substance abuse prevention.
Wilcox, Dr. Delynne	UA Office of Wellness & Promotion Assistant Director of Health Planning & Prevention	Assist with identifying, analyzing data on college-age youth and utilizing outcomes to prioritize prevention efforts on college campuses statewide. Provide recommendations on best practices for collecting and/or accessing university data.
Wright, Bennett	Sentencing Commission	Assist with identification of data sources relevant to crime and SA correlation to assist providers in prioritizing prevention efforts with law enforcement to promote effective environmental strategies.

Evidence Based Practices Workgroup

The EBP Workgroup has representatives from all four substance abuse planning regions and will meet formally four times a year. The role of the EBP Workgroup is to: a) advise prevention stakeholders 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 to stakeholders. The EBP Workgroup was originally formed under the auspices of the SPF-SIG. Since the inception of the SPF-SIG and the effectiveness of the EBP Workgroup processes, the SABG prevention providers will become beneficiaries.

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
Cheka, Rev. J Sandor III	Executive Director The Addiction Coalition	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 2
Deavers, Penny	President Southern Prevention Associates, LLC	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 2
Hayes, Jenny	Operations Director The Addiction Coalition	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 2
Hooper, Gail	Representative Drug Educations Council	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 4
Mayo, Greg	Representative Mental Healthcare of Cullman	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 1
Short, Susan	Executive Director Covington County Children's Policy Council Coalition	Based on the needs assessment, community characteristics and recommended by SAMHSA determination of fit, each assists with approval of selected interventions submitted in provider's prevention plans. All members based on organizational role and community participation from Region 4

State-Level Substance Abuse Prevention Partners

State-level substance abuse prevention partners are those agencies within the state whose mission, value, and goals surround substance use and abuse. Some of these organizations can be on an independent or non-profit basis, without the direction and lead of government or local

establishment. State-level substance abuse prevention partners, as representative within the table above, range from educational support, law enforcement protection, to non-profit agencies supporting domestic violence and teen pregnancy to military personnel. Nonetheless, all of the collaborative agencies have a common goal in tackling and preventing issues pertaining to substance abuse. Partnerships with these agencies provide greater access to data, expertise and training and technical assistance to all parties involved.

Other State Partners

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; (f) assist in the development of peer services and reimbursement mechanisms.
Alabama Department of Public Health (Maternal Health Authority)	(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 the AEOW. (g) Assist in the development of strategies to address prescription drug abuse. (h) Community needs assessment.
Alabama Department of Human Resources (Child Welfare Authority)	(a) Resource development in regard to services for abused and neglected children. (b) provides assistance in the provision of parenting education and training. (c) Collaboration in regard to multiple needs children.
Alabama Department of Education	(a) Collaboration in regard to substance abuse prevention in schools. (b) Assist in development of workforce development; strategy. (c) Collaborate on use of technological advances relative to adolescents and young adults. (d) Serve on AEOW. (e) Assist in establishment of policies, procedures and practices to support children experiencing trauma and their families
Alabama Department of Vocational Rehabilitation Services	Assistance in development of plan to address workforce issues for providers as well as clients in programs served by clients.
Alabama Department of Corrections (State Adult Correctional Agency)	(a) Collaboration in regard to community reentry services
Alabama Department of Youth Services (State Juvenile Justice Authority)	(a) Collaboration to assist ADMH in the development of trauma informed services for adolescents; (b) Collaborate for implementation of evidence-based substance abuse services for adolescents in the state’s legal system.
Alabama Administrative Office of the Courts	Assist in development of strategies for trauma informed services for individuals involved in the legal system. Development of Drug Courts.
Alabama Head Start Agency	Collaborate in the development of policies and practices relative to early childhood needs.
Alabama Department of Insurance	Collaborate with ADMH in regard to products offered on Alabama’s Federal Health Insurance Exchange and to insure that the needs of individuals with substance use disorders are met.
Alabama Primary Care Association	Assist in developing strategies to promote integration of behavioral

	health and primary care services.
Alabama State Service Commission	Assist Alabama citizens in disaster preparedness and links to local committees and volunteers in the devastated areas.

2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

The Alabama Department of Mental Health has not historically utilized MOUs to establish collaborative state partnerships and currently has no such agreements in place relative to substance abuse service delivery.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, 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 block grant 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 SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed in this area.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
 - 1.
 2. What mechanism does the state use to plan and implement substance abuse services? Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
 3. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
 4. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.
 5. *Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council*

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

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

Footnotes:

Not applicable to substance abuse application.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

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

* 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:

Not applicable to substance abuse application.