



Strategic Prevention Framework State Incentive Grant

Alabama State Strategic Plan

Division of Mental Health and Substance Abuse Services
Office of Prevention Services
September 12, 2012



lifting life's possibilities

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LIST OF ACRONYMS

AADA	Alabama Alcohol and Drug Abuse Association
ABC	Alabama Beverage Control
ABC	Alabama Building Capacity
ACCMHB	Alabama Council of Community Mental Health Boards
ACPTSA	Alabama Commission for the Prevention and Treatment of Substance Abuse
ACJIC	Alabama Criminal Justice Information System
ADECA	Alabama Department of Economic Community Affairs
ADMH	Alabama Department of Mental Health
AEDS	Alcohol Epidemiological Data System
AEOW	Alabama Epidemiology Outcomes Workgroup
ALSDE	Alabama State Department of Education
ALYTS	Alabama Youth Tobacco Survey
AOC	Administration of Courts
AOD	Alcohol and other Drugs
ARCOS	
ARDI	Alcohol-Related Disease Impact
ASADS	Alabama School of Alcohol and Other Drug Studies
ASAIS	Alabama Substance Abuse Information System
ASAP	Agency for Substance Abuse Prevention
ATOD	Alcohol, Tobacco and other Drugs
BHIS	Behavioral Health Information System
BRFSS	Behavioral Risk Factor Surveillance System
CADCA	Community Anti-Drug Coalitions of America
CAPT	Center for the Application of Prevention Technology
CDC WONER	Centers for Disease Control and Prevention Wide-ranging OnLine Data for Epidemiologic Research
CLI	Community-Level Instrument
CMHC	Community Mental Health Center
COB	Close of Business
CSAP	Center for Substance Abuse Prevention
DEA	Drug Enforcement Administration
DFC	Drug-Free Community
DHR	Department of Human Resources
DMHSAS	Division of Mental Health and Substance Abuse Services
DOC	Department of Corrections
DOR	Department of Rehabilitation
DPS	Department of Public Safety
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DUI	Driving Under the Influence
DYS	Department of Youth Services
EBP	Evidence-Based Programs, Policies, and Practices
Epi Profile	Epidemiological Profile
FARS	Fatality Analysis Reporting System
FTA	Federal Tax Administration
FY	Fiscal Year
GLI	Grantee-Level Instrument

GPRA	Government Performance and Results Act
LPC	Local Prevention Coalitions
MOA	Memorandum of Agreement
MRT	Management Reporting Tool
MRT-CLI	Management Reporting Tool-Community-Level Instrument
MUPS	Montgomery Unified Prevention System
NCS	National Co-Morbidity Survey
NOMS	National Outcome Measures
NPN	National Prevention Network
NREPP	National Registry of Effective Programs and Practices
NSDUH	National Survey on Drug Use and Health
NTHSA	National Highway Traffic Safety Administration
NVSS-M	National Vital Statistics System- Mortality
OCP	Office of Contracts and Purchasing
PLI	Participant-Level Instrument
PMRTS	Prevention Management Reporting and Training System
PRAMs	Pregnancy Risk Assessment Monitoring System
PRIDE	Parents Resource Institute for Drug Education, Inc
RFP	Request for Proposal
RVP	Responsible Vendor Program
RVR	Retailer Violation Rate
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMMEC	Smoking-Attributable Mortality, Morbidity, and Economic Costs
SAPT BG	Substance Abuse Prevention and Treatment Block Grant
SASD	Substance Abuse Services Division
SDFSCA	Safe and Drug-Free Schools and Communities Act
SECAPT	Southeast Regional Collaborative for the Application of Prevention Technology Team
SEW	State Epidemiological Workgroup
SIG	State Incentive Grant
SMVF	Service Members Veterans and their Families
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
SSA	Single State Authority
T/TA	Training and Technical Assistance
TA	Technical Assistance
TEDS	Treatment Episode Database System
UCR	Uniform Crime Reports
WebBGAS	Web Block Grant Application System
YPLL	Years of Potential Life Lost
YR	Year
YRBS	Youth Risk Behavior Surveillance Survey

Alabama Overview

- ✓ Location = Southeastern United States
- ✓ Population = Approximately 4,779,736
 - ✓ Capital City = Montgomery
 - ✓ Most Populous City = Birmingham
- ✓ 71.5% of population is Urban; 28.5% Rural
- ✓ Capital of the Confederacy; Civil Rights Movement
- ✓ 68.5% of the population is White; 26.2% Black; 1.1% Asian; 0.6% American Indian/Alaska Native
 - ✓ 17.5% Overall poverty rate

The State of Alabama, named after a southern Indian tribe, has been a central figure in the historical events that have shaped the modern-day United States. Alabama was admitted to the Union as the 22nd state in 1819, seceded in 1861 during which time Montgomery, Alabama was named as the capital of the Confederacy, and was re-admitted in 1868 following the end of the Civil War. Almost a century later, defining moments of the Civil Rights Movement would take place in Alabama, specifically the Montgomery Bus Boycott in 1955, Dr. Martin Luther King's Letter from a Birmingham Jail in 1963, and the Selma to Montgomery "Bloody Sunday" March in 1965.

Alabama is located in the southeastern United States, bordered by the states of Florida, Georgia, Mississippi, and Tennessee. The capital city of Alabama is Montgomery (located in Montgomery County) and the most populous city is Birmingham (located in Jefferson County). Alabama had an estimated population of 4,779,736 in 2010 in its 67 counties.

The majority of Alabama residents are white (68.5%) and African-Americans represent the largest minority group in the state (26.2%) followed by Asians (1.1%) and American Indian/Alaska Native (0.6%). Urban and rural areas of Alabama have different socio-demographic profiles, with rural areas being less advantaged than urban areas. In 2009, the state's overall poverty rate was 17.5% with rural areas having a higher poverty level (21%) than urban areas (16.2%). Similarly, residents in rural Alabama had a higher unemployment rate (11.9%) compared with residents in urban Alabama (9.1%).

Approximately 28.5% of Alabama residents live in rural areas. Alabama's Black Belt, its name originating from its agricultural history and rich soil but now indicative of its majority African-American presence, is a predominately rural region concentrated in the southwest and central areas of the state that consists of 19 counties: Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Hale, Lowndes, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, and Wilcox. Similar to other rural counties in Alabama, these counties are less advantaged than urban areas; however, these counties have even harsher economic conditions characterized by declining populations, lack of health care access, high unemployment rates, and high poverty rates as they are among the poorest counties in the state. Of the 10 poorest counties in Alabama, 9 of these counties are located in the Black Belt.

INTRODUCTION

The Alabama Department of Mental Health (ADMH), Office of Prevention Services presents this strategic plan for substance abuse prevention in Alabama. The strategic plan will serve as the guidance document for substance abuse prevention programs, policies, and practices that are funded by Alabama's Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the federal Center for Substance Abuse Prevention (CSAP) to address the state's priorities as determined by the SPF-SIG Epidemiological Workgroup and SPF-SIG Advisory Board. The priority is underage drinking. It is anticipated that the principles included in this document will be infused into Alabama's broader multi-systemic prevention system.

This document was developed by the Alabama SPF-SIG Management Team with guidance, oversight and approval from the Alabama SPF-SIG Advisory Board (SPAB) (Appendix 4) and the Alabama Epidemiology Outcomes Workgroup (AEO) (Appendix 2). The SPF-SIG Management Team (Appendix 1) consists of the Prevention Director, SPF-SIG Project Director/SPF-SIG Coordinator, Epidemiologist, State Evaluator, CSAP Prevention Fellow, and Advisory Board Chair. Input was included from various stakeholders of the AEO and SPAB; each group includes members from the following state agencies: law enforcement, court officials, consumer relations, faith-based communities, businesses, civic groups, and other groups and organizations with an interest in substance abuse prevention.

The guidance of the SPF-SIG process was overseen by the SPAB. The SPAB is comprised of twenty-four (24) cross-disciplinary agencies tasked with identifying gaps in prevention services; developing a state-level plan; and maximizing resources in order to address substance use issues in Alabama. The SPAB is comprised of original State Incentive Grant (SIG) advisory council members and new State Prevention Framework (SPF) advisory council members (Alabama received initial SIG funding in 2004 through the Alabama Department of Economic and Community Affairs), widely known as (ADECA). The final two years of the cooperative agreement was facilitated by ADMH.

The AEO, originally, the Alabama State Epidemiological Workgroup (SEW), was established on April 11, 2006 by authorization of the Alabama Commission for the Prevention and Treatment of Substance Abuse (ACPTSA) and ADMH's Division of Mental Health and Substance Abuse Services' (DMHSAS) Associate Commissioner. Members of the AEO and SPAB have all contributed to this Strategic Plan. A complete list of the contributors is provided (Appendices 2 and 4).

Alabama's Strategic Prevention Framework

In order for the State of Alabama to effectively implement the Strategic Prevention Framework at the state and community levels, planners acknowledge three overarching goals for this project:

1. Prevent the onset and reduce the progression of substance use, including underage drinking;
2. Reduce substance-related problems in Alabama communities; and
3. Build prevention capacity and infrastructure at the state and community levels.

In order to extend our thinking and the success of our results from an individual to a population-level change, we are challenged to develop a strategic plan that addresses the three SPF goals within a public health context. The Alabama SPF-SIG Strategic Plan outlined below intends to demonstrate the process with which the Alabama SPF-SIG priority was determined; how allocation of SPF-SIG funds address the identified priority; the expectations for change at the state and community levels; and how the State will support funded communities.

The Alabama SPF-SIG Strategic Plan presents its plan to address the five steps of the SPF.

- The Assessment section details substance abuse consumption and related consequences in the State of Alabama, describes the criteria, process, and rationale for determining the SPF-SIG priority, and provides an assessment of the existing prevention infrastructure and capacity at the state and community level.
- The Capacity section addresses areas in need of strengthening, state and community level capacity building activities, and the role of the AEOW in support of the Alabama SPF-SIG.
- The Planning section provides a description of the proposed approach to developing and deploying SPF-SIG grant resources and the programmatic mechanisms to address SPF-SIG priorities. It also provides an overview of the proposed community-level activities, resource allocation method, and the implications of this approach.
- The Implementation section focuses on the approach Alabama will take in implementing state level capacity and infrastructure activities, as well as the approach for supporting the implementation of community level evidence-based strategies to address the SPF-SIG priority. In addition, it provides a description of mechanisms the state will put in place to support the work of the communities, the role of coalitions, and Alabama's strategy for assuring that new dollars do not supplant existing initiatives.
- The Evaluation section provides a brief, preliminary narrative of state-level surveillance, monitoring, and evaluation activities. It describes what the state is expecting to track, how tracking will be managed and accomplished, and what Alabama is expecting to change through the SPF-SIG process.
- The Cross-Cutting Components section provides a description of Alabama's approach to addressing cultural competence, sustainability, and (our priority) within the context of the SPF-SIG, describes challenges encountered, as well as introducing projected timelines and milestones associated with project completion.

I. ASSESSMENT

A. Assessing the Problem (Epidemiological Profile)

This section summarizes the state-level needs assessment that was done to determine which substance is being used by the most persons; resulting in the most serious consequences (the full report is available in Appendix 8). Information about the AEW, the data selection process for data sources, constructs, and indicators conducted by the AEW to develop an epidemiological profile of substance use in Alabama, and a brief summary of substance use and substance related consequences in Alabama are all available in Appendix 8. The AEW identified which substance; who the predominant users are; what the worst consequences are; and where in the state the greatest need is seen. Communities with the greatest need will be eligible for funding using a Request for Proposal (RFP) process. Funded communities will then conduct their own needs assessment to identify why their data indicate such a great need by identifying the risk and causal factors in their communities that can be targeted for prevention activities.

Information gathered from the AEW provided preliminary data from which the needs assessment took direction. The AEW 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. A list of the AEW members and their affiliations is in Appendix 2. The AEW followed the following steps in assessing the problem:

1. Identify:
 - Possible data sources
 - Data sources that will be included and excluded;
2. Develop a set of key data indicators for use in assessing and monitoring substance use/abuse in Alabama;
3. Conduct a careful, systematic review and analysis of data;
4. Interpret and communicate findings;
5. Recommend objectives for review, modification and/or approval by the SPAB;
6. Consider and recommend which data indicators are appropriate for evaluation purposes; and
7. Implement the assessment procedure.

1. Data-Selection Process

The first task for the AEW was to review possible national and state data sources to include or exclude in the epidemiological profile (Epi Profile). The AEW members conducted a data-quality screening process to identify those data sources that would be appropriate for use in this assessment. First, the AEW started with data identified in the Behavioral Health Indicator System (BHIS). The BHIS, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a website that makes behavioral health related epidemiological data available to states. Second, in addition to the BHIS datasets, the AEW collected substance abuse data from state agencies. All the state agencies that had data pertaining to substance abuse were open to providing it. This is largely due to the AEW 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, a process consisting of reviewing each data source based on 5 criteria was conducted. The AEW was first emailed the definitions and the table with a summary of the information on each of the criteria for each data source. The AEW was then explained the criteria used to for selection of data sources (See criteria explanation below) to ensure they understood each of the criteria and how its attribute to the inclusion into the Epi Profile. The data sources then were discussed and the criteria for each. The AEW members then discussed the criteria and data sources which lead to inclusion and exclusion of the data source. The AEW unanimously decided to use the data sources stated below.

Criteria for Data Source Inclusion

1. Availability

- The data is readily available and accessible. The measure must be available in disaggregated form at the age, gender, race/ethnicity, geographic level.
- The data is currently available over at least three to five past years.

2. Validity

- There must be research-based evidence that the indicator accurately measures the specific construct and yields a true snapshot of the phenomenon at the time of the assessment.
- The indicator provides a true representation of what is actually occurring in Alabama.

3. Consistency

- The method or means of collecting and organizing data should be relatively unchanged over time, such that the method of measurement is the same from time i to $i+1$. Alternatively, if the method of measure has changed, sound data should exist that determine and allow adjustment for differences resulting from data collection changes.
- The questions are asked the same way over a period of years.
- The indicators are collected the same way over a period of time.

4. Periodic Collection over at Least Three to Five past Years

- The information is consistently available over a number of years preferably annually or at least biannually.
- There are no sporadic delays in the collection of the data.

5. Sensitivity

- Able to detect change associated with alcohol, illicit drug or tobacco (ATOD) use over time

The data sources that were reviewed for inclusion or exclusion by the AEW are provided below along with detailed information on the above criteria for each data source (Appendix 10). The following data sources meet each criterion and are included in the Epi Profile.

National Data Sources

Alcohol Epidemiologic Data System (AEDS)
Alcohol Related Disease Impact (ARDI)
Behavioral Risk Factor Surveillance System (BRFSS)
Fatality Analysis Reporting System (FARS)
National Survey on Drug Use and Health (NSDUH)

National Vital Statistics System Mortality (NVSS-M)
Sales Data for Tobacco
Treatment Episode Data Set (TEDS)
Uniform Crime Reporting Program (UCR)
Youth Risk Behavior Survey (YRBS)

Alabama Data Sources

Alabama Criminal Justice Information Center (ACJIC)
Pregnancy Risk Assessment Monitoring System (PRAMS)
Alabama Pride Survey (PRIDE)
Alabama Youth Tobacco Survey (ALYTS)

The AEW decided not to include the data sources in the Epi Profile if the data sources did not meet the pre-determined criteria. Data sources, such as the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC Wonder) and Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) were excluded because they are online databases used to calculate mortality. Also, SAMMEC does not provide enough information; the latest available data is for the year 2004. Others, were excluded because there were other data sources containing the same information that allowed more flexibility and an in-depth look at the available data. For example, the data for Tax Burden on Tobacco and the Federation of Tax Administrators (FTA) is found in the Sales Data for Tobacco dataset located on the BHIS. Also, the Alabama Accidents Summary data can be found on FARS. Both the BHIS and FARS online databases support software that facilitates analysis of data available on the databases. Lastly, the Automation of Reports and Consolidated Orders System (ARCOS) and State Health Facts - Alabama were excluded because they are unable to detect changes associated with substance use over time. The data in the State Health Facts - Alabama refers to AIDS data that is total of number of cases from the beginning of the epidemic approximately 1982 through 2010. Number of cases for individual years could not be determined. The data in the ARCOS only is collected from 1,100 distributors and manufacturers, but there are over 1,000,000 registrants in DEA's Controlled Substance Act database.

Data Sources Excluded from the Epi Profile

Alabama Accidents Summary
Automation of Reports and Consolidated Orders System (ARCOS)
Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC Wonder)
Federation of Tax Administrators (FTA)
Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)
State Health Facts - Alabama
The Tax Burden on Tobacco

After the data sources were determined based on the criteria (availability, validity, consistency, periodic collection, sensitivity), the AEW compiled a list of indicators starting with the national data sources found on BHIS.

Next, indicators for the state data sources that met the criteria were added to the list. The indicators on this list were organized by substance (alcohol, tobacco, and other drugs) and whether they were consequence indicator, consumption indicator, or risk/protective factor. Additionally, the indicators were categorized according to constructs for each substance (Table 1). A full list of indicators, organized by substance, type and, construct can be seen in Appendix 11.

Table 1. Alcohol, Tobacco, Other Drugs Consumption and Consequence Constructs

	Alcohol	Tobacco	Other Drugs
Consequences	<ul style="list-style-type: none"> • Abuse/Dependence • Alcohol-related Mortality • Motor Vehicle Crashes • Crime • Treatment • Treatment Gap 	<ul style="list-style-type: none"> • Tobacco-related Mortality 	<ul style="list-style-type: none"> • Abuse/Dependence • Drug-related Mortality • Crime • Treatment • Treatment Gap
Consumption	<ul style="list-style-type: none"> • Age of Initial Use • 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"> • Age of Initial Use • Current Use • Lifetime Use
Risk/Protective Factors	<ul style="list-style-type: none"> • Alcohol Use during Pregnancy • Riding with Drinking Driver 	<ul style="list-style-type: none"> • Friends Use • Tobacco Use during Pregnancy 	

After a full list of constructs and indicators were compiled based on the criteria availability, validity, period review, trend and severity, the AEW further reviewed the list of consumption and consequence indicators by examining them across four dimensions:

1. Magnitude

Magnitude describes the number of individuals directly impacted by a particular indicator. It illustrates the occurrence of ATOD in Alabama. Magnitude is described in terms or relative numbers (e.g. percentages or rates) and absolute numbers (e.g. total number of cases)

2. Relative Comparison

Prevalence for ATOD consumption and related consequences in Alabama compared to those for the US during the same year to determine if Alabama was better or worse off than the rest of the country. The United States is a good benchmark because of the large and relatively stable population.

3. Trends

Trends over time in Alabama were examined to determine if prevalence were increasing (deteriorating) or decreasing (improving). Trends help in detecting growing problems that may demand attention.

4. Severity

Severity examines the potential impact of outcomes on individuals or society that are associated with substance abuse. It helps to determine how serious is the extent of outcomes associated with substance abuse compared to those of other problems.

Using the dimensions magnitude, relative comparison, trends and severity, the AEW was able to identify areas of critical need. Subgroup analyses presented were interesting and informative. The AEW was first emailed the dimensions and the table of constructs and indicators. The AEW was then explained the dimensions used to for selection of constructs and indicators (See dimension explanation above) to ensure they understood each of the dimensions. The constructs and indicators then were discussed. The AEW members then discussed each construct and corresponding indicators for its inclusion in the Epi Profile. The AEW unanimously decided to use the constructs and indicators in Appendix 11. Where possible, data from different sources on the same indicators are presented to highlight any discrepancies among sources. Data on demographic characteristics were collected and summarized in tables and graphs. We used the U.S. population as a standard for comparisons on indicators, but also presented regional data where it was available. Age group or grade level data was shown where possible. In some instances, data was presented by gender. Substance use indicators were organized by common use patterns (e.g., past 30-day use, heavy use, binge use). Indicator analyses can be found in Appendix 11. The AEW presented to the SPAB information (data sources, data source criteria, constructs and indicators, constructs and indicators dimensions) used in the Epi Profile via electronic transmission on August 22, 2012 in preparation for an upcoming meeting/conference call yet to be determined. In the interim, the AEW chair made her self available to field discussions, clarifications, and questions. Individual comments were not received prior to the meeting scheduled on Sept. 7th. At the September 7, 2012 meeting, the AEW reintroduced the sections to ensure everyone understood each component. The SPAB unanimously approved the Epi Profile.

2. Brief Profile of Consequences and Consumption

The following is a brief summary of key findings of ATOD consequences, consumptions, and risk/protective factors in Alabama. The full Epi Profile can be found in Appendix 8.

Alcohol Consequences in Alabama

In 2007-2008, 4.5% of youth in Alabama aged 12 – 17 met the Diagnostic Statistical Manual, 4th Edition (DSM-IV) criteria for alcohol abuse or dependence. The prevalence of alcohol abuse or dependence among Alabama adults was higher for adults ages 18-25 compared with adults ages 26 years and older. In 2007-2008, 13.1% of adults ages 18-25 years and 5.3% of adults 26 years and older in Alabama met DSM-IV criteria for alcohol abuse or dependence, which was less than national estimates of 17.0% for adults ages 18-25 years and 6.1% for adults 26 years and older (NSDUH). Among individuals 12 years and older in Alabama, 6.1% abuse or are dependent on alcohol and 5.7% needed but did not receive treatment for alcohol abuse or dependence (NSDUH).

In 2007, the rate of homicides per 100,000 persons in Alabama is 10.4 compared to the US at 6.0 (NVSS-M). In 2008, 8.6 deaths per 100,000 persons were sustained in alcohol-involved vehicle crashes in Alabama compared to 5.1 deaths per 100,000 persons in the US (FARS). In 2009, there were 29,291 arrests in Alabama for alcohol-related offenses. DUI accounted for 48.6% of those offenses, followed by public drunkenness (32.8%), and liquor law violations (18.6%) (ACJIC).

The leading acute causes of alcohol-attributable deaths in Alabama between 2001 and 2005 were motor vehicle accidents, homicide, and suicide (ARDI). Years of potential life lost (YPLL) due to alcohol-related premature mortality among youth may

be due to alcohol exposure directly, e.g. riding in a car driven by someone who had been drinking. The leading contributors to YPLL among youth in Alabama between 2001 and 2005 were acute causes, specifically motor-vehicle accidents, homicide, and suicide (ARDI).

From 1992 to 2009, the number of total admissions reporting any use of alcohol decreased by 21% (TEDS).

Alcohol Consumption in Alabama

Although the per capita consumption of alcohol in Alabama in 2008 was among the lowest in the country, alcohol was identified as the most regularly consumed substance with the potential for dependence or abuse by both adults and youth. Alabama youth in 9th-12 grades were more likely to report first using alcohol before age 13 compared with US youth in 9th-12th grades (YRBS).

Alcohol use was reviewed by current use, heavy drinking, and binge drinking. Current use is defined as past 30-days or past month. For men, heavy drinking is typically defined as consuming an average of more than 2 drinks per day. For women, heavy drinking is typically defined as consuming an average of more than 1 drink per day. Binge drinking corresponds to 5 or more drinks on a single occasion for men or 4 or more drinks on a single occasion for women, generally within about 2 hours. Overall, current alcohol use was lower in Alabama (37.5%) in 2010 compared with the national median of 54.6% (BRFSS). Among youth 12-20 years old in Alabama, 24.4% reported consuming alcohol during the past month and 15.0% reported binge drinking (NSDUH). In Alabama, 4.2% of adults aged 18 years and older are classified as heavy drinkers (BFRSS). In the state, 33.9% of adults aged 18 years and older report binge drinking in the past 30 days, and 18.1% of adults over 25 reported binge drinking. This pattern was observed nationally, although the national prevalence of binge drinking was higher than Alabama within both age groups (BFRSS).

In 2009, 39.5% of Alabama youth in grades 9 – 12 reported having at least one alcoholic drink in the past 30 days, which was slightly lower than the national estimate of 41.8% (PRIDE). For Alabama youth aged 12-17, 19.4% reported using alcohol in the past 30 days (YRBS). In 2009-2010, Region 4 (19.2%) had a higher percent of youth in 12th grade who reported drinking and driving compared with the other regions. Region 1 (16.5%) has the lowest (PRIDE). In 2009, 12.3% of Alabama youth in 9th-12th grades reported driving after consuming an alcoholic beverage within the past 30 days, which was higher than the national average (9.7%). During that same year, 32% reported riding in a car driven by someone who had been drinking (YRBS).

Alcohol Risk/Protective Factors in Alabama

In 2009, 16.9% of mothers in Alabama reported drinking during pregnancy & gave birth to low birth weight baby (PRAMS)
In 2009-2010, the percent of youth who reported riding in a car with a driver who had been drinking alcohol was lowest in Region 1 (21.1%) and highest in Region 4 (25.2) (PRIDE) which is a risk factor for serious injury or death.

Tobacco Consequences in Alabama

From 2000 to 2007 the rate of lung disease deaths increased from 44.6 deaths per 100,000 persons to 53.6 deaths per 100,000 in Alabama. In 2007, the rate of lung cancer deaths was 68.2 deaths per 100,000 persons which were higher than the US rate (52.6) (NSSV-M).

Tobacco Consumption in Alabama

The per capita sales of cigarette packs have declined since 2000 in Alabama, but remain higher than the national average (The Tax Burden of Tobacco). In 2007-2008, the percentage of current cigarette smoking among person aged 12 or older in Alabama was more than the US percentage (NSDUH). The age at first use of cigarettes has declined in Alabama and the United States since 1995 (YRBS). In 2009, 6.6% of Alabama adults reported ever using smokeless tobacco, with significant differences between men (11.8%) and women (1.9%) (BRFSS). In 2007-2008, the percentage of current cigarette smoking among person aged 12 or older in Alabama (27.2%) was more than the US percentage (24.1%) (NSDUH). In 2007, there was not a statistically significant difference by smoking status during pregnancy, with 8.5% of women who smoked during pregnancy and 8.1% of women who did not smoke during pregnancy giving birth to low birth weight babies (PRAMS).

Tobacco Risk/Protective Factors in Alabama

Region 1 (68.2%) had the highest percent of youth (6th-12th Grades) who reported that their friends use tobacco while Region 3 (55.5%) has the lowest percent who reported that their friends use tobacco use (PRIDE). This is a risk factor for increase risk of a youth smoking if youth have friends that smoke. In 2009, 15.8% of mothers smoking during pregnancy and giving birth to low birth weight baby

Other Drugs Consequences in Alabama

In 2007-2008, 7.9% of adults in Alabama ages 18-25 years were dependent or abused illicit drugs in the past year compared to 2.1% of adults ages 26 years and older. In 2007-2008, 4.2% of youth in Alabama ages 12-17 years were dependent or abused illicit drugs in the past year. The national and state-level estimates were comparable within each age group and there were no statistically significant changes between 2005 and 2008 (NSDUH).

In 2007-2008, 4.2% of youth in Alabama ages 12-17 years were dependent or abused illicit drugs in the past year. The national and state-level estimates were comparable and there were no statistically significant changes between 2005 and 2008. In 2007-2008, among individuals 12 years and older in Alabama, 3.1% abuse or are dependent on illicit drugs and 2.6% needed but did not receive treatment for illicit drug abuse or dependence (NSDUH). Since 1999, the percentage of total admissions reporting stimulants as their primary substance of abuse has increased from 1.5% to 7.8% in 2009 (TEDS).

The number of deaths due to drug-related overdose/poisoning increased from 197 deaths in 2000 to 511 deaths in 2007 (NSSV-M). In 2006, the rate of drug-related overdose/poisoning deaths in Alabama is 8.7 deaths per 100,000 population compared to 11.5 deaths per 100,000 population in the United States. The majority of arrests for both adults (84.9%) and youth (94.1%) were due to drug possession in 2010. The majority of arrests for both adults (84.9%) and youth (94.1%) were due to drug possession in 2010 (ACJIC)

Other Drugs Consumption in Alabama

The percent of Alabama adults who reported using marijuana was relatively stable between 2005 and 2008, with more people in the 18-25 year age group reporting use than the 26 and older age group. The proportion of Alabama adults who reported using marijuana was lower than national estimates within both age groups (NSDUH). Nonmedical use of pain relievers in past year by among 12-17 year olds has declined in Alabama, but has been consistently higher than the US from 2003-2004 (US=7.53 vs. Alabama=8.6) to 2008-2009 (US=6.54 vs. AL=7.55).

The percent of Alabama adults who used illicit drugs other than marijuana (cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically) was also relatively stable between 2005 and 2008, with more persons in the 18-25 year age group reporting use than the 26 and older age group. During this same time frame, the proportion of Alabama adults who reported using illicit drugs other than marijuana was comparable to national estimates within both age groups; however the estimates for Alabama were slightly higher than national estimates for non-medical use of prescription pain medications for both the 18-25 year age group (13.3% vs. 12.1%) and adults over 25 (3.8% vs. 3.4%) (NSDUH). Among individuals 12 years and older in Alabama, 8.0% reported marijuana use during the past year; 5.6% reported non-medical use of prescription pain relievers during the past year; and 1.9% reported cocaine use during the past year (NSDUH). From 2001 to 2005, the percentage of students in 9th-12th grade reporting any use of heroin in their lifetime increased from 2.5% to 5.3% (YRBS). Approximately 12% of boys and 6% of girls reported trying marijuana before age 13, with a slight increase for girls between 2005 and 2009 (YRBS).

B. Assessing the Systems (Capacity and Infrastructure)

1. Alabama's Prevention Infrastructure

a. Systems

At the state level, prevention services are managed through the ADMH. The ADMH was established by Alabama Acts 1965, No. 881, Section 22-50-2. Act 881 defines "mental health services" as the diagnosis of, treatment of, rehabilitation for, follow-up care of, prevention of and research into the causes of all forms of mental or emotional illness, including but not limited to, alcoholism, drug addiction, or epilepsy in combination with mental illness or intellectual disability. 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 is comprised of three unique divisions: Administration, Developmental Disabilities, and 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. Historically, ADMH's responsibilities for mental illness services and substance abuse services were under the supervision of two distinct Associate Commissioners who operated two separate service divisions, respectively. In March 2011, seeking to create an organizational structure that would enable more efficient and effective service delivery for individuals who have mental illness, substance use, and co-occurring mental illness and substance use disorders, ADMH's

Commissioner merged the operations of the two divisions. Now functioning under the supervision of one individual, the Associate Commissioner of DMHSAS, this newly combined division is working towards systems integration through the establishment of a common vision and mission, development of unified policies and procedures, and realignment of staff roles and responsibilities.

The ADMH works in collaboration with the ACPTSA. Since the 2004 establishment of the ACPTSA, Alabama has expanded the collaborative efforts to establish the SPAB. The ACPTSA (state decision-makers; cabinet-level members) serves an advisory committee to the SPAB (state implementers; direct contact members) and is composed of twenty-five (25) state stakeholders in the areas of prevention, treatment, education, health and/or enforcement. The 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. A full description of the functions and roles of the SPAB and AEW can be found in the Capacity section, page 28.

The ADMH also supports two regional clearinghouses, in North and South Alabama, to disseminate information and training on substance abuse and substance abuse related problems to prevention providers, coalitions, schools and communities. The North Regional Information Clearinghouse is provided by the Agency for Substance Abuse Prevention (ASAP) and provides services to thirty-three (33) counties in the northern part of the state. The South Regional Information Clearinghouse is provided by the Drug Education Council, Inc., providing the same services to the remaining thirty-four (34) counties in the southern part of the state. The Clearinghouses provide training to prevention providers throughout the year. Training topics include, but not limited to, bullying, HIV and other STIs, managing disruptive audiences, SPF SIG and ethics. Trainings are determined through an assessment of prevention plans and the identification of training and technical assistance needs. Once the clearinghouse is on-site to provide the necessary trainings, follow-up training schedules and needs are determined. Clearinghouse-provided trainings are offered at no cost to Alabama prevention professionals. Prevention providers and communities are informed of training opportunities through e-mail distribution, clearinghouse websites, various workshops and planning meetings. The Clearinghouses are accessible to providers, as well as the community, and serves as an informational source to include the distribution of pamphlets, brochures, booklets, publications and reports in the substance abuse and mental health fields. A toll-free number allows providers and communities to readily access clearinghouses for technical assistance needs, as well as, information dissemination. The clearinghouse receives requests for technical assistance, information dissemination, and/or health fairs from providers and the community. The clearinghouse will then check personnel/resource availability to fulfill the request at the specified date and time. In the event the clearinghouse cannot fulfill the request, coordination with the alternative clearinghouse is made to fulfill needs. Examples of technical assistance provided by the clearinghouses include, but not limited to, assistance with prevention plans, environmental strategy implementation and prevention standards compliance. The operation of clearinghouses is under the auspices of two certified prevention providers. The prevention providers submit prevention plans based on the providing agency. Beginning FY13, in addition to agency plan submission, clearinghouses will submit separate narratives for the clearinghouse to ADMH. The additional reporting requirement will at a minimum allow ADMH to ascertain the number of technical assistance and training needs, number of technical assistance and training needs fulfilled, providers served, populations served, provider contacts, community contacts and any identified barriers.

b. Personnel

The Director of Prevention Services, Dr. Maranda Brown, manages all prevention services for the newly combined division, DMHSAS and serves as the state representative to the National Prevention Network (NPN). In addition, Dr. Brown manages the prevention component of the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) and serves as the liaison for the state's sixty-seven (67) counties, community mental health boards, non-profit organizations, community coalitions, schools, and free-standing entities. Furthermore, Dr. Brown coordinates multi-various prevention duties, including representing ADMH on the Tobacco Advisory Council, Governor's Advisory Committee, Safe & Drug Free Task Force, and the School Safe and Systems Improvement Initiative. Dr. Brown is also the Synar Coordinator.

As the Director of Prevention Services, Dr. Brown reports to the State-level Office of Prevention Services which is overseen by Dr. Beverly Bell-Shambley, who serves as the Associate Commissioner of the Alabama Department of Mental Health's, DMHSAS. DMHSAS has only four prevention positions: the Prevention Services director, the SPF-SIG Director, an Epidemiologist, and a Prevention Associate. The SPF-SIG will also hire two additional personnel to include a Law Enforcement Specialist and Media Specialist. In addition, Alabama has one Prevention Fellow sponsored by CSAP's Prevention Fellowship Program. Staff members that report directly to Dr. Brown are as follows: Catina James, Epidemiologist; Brandon Folks, Prevention Associate, Dr. Katherine Whiteley, SPF-SIG Evaluator, and Beverly Johnson, SPF-SIG Coordinator. The following staff report directly to Beverly Johnson: Lauren Blanding, Prevention Fellow, and the two vacant positions include Media Specialist and Law Enforcement Specialist. Although the Epidemiologist, Prevention Associate, SPF-SIG Coordinator and Evaluator report directly to the Director of Prevention Services, they all assist with the functioning of the SPF-SIG. For a full description of the roles and responsibilities, including experiences and qualifications, of each member of the SPF Management Team, refer to Appendix 1b.

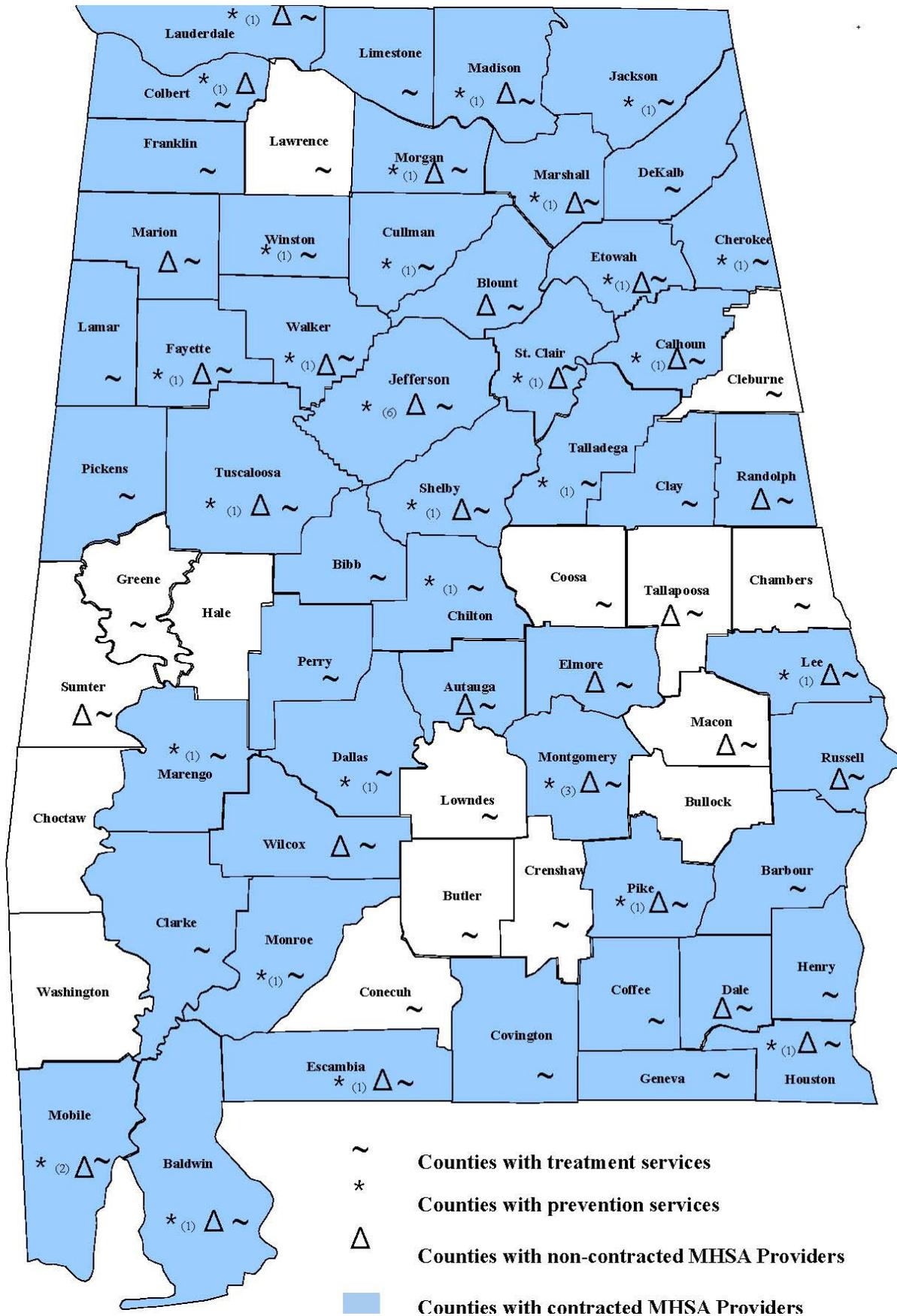
In addition, the SPF SIG Management Team utilizes the services of SAMHSA's Center for the Application of Prevention Technologies (CAPT), which provides training and technical assistance to U.S. states, tribes and jurisdictions around the implementation of the Strategic Prevention Framework (SPF) and workforce development around the implementation of the SPF. The SPF SIG Management Teams continuously works with the CAPT to identify and address service training and technical assistance needs in Alabama around the aforementioned areas in order to prevent and reduce substance abuse and promote positive mental health in the state. For a description of the CAPT's roles and responsibilities, refer to Appendix 1b.

c. Funding Resources

ADMH is designated as the 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. However, ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services. The agency currently enlists the services of ninety-eight (98) certified prevention, treatment and/or recovery support programs across the state. 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, representative of all four regions described in Figure 1. The sixty-four (64) contractual entities provide services in the area(s) of prevention, treatment, and/or recovery support.

Based upon the MHSAs established billable rate system, each of these organizations receives annual funds from ADMH to provide one (1) or more of six (6) levels of care that together, compose the state's treatment service continuum; funds to provide one or more of the six (6) primary prevention strategies; and/or funds to provide recovery support services. In addition to the sixty-four (64) contractual entities, ADMH also certifies thirty four (34) substance abuse service providers within this same system, but does not have a contractual relationship with them. Figure 1 reflects the ADMH substance abuse delivery service system detailing counties providing prevention services, which includes contracted providers, as well as, non-contracted providers. It is important to note that counties detailing prevention services could potentially have multiple providers within the designated area.

Figure 1. Substance Abuse Delivery Service System



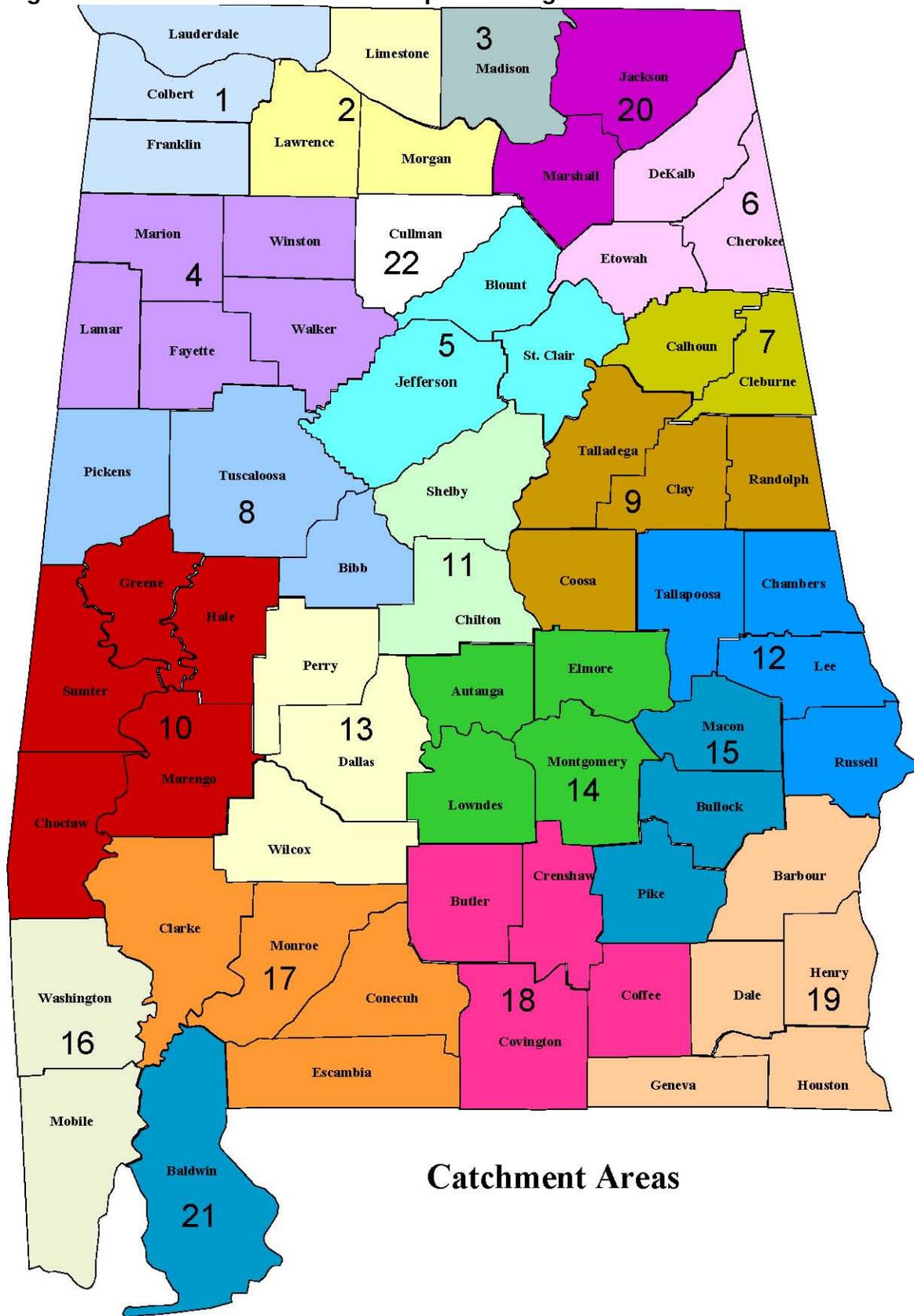
In addition, ADMH currently funds three coalitions dedicated to the reduction of substance use in Alabama: Council on Substance Abuse Montgomery Unified Prevention System (MUPS), Elmore County Partnership for Children, and Selma Dallas Prevention Collaborative. Together, the coalitions annually receive a total of approximately \$200,000. These coalitions consist of youth, parents, teachers, churches, civic and business leaders et al. that are making positive influences and changes throughout their communities. Extensive efforts have been focused on excessive alcohol use, illicit drugs, and alcohol and tobacco ordinances all resulting in reduction of substance use and abuse. Appendix 7 illustrates coalition infrastructure.

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

In addition, state funding is provided by the Alabama State Legislature. The Alabama Medicaid Agency makes payment through ADMH to providers for services rendered through its rehabilitation services option for eligible Medicaid recipients. Providers are reimbursed by ADMH on a fee-for-service basis. Through these funding sources, the SSA provides funding to the "310 Boards" through annual contracts that outline contract requirements, deliverables, and accountability. The "310 Boards" were created in 1967, as a result of Act Number 310 of the Alabama Administrative Code, which provided for the formation of public corporations to contract with the ADMH in constructing facilities and operating programs for mental health services. These entities are commonly referred to as "310 Boards". Currently, twenty-two (22) corporations, representing twenty-two (22) catchment areas, which cover two (2) to six (6) counties each, comprise the "310." Within the "310" catchment area all sixty-seven (67) counties and four (4) regions of the state are included. Figure 2 reflects the Alabama catchment area composition. The "310" are entities that function under the authority of the Alabama Administrative Code and act accordingly with the laws set forth by the state of Alabama. Operating under the state's statutory authority ensures partnership consistency with the "310". Since inception, the role and function of the "310", in conjunction with the ADMH, is to plan and take steps which lead to comprehensive state and community action to combat all forms of mental or emotional illness or debility, including but not limited to, alcoholism, drug addiction, epilepsy and intellectual disability. Representatives of the "310" are an integral part of all planning meeting processes of ADMH. Due to "310s" representing comprehensive mental health centers, no "310" solely operates prevention services. However, "310s" provide any one or more of the following services within the state: Inpatient, Outpatient/Therapy Services/Case Management, Partial Hospitalization, Emergency Care, Community Education and Consultation, Diagnosis, Evaluation, Rehabilitation/Habilitation, Pre Care, Residential Care/Respite Care, Aftercare and the prevention of all forms of mental or emotional illness, including, but not limited to, alcoholism, drug addiction, epilepsy, or intellectual disability. In addition, 78% of ADMH certified prevention provider network operates under the auspices of the "310". Lastly, Alabama has seven (7) regular Drug-Free Community (DFC) grantees, which are community-based coalitions organized to prevent youth substance use. The philosophy behind the DFC program is that local drug problems require local solutions. Through training, technical assistance, awareness and availability of additional resources, DFC capacity is be increased. In sum, the prevention system in the State has been in place for almost 25 years and has many long-term staff at the local levels. The state prevention system includes thirty-two (32) certified

prevention providers out of the ninety-eight (98) total substance abuse service providers in the state, with twenty-five (25) of those thirty-two (32) regionally identified certified prevention providers operating under the auspices of the “310” Boards. With the majority of certified prevention providers already operating under the “310” umbrella, it further ensures the continuity of established community partnerships, input, planning and decision-making with ADMH.

Figure 2. Alabama Catchment Area Map Reflecting “310” Boards



2. Gaps in Alabama's State-Level Substance Abuse Prevention Infrastructure Prevention Resources

Data were 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 the summer and fall of 2011. See Appendix 9 for a full description. Thirty (30) of the thirty-two (32) prevention providers, who represent the entire State, responded to the survey. The following gaps were identified:

a. Awareness & Coordination

There is a lack of awareness relative to the state prevention system, which often leads to state and local service overlap. Alabama has a prevention infrastructure that many individuals are not aware of or are uncertain as to its existence and/or function, to include funding stream awareness. There is a state-level need for increased awareness of existing prevention workforce development programs. For example, in an effort to increase cultural relevancy within the prevention system, it is essential to increase awareness, as well as, opportunities for the prevention workforce to address various populations including vulnerable populations (e.g., military families, deaf, and Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) populations). Although cultural competence of the aforementioned populations is incorporated into the state's training, more emphasis needs to be placed on the awareness and coordination of these trainings. For example, the Alabama School of Alcohol and other Drug Studies (ASADS), the largest substance abuse conference in the state, incorporates military family and LGBTQ tracks. However, there is also a wealth of additional topics of importance to the prevention service provider during this conference. Therefore, in selecting tracks, it may be the lack of opportunity for the service provider to fulfill the inclusion of all topic areas. This is a coordination area that ADMH will focus on to ensure that all prevention providers are afforded the opportunity to attend culturally relevant workshops. For example, coordinated trainings with the clearinghouses could be an option. Culturally relevant trainings conducted during conferences could be integrated into the existing clearinghouse training structure to ensure access and opportunity. Overall, there is a need for increased information sharing about various aspects of the state prevention system to include availability and awareness of resources, such as available state databases and access to prevention and epidemiological expertise available at the State level for prevention service providers requiring support.

Related to this, the assessment also revealed a need for coordination of funding streams including coordination and collaboration across prevention partners. Coordination and collaboration within the prevention system will reduce duplication of services – the left hand will be aware of what the right hand is doing, thereby, creating capacity to service identified underserved populations. Information sharing will serve as the basis for the coordinated effort and further development needed prevention initiatives. Currently, there is no formal coordinated communication structure that allows all prevention providers to connect on a consistent basis. The incorporation of a quarterly prevention provider network meeting will serve as the catalyst of this awareness initiative. Also, in an effort to increase awareness and capacity across the state system, the identification of resources and availability of resources will assist with planning efforts and thus increase the likelihood of sustainability. This effort will also be a component of the quarterly prevention provider network awareness initiative.

There is also a lack of common prevention language, specifically, consensus on the definition of substance abuse prevention across disciplines. This means that different agencies often operate under different assumptions and approaches, which limits the state's ability to recognize how they fit together and can potentially alter adequate annual reporting compilation. Participants of the assessment were uncertain as to a common prevention language, which may suggest a need for the state prevention system to be more prescriptive and explicit with funded communities about what effective prevention programs are and are not. Through these aforementioned endeavors, Alabama's prevention agencies will become better connected and more resilient.

b. Training

As mentioned earlier, 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.

In regards to the SPF, many prevention providers have already been exposed to the SPF and have a basic understanding of the framework, but may require more in-depth training on how to implement the SPF within their communities. A similar need is evident in regards to local evaluation.

In addition, although agencies and organizations have received training on evidence-based programs and policies as related to the priority, there is need for training on selecting programs and policies with practical fit and adaptation.

c. Data Collection

Alabama does not have a current state-wide data system in place that contains data related to substance abuse in the state. Instead, BHIS is the go-to place for all substance use data. BHIS is an interactive, web-based data monitoring system supported by the SAMHSA and the CSAP. The goal is to create a comprehensive national and state-level substance abuse monitoring system and host key mental/behavioral health indicators and shared risk/protective factors as they relate to substance abuse. This interactive site provides data that is available by sub-categories such as age group, race/ethnicity, gender, and by U.S. comparison. Since this is not Alabama's state-wide data system, county, region, and catchment areas are not included in the sub-group population. Vulnerable populations (e.g., military families and Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) populations) are excluded from the data system as well. Alabama needs better epidemiological data for vulnerable populations.

Although BHIS is a useful instrument in locating substance use and/or abuse for the state, gaps in Alabama data is still a significant problem. State agencies at this time do not submit data to BHIS, but there is the option for the state to start submitting data. National data sources information is located on BHIS, but all of the statistics are not up-to-date for each data source. For example, a particular agency may have the statistics for 2011-2012 binge drinking percentages for Alabama adults ages 18 or older, but when utilizing BHIS as a resource, the latest year for this indicator is 2009. This is one of the reasons as to why it is of importance that the state of Alabama develops its own data system.

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

3. State Capacity to Implement SPF

a. SPF SIG Management Team

The SPF SIG Management Team works in collaboration with several other supporting groups to address substance abuse prevention in the state. For example, efforts to achieve Alabama's prevention goals are overseen by the SPAB operating as a subcommittee of The ACPTSA. The role of the ACPTSA is to a) serve as the advisory committee for SPF-SIG and b) expand collaborative efforts.

b. SPF-SIG Advisory Board

As a subcommittee of the ACPTSA, the SPAB functions as an advisory board for prevention services in general, but it is also designated as the official SPF-SIG Advisory Board. The responsibilities of the SPAB include: a) overseeing the development and implementation of the SPF-SIG, 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 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.

For a full description of the membership make-up, see Appendix 4.

c. Alabama's Epidemiological Outcomes Workgroup

The AEW 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 AEW provides information and data about substance abuse to the SPAB. The AEW was established in 2006 and the role of the AEW is to: a) Provide ongoing surveillance assessment and analysis of consumption and consequences in the State, b) Establish a process for collecting and reporting ATOD data relevant to the prevention services system, c) Monitor State and community ATOD data needs and develop strategies to address those needs, d) Facilitate the use of ATOD data (consumption and consequences) by community organizations throughout the State for planning, e) Develop and maintain reporting procedures for continual assessment, f) Develop an annual epidemiological profile that describes the burden of SA in Alabama, g) Establish priorities and parameters for ATOD needs assessment; and assist with conducting statewide community needs assessments, h)

Collaborate with community organizations to provide technical assistance and support for local ATOD prevention planning and i) Establish partnerships with state and local universities and colleges to encourage the study, collection and use of ATOD epidemiological information.

Since the AEW establishment in 2006, active participation has remained. The AEW meets face-to-face on a quarterly basis, and via conference call or a special-called session by the Epidemiologist. The AEW, in keeping with the CSAP Strategic Prevention Framework, has focused efforts on a systematic assessment of statewide need in order to assure wise use of limited resources. In addition to monitoring ATOD consumption and consequence patterns in Alabama, the AEW 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 workgroup has proven to be an invaluable resource to the SPF-SIG progress, particularly with addressing state data needs/gaps, relevancy of data and epidemiological input. See Appendix 3 for the AEW Charter, a full description of the AEW mission, objectives and activities, and the AEW relationship to the SPAB.

The AEW and the SPAB are instrumental in the SPF-SIG process. Both play vital roles and work invariably to develop and implement a plan for the SPF-SIG.

d. Evidence Based Practice Workgroup

In addition to the SPAB and AEW, the SPF SIG Management Team works in close collaboration with Alabama's EBP Workgroup. The EBP Workgroup has representatives from all four mental health regions, and will meet formally four times a year. The role of the EBP Workgroup is to: a) advise the SPF-SIG 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 the SPF-SIG. The EBP Workgroup will be actively involved in T/TA related to evidence based practices, program, and policies; as well as sustainability and cultural competence.

In August 2011, the EBP Workgroup met to address the needs of Alabama prevention. As a requirement of the SPF-SIG, all the interventions provided with SPF-SIG funding must be considered "evidence based." To truly meet the varying needs of the individual communities, SAMHSA released a publication that outlined the guidelines for deeming an intervention as evidence based. During the initial meeting of the EBP Workgroup, representatives were provided with an overview of the SPF (see Appendix 5). EBP Workgroup membership was also provided with Smash's "Identifying and Selecting Evidence-Based Interventions". If an organization wants to ensure their program is recognized as evidence based, this guiding document will serve as the basis of the approval process. The EBP Workgroup, along with the State Evaluator, will ensure adequate trainings and training needs are identified and met to meet the needs of Alabama's prevention system. The role of the EBP Workgroup, as well as trainings, will be ongoing to ensure interventions are evidence-based.

e. Partnering State-Agencies

ADMH is supported by numerous prevention partners throughout the state of Alabama. These partners include prevention providers, state-level substance abuse prevention partners and state partners. As stated previously, Alabama prevention providers consist of thirty-two (32) agencies located throughout the state providing prevention services to local community members in each of the sixty-seven (67) counties. Operating directly under the umbrella of the

Department of Mental Health, DMHSAS, prevention providers are a main source of contact for Alabama communities. It is the prevention provider who provides direct contact, impact, expansion and sustainability of the necessary capacity to prevent substance use disorders in Alabama's communities. Thus, being a pinnacle resource of the promotion of healthy lifestyles across the lifespan and the implementation of the SPF.

An over-arching identified gap in the state prevention system stems around awareness. Gaps such as availability and awareness of resources; coordination of funding streams; coordination and collaboration across prevention partners; consensus on the definition of substance abuse prevention; lack of a sustainability plan; a method to reduce duplication of services; and a process for securing and delivering training and technical assistance to prevention partners can all be addressed and enhanced through the prevention provider network, its established relationships, collaborative efforts and evidence-based policies, practices and programs. Through enhanced state and community awareness, coordination, and training and technical assistance, the previously identified gaps can be filled.

f. 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 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.

Alabama state-level prevention partners include entities such as the National Guard Counterdrug Program. The Counterdrug Program provides military personnel and equipment to support federal, state, and local drug law enforcement agencies as well as community based organizations that work to reduce the demand for drugs. Another key section in the Counterdrug Program is prevention, treatment and outreach (PTO), whose role is described below. This collaborative military personnel support is essential to the SPF-SIG process and coincides with the efforts of Smash's eight strategic initiatives. The outlined goals of the strategic initiative are **1:** Improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE, Department of Defense (DoD), and Veterans Health Administration services; **2:** Improve the quality of behavioral health-focused prevention, treatment, and recovery support services by helping providers respond to the needs within the military family culture; **3:** Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health; **4:** Develop an effective and seamless behavioral health service system for military families through coordination of policies and resources across Federal, national, State, Territorial, Tribal, and local organizations.

The ADMH will partner with the National Guard Counterdrug Program (PTO) to develop and deliver substance abuse prevention training for military members and their families. Collaborative with military personnel will enhance Alabama's planning efforts to address the needs of the military service member and families. Furthermore, with the involvement of the military in the strategic planning process, cultural competence and a strengthened community-based substance abuse provider system can be incorporated to address needs.

State partners also include those Alabama governmental agencies such as the Alabama Department of Education, Human Resources, Public Health, Rehabilitation, and Faith-based Initiatives that are collaborating with ADMH in the SPF-SIG process. The same entities are reflective of the AEW makeup. See Appendix 2. Each of these entities brings in experienced individuals from their respective area to achieve a common goal. For example, those in the education system provide prevention services in issues dealing with youth and young adults including school dropouts, graduation rates, teen pregnancy, substance abuse, etc. Furthermore, education has historically partnered with ADMH in the administration of the PRIDE Survey. The purpose of the PRIDE Survey is to help local schools measure student alcohol, tobacco and other drug use. Although funding limitations potentially threaten the acquisition and utilization of the survey, ADMH and the Department of Education will continue to strategically plan and explore possible implementation methods. The ADMH will continue to partner with the Department of Education to collect state-wide youth-survey data.

Another example is the Department of Human Resources (DHR) which provides services in areas including adult and child protection, family assistance and services, foster care, food assistance, and child support. A mission of the DHR is to provide for the protection, well-being, and self-sufficiency of children and adults. An agency that consistently explores risk and protective factors to ensure adequate needs are met is essential to the success of the AEW. Serving a population with risk factors that could potentially impact the involvement of DHR, makes the collaboration essential. Simultaneously, agency collaboration will potentially reduce the number of substance abusing youth and adults and reduce the DHR involvement caseload. DHR has consistently partnered with ADMH committees as an agency charged with helping Alabama's children in need. DHR will continue to serve as a valuable member of the AEW.

The Department of Public Health is a central location for obtaining information related to health and wellness. Selecting representatives from this agency added value to the SPF-SIG process as the department provides various services including disease prevention and control, injury prevention, health care access, among several others. An agency responsible for eliminating unwanted exposure, sickness, and death, as well as, reducing the economic burden caused by tobacco use in Alabama, Public Health continues to be consistently involved in ADMH prevention planning. Much like DHR, prevention of a substance abusing population will also contribute to the reduction of health-related illnesses. Successful outcomes with SPF-SIG yield successful outcomes for Public Health.

The Department of Rehabilitation (DOR) enables Alabama's children and adults with disabilities to achieve their maximum potential. Formerly under the Alabama State Department of Education, DOR has a historical collaborative relationship with ADMH in planning efforts to serve the needs of Alabama's children and families. The mission of DOR Services is to enable children and adults with disabilities to achieve their maximum potential. ADMH, servicing substance use, mental illness, and intellectual disability populations is synonymous with the expectations of DOR. Cultural competence and sensitivity is an integral component of the SPF and DOR representation further ensures that needs of the disabled population are addressed, met and understood.

Alabama's Governor's Office of Faith-Based and Community Initiatives works to increase an ethic of service and volunteerism in the State of Alabama, to strengthen the capacity of Alabama's faith and community-based organizations, and promote collaboration among individuals and organizations striving to meet some of the greatest needs in our state, thus supporting substance abuse prevention efforts. Through the assessment of the nature and

extent of the substance use behavior and related problems, risk and protective factors that influence them, and existing resources, collaborative state partners contribute to the readiness and capacity of Alabama's SPF SIG.

Other collaborative state partners include the criminal justice segment - the Alabama Pardons and Parole Agency (APPA), Department of Corrections (DOC) and Department of Youth Services (DYS). It is the mission of Alabama Pardons and Parole agency to "promote and enhance public safety through cooperation and collaboration with the legislature, courts, DOC, other criminal justice agencies, victims, and the community by providing investigation, supervision, and surveillance services in a holistic approach to rehabilitating adult offenders", thus preventing repeat offenders and repeat victimizations. The Department of Public Safety (DPS) is a full-fledged, statewide law enforcement agency comprising six divisions: administrative, Alabama Bureau of Investigation, driver license, highway patrol, protective services, and service. The department's employees are committed to preserving the safety of Alabamians and visitors to our state through a variety of enforcement, licensing, and educational programs. DPS conducts several annual initiatives relative to underage drinking prevention and safety. DYS enhances public safety by holding juvenile offenders accountable through the use of institutional, educational, and community services that balance the rights and needs of victims, communities, offenders. An emphasis of DYS is to provide for early intervention as an alternative to long-term incarceration. These state partners routinely work closely with ADMH on workgroups, committee's, and data sharing. ADMH was recently called upon by APPA to serve on an evaluation committee which oversaw the review and scoring of prospective service providers for incarcerated individuals with substance abuse needs transitioning out of the penal system into a residential environment prior to release to the community. Representatives from the DYS work collaboratively with ADMH on various committees, for example, Child & Adolescent Multiple Needs and Adolescent Advisory Board. Additionally, an ADMH contracted and funded adolescent treatment provider works on one of the DYS campuses providing substance abuse services. DYS data is used to inform the Epi profile.

g. North and South Clearinghouses

As described in the previous section, "State Prevention Infrastructure" on page 19, two regional information clearinghouses serve as prevention resource centers to seven (7) stand-alone providers (not contracted by ADMH) and three (3) state coalitions. Services provided by each of the clearinghouses focus on awareness, education, training and technical assistance. In addition, the clearinghouses serve as a prevention resource to the 32 ADMH-certified prevention providers across the state. The North Regional Information Clearinghouse is provided by the ASAP and provides services to 33 counties in the northern part of the state. The South Regional Information Clearinghouse is provided by the Drug Education Council, Inc., providing the same services to the remaining 34 counties in the southern part of the state. All 4 regions of the state have services accessible to individuals, whether through a prevention provider or the 2 regional information clearinghouses. In collaboration with ADMH, the clearinghouses will continue to provide training and technical assistance to the 7 stand-alone providers, 3 coalitions and 32 ADMH certified providers, as it pertains to the SPF-SIG.

h. State Coalitions

In addition, ADMH supports three coalitions: Council on Substance Abuse Montgomery Unified Prevention System, Elmore County Partnership for Children, and Selma Dallas Prevention

Collaborative. These coalitions consist of youth, parents, teachers, churches, civic and business leaders et al. that are making positive influences and changes throughout their communities. The efforts of these coalitions address excessive alcohol use, illicit drugs, and alcohol and tobacco ordinances all resulting in reduction of substance use and abuse. Each coalition provides access data and expertise from various state and community agencies, including but not limited to education, law enforcement and ministry. The Chair of the Elmore County Partnership for Children is a current acting member of the SPAB. Appendix 7 illustrates coalition infrastructure.

ADMH is also charged with the receipt and administration of the Mental Health and SAPT BG provided by SAMHSA. The SAPT BG is available to States to allow States to address their unique behavioral health issues. There are two block, grants, the SAPT BG and the Community Mental Health Services Block Grant. The ADMH DMHSAS has always made application through the SAPT BG. Most recently, SAMHSA changed the FY2012/2013 Block Grant application process, allowing for states to submit a combined plan. The DMHSAS plans to submit a Unified Application for the Community Mental Health Services Block Grant and SAPT BG FY2012-2013 for Federal fiscal year 2013. The SAPT BG application, prepared by a collaborative treatment and prevention team, is submitted to SAMHSA by September 1st of every year. After the SSA has reviewed the prospective application the content is uploaded to Web Block Grant Application System (WebBGAS). Through the SAPT BG application, the State reports on activities consistent with the identified goals, intended use/plan, compliance, and progress to date on the goal. Information gathered for the SAPT BG application process can assist Alabama with describing and analyzing sub-State prevention needs, and plan strategies to address gaps in service. The data can also be used to report to the State legislature and other State and local organizations.

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

4. State Data Capacity

Despite the challenges and gaps in the state data infrastructure, Alabama has key strengths in data capacity. Alabama will utilize the BHIS as a database of substance abuse related data for Alabama and works with its prevention providers to also use the database as a resource. Community-level partners will be able to submit outcomes data updates to the State, with the state entering those updated data sets directly into the BHIS for state-wide access. State and community-level partners will have access to the ASAIS database to enter and resource prevention data not related to the NOMs, GLI, CLI, and PLI. The third component of data access and capacity is the MRT, which will be utilized to enter and access NOMs, GLI, and PLI data. This triangulation of three data bases will increase the capacity of state and community-level partners to enter, access, and resource data for continuous community level implementation monitoring and data-driven decision making.

Role of the State Epidemiological Workgroup

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 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 will meet 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 of the SPF-SIG funded programs on ATOD use in Alabama. With the collection and analysis of the data, electronic access to data will be available by the posting of epidemiological profiles and related substance abuse data online. Having online access to this data will facilitate local and state level prevention needs assessment and planning.

Throughout all the SPF-SIG steps, training and technical assistance will be provided to the AEW by the Center for the Application of Prevention Technologies (CAPT) Epidemiologist on data related issues in collaboration with the state epidemiologist.

5. Community-Level Infrastructure

The Alabama sub state prevention system has been in place for almost 25 years and has many long-term staff at the local levels. The basic prevention system is based on Community Mental Health Centers in 22 catchment areas, each with its own local “310 Board” named after the Regional Mental Health Boards. Within the “310” catchment area all sixty-seven (67) counties and four (4) regions of the state are included. The “310” are entities that function under the authority of the Alabama Administrative Code and act accordingly with the laws set forth by the state of Alabama. Operating under the state’s statutory authority ensures partnership consistency with the “310”. Since inception, the role and function of the “310”, in conjunction with the ADMH, is to plan and take steps which lead to comprehensive state and community action to combat all forms of mental or emotional illness or debility, including but not limited to, alcoholism, drug addiction, epilepsy and intellectual disability. Representatives of the “310” are an integral part of all planning processes of ADMH.

As mentioned earlier, the SSA also supports two (North and South) regional clearinghouses responsible for disseminating information on substance abuse and for providing technical assistance resources to the communities in their respective areas. In addition the SSA supports three (3) prevention coalitions: Council on Substance Abuse Montgomery Unified Prevention System, Elmore County Partnership for Children, and Selma Dallas Prevention Collaborative. The prevention coalitions are a conduit of change throughout the communities that encompasses local stakeholders, organizations, and individuals to influence local changes.

These coalitions consist of youth, parents, teachers, churches, and civic and business leaders 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. Appendix 7 illustrates coalition infrastructure.

6. Effectiveness of the Community-Level Prevention Infrastructure

Data were collected from 30 of the 32 certified prevention providers concerning their perception of the effectiveness of the community-level prevention infrastructure as a part of the prevention system needs assessment conducted in the summer and fall of 2011. The certified prevention providers were selected because they are representative of the state's community-level prevention infrastructure. They are representative of all four regions of the state and service diverse populations. While these certified providers may not be representative of every prevention effort of the state, they serve as a representative model from which some generalizations can be made about the community-level infrastructure across the state. The data indicate four significant areas including awareness, cultural competence, training/technical assistance and data analysis/collection.

Alabama's prevention providers work with partner agencies within the catchment areas to provide prevention services for children, adolescents, and adults. Many of the 32 providers work with their school districts to implement evidence based prevention curriculum programs in the schools for elementary, middle and high school students. Prevention providers are encouraged to consider the cultural needs of the population when selecting the program that they plan to implement. Prevention providers are required to submit biannual prevention plans addressing the agency's prevention philosophy and outline all prevention services provided by the organization. The plan states the amount and type of prevention services provided to each county within the catchment area and is updated biannually, with specific off-year updates, and if any necessary plan amendments exist.

Prevention providers are also required to secure documentation to collect data on each prevention service rendered. Documentation contains the following: Date and physical location of each service delivery; topic addressed; description of activities provided; length of presentation; number of recipients by gender, age and race/ethnicity; domain; prevention strategy; attendance log; applicable billing codes; and the signature of the person providing the service. Guidelines for the requirements are provided through ADMH Prevention Certification Standards, ADMH Prevention Newcomer's Guide, technical assistance, prevention consultants and regional clearinghouses.

In addition to educational programs, prevention providers also provide informational presentations to children, adolescents, and adults throughout their respective areas, and they work with various community partners to reach these audiences. Schools, faith communities, job sites, community civic clubs, law enforcement agencies, non-profit service organizations, and other local agencies such as social services, court systems, and health departments are just some of the partners that a prevention provider may work with to provide information on alcohol, tobacco, and other drugs to the general public.

Alabama also focuses efforts on increasing the use of evidence-based environmental prevention strategies. Prevention providers are required to formulate an effective plan for evidence based programs, practices and policies. ADMH and Public Health have worked collaboratively since 1994 regarding the Synar initiative. In accordance with the tobacco regulations, States are required to provide detailed information on progress made in enforcing

youth tobacco access laws and future plans to ensure compliance with the Synar requirements to reduce youth tobacco access rates. The Alabama Alcoholic Beverage Control (ABC) Board is the responsible agency for conducting random, unannounced Synar inspections and enforcing youth tobacco access laws. Enforcement is conducted at a combination of outlets randomly selected for the Synar survey and outlets not randomly selected for the Synar survey. Alabama completes over 2,500 non-Synar compliance checks every year in addition to required Synar checks. In addition to enforcement, merchant education and/or training and incentives for compliant merchants are implemented through ABC's Responsible Vendor Program (RVP). Community education regarding youth access laws and community mobilization to increase support for retailer compliance with youth access laws are also provided. The increase of compliance checks in conjunction with merchant education through the RVP is essential in reducing youth access to tobacco products. The RVP was implemented by the Alabama ABC Board in October, 1990. The program requires the training of all employees involved in the management, sale, or service of alcoholic beverages. An average of 1,000 employees is trained each month throughout the State of Alabama. Training includes Alabama law regarding the sale or service of alcohol, practical techniques for determining if the customer is of legal age, civil and criminal penalties, and techniques for reducing the risk inherent in the sale/service of alcohol. Licensees who voluntarily join the program are required to establish policies ensuring legal and responsible sales and service, and to train employees in these policies. Alabama has consistently maintained a low non-compliance rate. FY2011 yielded a 7.6% retailer violation rate (RVR) for Alabama. This report is below the 8.5% national average. The successes of the three-agency collaboration will only continue to enhance prevention education, capacity and sustainability.

In addition to the environmental approaches described above for tobacco in FY 2011, Alabama also placed an emphasis on addressing prescription drug use/misuse, education, and media. The National Prescription Drug Take-Back is a program sponsored by the U.S. Drug Enforcement Administration (DEA) to combat the abuse or misuse of potentially dangerous medicines that have expired or are no longer needed by those for whom these controlled substances were prescribed. ADMH collaborated with the Alabama Attorney's General Office to involve the prevention community in the initiative. Throughout the state, prevention providers collaborated with their local law enforcement community in the National Prescription Drug Take-Back effort. 2012 Take-back efforts yielded a disposal of 4,045.48 pounds of expired, unwanted, and unused prescription drugs. The Attorney General's Office reported a 106% increase in the amount collected over the previous event in 2011. In addition to this collaboration, it extended an opportunity for the inclusion of the Alabama Attorney General's Office SPAB membership representation.

ADMH also participated and created an underage drinking video for communities. With support from SAMHSA, ADMH was able to partner with prevention providers, law enforcement agencies, school officials, judicial officials, and local governments in the establishment of a statewide video addressing underage drinking. The purpose of the initiative is to increase awareness of underage drinking and mobilize young people, their families, and their communities. Alabama's video initiative to prevent underage alcohol use supports Smash's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness, which states, "prevention of underage drinking is a priority for states, territories, tribal entities, universities, and communities." The video will be utilized by prevention providers, law enforcement agencies, faith-based communities, parent-teacher organizations and more to enhance local underage drinking prevention communication efforts.

Prevention providers are encouraged to work with current and/or former Drug-Free Communities-funded coalitions in their area, as well as other substance abuse prevention coalitions and human service coordinating councils, youth boards, etc., to strengthen their capacity to provide comprehensive prevention services throughout the catchment area. Prevention providers and coalitions are encouraged to embrace cultural competency as they work together in their local areas. Some areas of the state have stronger collaborations than others. Through various trainings and technical assistance and opportunity for collective dialogue, the opportunities will allow the weaker areas to be strengthened through lessons learned, model programs, resource availability and more.

7. Service Gaps and Barriers in Community-Level Prevention Infrastructure

As previously stated, the current prevention system varies by jurisdiction. Thus, the gaps and barriers also vary by jurisdiction. With the economic climate of the past several years, service gaps and barriers are a continually evolving process as state and local budget cuts impact staffing and programmatic decisions. Another large gap is the currently evolving loss of Safe and Drug Free Schools and Communities Act (SDFSCA) funding at the local-level. For example, Alabama schools have the option to administer PRIDE surveys at their district level; however, funding for surveys and data analysis will be the responsibility of the individual school district. At this time, the changing nature of budgets precludes a formal assessment of these gaps.

According to Alabama's 2011 state assessment survey, two lacking components of the system were identified, communication and collaboration.

a. Communication

The survey revealed that many providers feel there is a significant communication gap among its partners, including the state system. The communication gap could possibly be interpreted as almost half respondent interpretation of limited decision making influence and technical assistance availability. Reference survey results in Appendix 9. It is uncertain as to the historical significance of this perspective. However, the assessment reveals a need to enhance involvement, input, and ownership of the prevention planning processes. As mentioned earlier, awareness of the state prevention system and its offerings will be an integral component of the successes of the prevention system as a whole. Through this increased awareness and creative technical assistance availability through face-to-face offerings, conference calls, quarterly meetings, monitoring, monthly one-on-ones, this gap will be diminished.

b. Collaboration

Almost half of the respondents indicated dissatisfaction or some form of uncertainty with collaborative efforts. The survey revealed that part of this may be attributed to a lack of shared responsibility for the state prevention system. In addition, gaps and barriers were identified around the lack of adequate resources. Currently the state of the economy has led to an increased need for services and a decreased financial allotment across state government. ADMH is not exempt. Although it is uncertain to respondents interpretation as to what is meant by lack of resources, it could possibly be interpreted that financial resources are limited, particularly to smaller prevention providers and/or prevention providers servicing smaller geographic areas. Also, an additional interpretation could potentially result from workforce development issues relative to the aforementioned. Larger agencies sufficiently staffed could

potentially feel that smaller agencies with limited staff are not sharing the servicing area loads. Whether these interpretations are accurate or inaccurate, increased collaboration will significantly increase the opportunity for collaborative projects which will in turn increase capacity and sustainability and thus alleviate what may or may not be considered an inequitable system.

Further, the survey indicated that there is a need for consensus on a guiding definition of substance abuse prevention. A lacking common definition, may lead to confusion around the types of services that prevention providers feel that they can provide. The lack of a common definition may also affect what data is collected and shared.

c. Training

The survey also indicated that prevention providers feel that there is gap in training and technical assistance around access to these services. In regards to the SPF, many prevention providers have already been exposed to the SPF and have a basic understanding of the framework, but may require more in-depth training on how to implement the SPF within their communities. A similar need is evident in regards to local evaluation.

In addition, although prevention providers have received training on evidence-based programs and policies as related to the priority, there is need for training on selecting programs and policies with practical fit and adaptation.

Again, the implementation of awareness will alleviate the identified training gaps. The employment of creative technical assistance availability through face-to-face offerings, conference calls, quarterly meetings, monitoring, monthly one-on-ones, will increase training opportunities and eliminate potential barriers such as financial, travel, staff coverage, etc.

8. Capacity of Communities to Implement the Strategic Prevention Framework

Assessing overall community-level capacity in Alabama is a challenge because every community varies in their knowledge and ability to implement the SPF and utilize data to inform decisions. The majority of the following information pertains to the communities that have received prevention funding and/or certified to provide prevention services in Alabama. Information about current capacity to implement the SPF and the use of data-driven decision making in communities outside of the certified prevention system network is not available, though it is anticipated that their current capacity to collect, analyze, and report back data is minimal. The Alabama SPF-SIG project intends to work with these partnering communities to build their capacity to collect, analyze, and report data, as is detailed in the Capacity Building section of this strategic plan. Although there is limited information about non-certified communities, there have been multiple SPF trainings available to all Alabamians and encouragement of certified agency collaboration.

During provided trainings, emphasis is placed on engagement of key stakeholders at the State and community levels as a critical element of the planning and implementation of successful Alabama prevention activities that will be sustained over time. Key tasks may include, but are not limited to, convening leaders and stakeholders; building coalitions; training community stakeholders, coalitions, and service providers; organizing agency networks; leveraging resources; and engaging stakeholders to help sustain the activities. Various trainings have been

offered in conjunction with the CAPT on the SPF. Three of the heaviest populated state trainings related to substance abuse and mental illness are the annual Alabama School of Alcohol and other Drug Studies (ASADS), Alabama Council of Community Mental Health Boards (ACCMHB), and the Alabama Alcohol and Drug Abuse Association conferences (AADAA). All three of these conferences offered SPF trainings in conjunction with the CAPT. Training topics included Substance Abuse Prevention Skills Training (SAPST), Introduction to the Strategic Prevention Framework and its Application in Alabama, Introduction to Environmental Strategies, and Integrating Mental Health and Substance Use. Utilizing these forums to reach prevention professionals and potential SPF sub recipients are critical to the success of Alabama's SPF.

9. Capacity of Communities to Collect, Analyze, and Report Data

Based on the 2011 state assessment, respondents indicated to a large degree that they feel their agencies base decision making on carefully collected and analyzed data. For the most part, respondents share data with other system partners. Overwhelmingly, respondents have acquired the skill-set to use and incorporate data for planning and decision-making. It is apparent that a significant strength of the system is founded in the areas of data collection and analyzing. A goal of the SPF will be to further enhance the information sharing aspect. The quarterly prevention provider meetings will serve as a basis for information sharing.

The ADMH will provide the sub recipients with an annually updated data disc to assist with the planning efforts of their respective prevention coalitions. The coalitions can either be one of the three contractual coalitions with ADMH or an established Drug-Free community coalition. Categories of data provided include:

- Data related to adult and juvenile arrests for: drugs and narcotics; Driving under the influence (DUIs), drunkenness; liquor law violations; and attendance and dropout rates.
- Motor vehicle accident facts.
- Alabama Department of Education: discipline, crime and violence reports.
- All of the National Outcome Measures (NOMS) data at the state-level compared with national NOMS.
- NSDUH data by health planning region.
- Evidence-based programs conducted by sub recipients and recognized trainers of these programs. As previously mentioned, the capacity of communities across the state varies. This includes the capacity of any given community to collect, analyze and utilize data. Technical assistance will be provided by the SPF Management Team, trainers, ADMH staff and collaborative partners to insure that all funded communities are adequately collecting, reporting and analyzing data. Funded communities will report quarterly progress to ADMH.

C. Criteria and Rationale for SPF-SIG Priorities

1. Prioritization Process

The SPAB is a standing sub-committee of the ACPTSA. The SPAB's mission is to support Substance Abuse Services Division (SASD) prevention efforts; moreover, the executive order also empowers SASD with responsibility for coordinating other state agencies' efforts to combat Alabama's critical substance abuse problems. The SPAB works collaboratively with the AEW, the SPF-SIG Management Team, and DHMSAS to implement state-level activities. The SPAB

spearheaded the development of the strategic plan, utilizing data from the statewide needs assessment and the original SIG strategic plan. This process aided the development of a data-driven strategic plan that allowed for the identification of priorities that will be the target of the Alabama SPF.

The Southeastern CAPT conducted a TA visit with the SPF-SIG Management Team on November 30, 2011. This TA visit provided an opportunity for the team to discuss the efforts to date and to process the next steps with development of the strategic plan and selection of priorities. This visit also provided insight on how previous cohorts had broached the task of selecting priorities, and as a result the SPF-SIG Management Team requested rubrics to assist in the process of determining priorities. A two-phase prioritization process was implemented.

a. Phase 1: Using Epidemiological Data to Assess the Problem

At the combined SPAB and AEW meeting held on January 13, 2012, sixteen members were present to review and discuss the substance abuse indicators and related data recommended by the SPF-SIG management team. Updates for the SPF-SIG were provided by Beverly Johnson, SPF-SIG Coordinator, including informing the AEW and SPAB that the Epi Profile data is complete and will be used to make informed decisions. Then, the members were instructed to break off in to groups with approximately 5 people in each group. Each individual counted off to help develop groups that had diverse backgrounds since individuals from the same area were likely to sit together. It was emphasized that all decisions made shall be “data driven”. The Epi Profiles were handed out to each group to facilitate the discussion about the stage in the SPF-SIG process Alabama currently held. Dr. Katherine Whiteley followed with a brief overview of the ranking for indicators. She described the rigorous process of the unweighted scoring approach to identify indicators. To ensure the groups understood data they should be examining, Epidemiologist, Catina James, talked to each group to ensure the groups understood the epidemiological dimensions to be used to evaluate the substance abuse indicators and choose the substance of priority. These were magnitude, relative comparison, trends over time, and severity. See Appendix 12 for the methodology use to score each dimension for prioritization.

After each group individually discussed the indicators, they presented to the whole group the findings and feedbacks. After the presentations from the AEW/SPAB, five major areas: 1) Alcohol-related motor vehicle accidents 2) Drinking and driving and/or riding 3) Underage drinking 4) Current alcohol drinking, both adults and youth, and 5) Current Drug Use: Nonmedical use of Prescription drug, both adults and youth surfaced from the feedback. Note that due to the successful activities of Public Health, it was decided that the SPF-SIG money would not be used for tobacco use prevention, but to address prevention of other substances with a need for funding. Alabama currently receives Master Settlement Agreement funds through Public Health. Through the settlement allocation, counties with the highest rates of tobacco use are funded. A total of 18 grantees are awarded approximately \$30,000, which may be used for school surveillance, reviewing local policies, and making a presentation to the school board. Grantees are also required to make community presentations, conduct information events, and disseminate information on teen cessation. Also, since some indicators did not have data available for all the dimensions to be calculated they were not used. This is to make sure consistency is across all the indicators. Eighteen tobacco indicators, ten drug indicators, and three alcohol indicators were removed. After the removal of the indicators, eighty were left.

The dimensions data for the indicators along with dimensions scores was entered into a Microsoft Excel table developed by the SPF-SIG Epidemiologist for the order in which to calculate the average ranking scores (Appendix 13 & 14). The top quartile (20 out of 80 indicators) was selected which stopped at the score of ten. Since multiple indicators were tied for a score of 10, they were all included for a total 31 indicators. The AEW agreed on using the top quartile and the indicators that tied at the score of 10. Following feedback from the SAMHSA/CSAP Project Officer's initial review of the Strategic Plan it was necessary to enhance the Epi Profile. As a result of these enhancements the AEW met on August 22, 2012 to discuss revisions to the Assessment and Priority Sections of the plan as well as revisions to the Epi Profile. . All AEW members were provided the enhanced Epidemiological Profile for review prior to the meeting to allow members an opportunity to review the information individually. The AEW reviewed the Epi Profile to ensure data used was clear and consistent throughout the process. The revisions were primarily to the structuring and formatting of the document. The only data addition was treatment data from the data source, TEDS. All members were on one accord with the methodology that was taken to develop the Epi Profile and priority. No objections was made to the priority, underage drinking.

b. Phase 2: Considering Additional Criteria in Establishing Priorities

Additional criteria are applied to the five major areas after the four epidemiological criteria listed above. Based on the consensus of advisory board members and the AEW, the SPF-SIG management team took further steps, upon approval of the SPAB, to narrow down the five major areas to the top three indicators (underage drinking, non-medical use of prescription pain relievers, and alcohol related motor vehicle accidents) that seemed to have the highest need for the state.

First, the SPF-SIG management team decided current alcohol drinking was excluded due to its evaluability. A lack of county-level data that is readily available was not consistent for this indicator. Current alcohol drinking was measured effectively on the state-level, but since Alabama SPF-SIG is going to be applied on the county-level, county-level data was needed but was not available. Second, the SPF-SIG management team excluded drinking and driving due to its evaluability. For this indicator a clear measurement was unavailable and data was not consistently available. Variations in drinking and driving arrests in an area can be dependent on law enforcement in that particular area. It is unclear if a decrease or increase is due to alcohol causing difficulty in comparison from county to county. Applying the additional criteria after the epidemiological criteria allows for the epidemiological assessment to form the basis for prioritization, but still taking into account the broader social and political environment. The following criteria were examined to facilitate with final priority selection:

- Evaluability
- Changeability

Evaluability

Evaluability refers to the extent to which we can measure outcomes. Three factors are

examined to determine the complexity of evaluating the changes in outcomes:

- Data readily available
- Access to data timely
- Defined clearly enough to measure

Aspects to consider include whether data are readily available at the community or state level for the measure of interest or whether primary data need to be collected. If data are already available, then we must consider whether data are available at two time points (i.e., pre-intervention [baseline] and post-intervention). Furthermore, access to the data must be timely; a delay of data to be released may cause a measure not to be evaluated for the year. Finally, outcome measures, or good proxies for the outcome, must exist. Furthermore, we must be able to define the measure clearly enough to measure it.

In order to successfully address the critical need, it is important that evidence-based interventions exist, i.e., interventions shown to change the rates of drinking and driving. There are data supporting effectiveness in programming among college aged individuals as well as high school students and entities, such as The Community Guide (<http://www.thecommunityguide.org/mvoi/AID/index.html>, CDC) which recommend several environmentally effective interventions. Jurisdiction-specific data should allow for clear identification of local changes subsequent to intervention implementation. The evidence indicates that the identified negative consumption patterns, important intermediate steps along the pathway leading to underage drinking and driving, can also be modified. However, baseline consumption data are not always available on the jurisdiction level, making it difficult to assign a valid expectation of change. These data will be monitored once local survey results become available.

Changeability

Changeability refers to the feasibility of affecting significant change of the targeted problems within 5 years (the time frame of the SPF-SIG). Three factors were examined when determining if an indicator is changeable:

- Time
- Multiple Causal Factors

The first factor is time. The effect of interventions may not be seen for years to come with some outcomes. For example, cirrhosis deaths generally occur after years of drinking in a person's life. If we reduce drinking rates in the short term, it may take many years before we notice a drop in cirrhosis deaths. Next are multiple causal factors. Changing one of the indicators may or may not result in change at the outcome level.

c. SPAB's Role and Process for Choosing the SPF-SIG Priority

Once the top three indicators were selected, SPAB and AEOW members were sent a survey on March 2, 2012 through Survey Monkey via email so that each respective member could rank the three based on the analysis of the data and the ability for the priority to be evaluated and changed based on the expertise in the prevention field. The context of the email was as follows:

Good Afternoon All,

Below you will find the link for the Alabama SPF-SIG Priority Selection Survey. The survey contains questions for the selection of a final priority for the SPF-SIG. Please be sure to complete all questions in an appropriate manner, as this will be a reflection for the state of Alabama. Return the survey by close of business (COB) Tuesday, March 6, 2012 at 5:00PM.

<http://www.surveymonkey.com/s/ZNWKPRC>

Two additional surveys are forthcoming to determine the funding allocation model and the priority ranking of counties. Once these steps are completed we will have a draft version of the Strategic Plan Outline for your review, advisement, and feedback prior to submission to SAMHSA and will be one step closer to releasing needed funds to the community. Should you have questions about the survey design, please feel free to contact our Epidemiologist Catina James at catina.james@mh.alabama.gov or at 334-242-3212.

Thank you in advance for your continued assistance, time and cooperation in this process.

Alabama SPF-SIG Priority Selection Survey

Below you will find the Alabama SPF-SIG survey. The three priorities listed for question #2 represent the indicators that were discussed and agreed upon at the combined SPAB/AEOW meeting on Jan. 13, 2012. Members ranked the priority based on epidemiological data and expertise that which would have the greatest impact for Alabama. Thank you for your time and cooperation.

*

1. Select which group(s) you serve on for the SPF-SIG.

SPAB

AEOW

Both

2. Rank the following priorities in order of importance and great need with first represent your primary chose for the final priority.

	First	Second	Third
Alcohol-related Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Underage Drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	First	Second	Third
Non-medical Use of Prescription Pain Relievers	=	=	=

Members had until COB on March 6, 2012 to complete the priority selection survey, and based on those results, a final priority (underage drinking) was selected so that we could enter the next phase of the SPF-SIG. Sixteen (16) of the thirty-eight (38) members participated in the voting. Each of the four (4) mental health regions was represented in the response which allows for proper representation of the issues of the state. Members who anticipated making application for the SPF-SIG funds were asked to reclude themselves from the voting process and thus did not vote.

The SPAB was also present at the August 22, 2012 meeting. Like the AEW, the SPAB met to review and discuss plan revisions. The forum was utilized as an opportunity for the SPAB to pose questions, comments, and/or concerns relative to the plan, as well as, the revisions of the SAMHSA/CSAP Project Officer. Consensus of plan approval was made.

Upon meeting on September 7, 2012 the SPAB unanimously approved the state priority, underage drinking. During this approval process, eleven of the twenty-four SPAB members were present for the voting process. The SPAB members that were unable to attend the meeting were called individually post the meeting to obtain documented vote, with the exclusion of the SAMHSA/CSAP Project Officer. Due to the SAMHSA/CSAP Project Officer residing as a federal reviewing representative of the state's plan and not an official member of the Alabama community, the one vote was not solicited for this purpose. For complete description of the steps for the prioritization process, see Appendix 16.

D. Description of SPF-SIG Priorities

The AEW and the SPAB concluded that the key outcome resulting in the greatest burden to the population in Alabama was underage drinking: 1) rate of drinking & driving amongst 6th-12th graders; 2) rate of riding with someone who had been drinking amongst 6th-12th graders; 3) rate of binge drinking amongst 6th-12th graders. The previous indicators were selected due to availability of the county-level data within the underage drinking age group (12-20 years old). Also, the magnitude effect on the population was great. In conducting assessment efforts, a number of data sources have been identified that provide statistics related to underage drinking. The usage of PRIDE survey statistics provides data for 6th -12th grade students. The PRIDE student survey may provide additional community level outcome data. The PRIDE survey is no longer distributed by the State Department of Education to local school jurisdictions due to cuts in funding. Communities may choose to use the PRIDE survey, and sub-grantees may use SPF-SIG funds to pay for survey distribution and analysis. In addition, consumption data will be gathered by multi-pronged methods, to include DPS data, to obtain valid, generalizable, local data for residents in the 15 to 20 year age group. Alabama issues restricted driving privileges to individuals starting at age 15. The age range for targeted efforts for underage drinking while driving is 15 to 20 years old. For colleges and universities, statistics from current programs which are collecting data that address underage drinking will fill data gaps for the 18-20 age groups. Educating students at this age before they enter a college/university with the knowledge of the impact alcohol may play has an affect on the number of 18-20 year old students who are deterred from engaging in underage drinking when dealing with the increased stress and peer

pressure that college brings. The goal would be to see a decrease in the number of students entering college who have engaged in underage drinking. Also, they do not start drinking when once they start attending college. A survey on substance abuse, followed by focus groups, will be conducted in order to gather substance abuse data on each geographic region and demographics. As local data on consumption becomes available, evaluation efforts will monitor patterns, including binge drinking, current use of alcohol, and drinking and driving among youth in an effort to examine the occurrence of underage drinking in Alabama.

II. Capacity Building

A. Areas Needing Strengthening

Although the ADMH has statutory responsibility for substance abuse services and codified standards for providing the services, prevention in our state still has little structure. To further complicate matters, state-level planning and implementation efforts have historically focused on the management of our provider network rather than the management of our prevention service system as a whole. Consequently, in Alabama comprehensive, strategic prevention services such as those espoused by the SPF are sporadic, at best. The following are system issues that we have and/or continue to wrestle in AL, and are clear indicators of our need to enhance our infrastructure. Below table 2 illustrates a summary of Alabama’s identified gaps as well as solutions to address the gaps.

Table 2. Alabama Identified Gaps and Solutions

Identified Gaps	Solutions
State and local level services tend to overlap resulting in redundancies.	Establish additional state and local collaborative venues to enhance communication and awareness of the left and right hands. The venue can be incorporated within the existing prevention provider network.
Alabama prevention providers often fail to engage in activities that focus on community change. Critical activities such as community mobilization, capacity building, and environmental strategies are not given adequate chance to succeed.	Technical assistance will orient prevention providers as to the essential elements of an effective organization affecting community change. Increased training in the areas of community mobilization, capacity building, environmental strategies and the integral role the components play will be incorporated.
Funding streams are not coordinated and often lead to service redundancies	Encourage and promote coordination of prevention efforts, to include funding, in respective prevention regional areas to eliminate or reduce service duplication.
There is a need for increased evaluation and monitoring so that more reliable program participation reporting methods are developed.	Implementation of program evaluation, to include on-site monitoring as well as quarterly reporting, to be conducted to measure program service delivery, and determine program effectiveness so that dysfunctional programs are improved or

	replaced, and service redundancies are eliminated.
There is a need to increase the number of programs that target economically disadvantaged populations. For example, some providers under serve rural (isolated populations), urban (inner city) populations, and economically disadvantaged youth and adults	Annual review of the data obtained from the prevention provider network plan highlights the disparity in populations served. The EBP Workgroup will use this review data to aid in the identification of appropriate evidence-based programs, policies, and practices to best address this target population. Training in the areas of capacity building and collaboration will be employed to broaden the scope of service areas.
Since SPF encourages addressing prevention across life spans, we need to begin efforts to reach college and pre-school students, which traditionally are two of our larger underserved populations	Utilization of the existing collaboration with the Alabama Department of Education to assist with best approaches and ideologies in reaching pre-school and college-aged individuals.
Gender specific programs should be utilized where appropriate.	Employ training that will provide awareness, knowledge and strategies to foster a culturally competent environment. The EBP Workgroup will partner with T/TA providers to align training that will best provide awareness, knowledge, and strategies to support gender specific programs.
Many of our service providers only began using Evidence-Based Program and Practices in 2003 during our SIG project period, thus, there is a need for ongoing training and technical assistance to ensure Evidence-Based Program and Practices institutionalization.	Employment of Best Practices in Evidence Based Program for Substance Abuse Prevention training for the provider network. T/TA may be of benefit on EBPP to expand provider knowledge base of the EBPP that currently exist that they might not be aware of. Due to funding constraints ADMH has not been able to support the level of continuing education opportunities that it has been able to in the past which has tremendously limited providers' ability to learn of new and innovative EBPP's. Thus, the EBP workgroup will be paramount in assisting this process.
The continuum of services should be expanded to include children under age five and the elderly. Both populations are underserved and are at risk of developing substance abuse problems.	Utilization of the existing collaboration with the Alabama Department of Human Resources and relationship establishment with the Alabama Department of Senior Services to assist with best approaches

	and ideologies in reaching children under five and elderly populations.
Local planners should examine the ethnic makeup of their programs and compare them to the ethnic makeup of their target community. Programs should perform additional outreach and needs assessment among these ethnic groups to understand how they can better meet their prevention needs.	Employ training that will provide planners with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan; interpret the results while maintaining cultural integrity.

Thus, one of the primary goals for the SPF-SIG is to build prevention capacity and infrastructure at the state and community levels. Increased capacity will allow Alabama to support effective substance abuse prevention services at both the state and local levels.

As referenced in the Demographics section, Alabama is located in the southeastern United States, bordered by the states of Florida, Georgia, Mississippi, and Tennessee. The capital city of Alabama is Montgomery (located in Montgomery County) and the most populous city is Birmingham (located in Jefferson County). Alabama had an estimated population of 4,779,736 in 2010 in its 67 counties, with 28.5% of the population residing in rural areas. The majority of Alabama residents are white (68.5%) and African-Americans represent the largest minority group in the state (26.2%) followed by Asians (1.1%) and American Indian/Alaska Native (0.6). Urban and rural areas of Alabama have different socio-demographic profiles, with rural areas being less advantaged than urban areas. In 2009, the state's overall poverty rate was 17.5% with rural areas having a higher poverty level (21.0%) than urban areas (16.2%). Similarly, residents in rural Alabama had a higher unemployment rate (11.9%) compared with residents in urban Alabama (9.1%). Alabama's communities vary on risk, protective factors and resources regarding substance abuse. Multiple approaches will be necessary to address the differentials to meet the unique needs of the respective community to ensure the diverse population needs are met.

B. State- and Community-Level Activities

1. State Capacity Building Activities

Internally, the 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, the SPF model, data collection and use, and underage drinking. 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. DMHSAS will continue to provide training to the sub recipients, coalitions, prevention providers, and various community entities to support the development and implementation of community-based prevention planning and programming and will support the SPF-SIG priority. DMHSAS will provide on-going TA so that local multisystem coalitions, prevention providers, local communities, and collaborative programming will support the inclusion of the data, the SPF process and the chosen SPF-SIG goal. TA will provide the necessary preparation and guidance of each step of the SPF framework to be implemented in respective communities. 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 SPF and to adequately collect, analyze and report on data.

In addition, SPF sub-grantees will be required to mobilize and train local stakeholders by establishing community-level advisory councils called Local Prevention Coalitions (LPCs). The primary task of the LPCs will be to assist their SPF sub-grantee agency in developing the local strategic prevention plan and facilitate community input. LPCs will be required to have representation across the lifespan, and at least one member with substantial prevention experience and/or prevention certification. The SPF-SIG Management Team will closely monitor LPCs to ensure that they are culturally diverse and include members of the target population. The SPF Management Team will provide T/TA to ensure that LPCs 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 EBPs
- Collaborate with existing prevention-related coalitions to prevent duplication

Pivotal to the success of the SPF-SIG will be an ongoing statewide epidemiological needs assessment process that assesses the magnitude of substance abuse and related mental health problems in Alabama. The Office of Prevention Epidemiologist will utilize the insight gained during the development of the strategic outline and from dialogue with an independent needs assessment process conducted by Collaborative Research, Inc. to enhance the epidemiological needs assessment process to refine the existing processes and outcome. 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 SPF sub grantees 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 incorporated into the state prevention certification standards, the evaluation, reporting and monitoring process will apply across the board to providers, as well as, sub-recipients. Lastly, the Office of Prevention will look at their current funding approach and determine if there is potential to sustain the two additional staff members that will be employed for the SPF-SIG beyond the life of the award. If this is not plausible, office reorganization and work distribution will be explored to ensure the needs of the state are accomplished.

2. Community Capacity Building Activities

a. Collaboration & Communication

Community collaborative efforts will assist in ensuring that there is adequate representation from the respective areas to have a voice in each facet of the SPF process. Representation of an entire community such as school officials, law enforcement, clergy, parents, etc. will

establish an all-encompassing decision-making forum that will enhance the existing coalition infrastructure. The forum, facilitated by area prevention providers, will allow diverse community representatives to dialogue to determine who, what, and how needs are addressed in their communities around SPF SIG. With the familiarity of the community provider network and the network's knowledge on best logistics and cultural practices, their facilitation will lend to increased involvement and buy-in regarding capacity-building efforts. Participatory stakeholder dialogue will focus on both direct and indirect services. Discussion will include items such as establishing a community outlet for youth (indirect) or teaching youth in an after-school program (direct).

Prior to accepting applications for community-level funding, the SPF Management Team and the State Evaluator will provide training and technical assistance on the SPF-SIG process and eligibility requirements for application to potential sub-grantees. The training and technical assistance will include on-site, conference call, and email, as well as semi-annual SPF SIG Workshops that will, at a minimum, cover topics such as cultural competency, sustainability, evaluation, evidence-based practices, adaptation, environmental strategies, and coalition-building. In addition, the AEW, the SPAB, the EBP Workgroup, and the SPF-SIG Management Team are working closely with the Southeast Regional CAPT Team (SECAPT) to have a technical assistance and training work plan in place and to address needs as they are identified. Once sub-grantees are awarded, the State Epidemiologist will work closely with the award recipients to provide T/TA to prepare them to conduct needs assessments. The State Evaluator will provide any necessary T/TA to assist sub-recipients to develop and implement their community-level strategic plans based on the SPF process. Trainings will be designed regionally, as well as individually. The EBP Workgroup will provide T/TA to awardees to assist them to select and implement appropriate evidence based policies, programs and practices. The State Evaluator will provide T/TA on all aspects of NOMs data collection and the CLI parts 1 and 2, as well as continuous support to ensure valid and robust data collection and analysis. See training timeline Table 3.

The SPF Management Team will facilitate information sharing between the AEW and the SPF sub-grantees to assist them with community mobilization efforts, needs assessments, and capacity building.

b. Training

SPF-SIG Management Team staff and CAPT will provide TA to all communities. Training will be provided to include, but not limited to, AEW, SPAB, EBP, coalitions, sub-recipients, and prevention consultants. The method of training delivery will be via meetings, workshops, conferences and conference calls regarding the SPF process to ensure successful completion of the five-step process and enhance sustainability efforts. The T/TA needs of the communities will be assessed to respond to particular identified needs in the respective areas such as evidence-based programs, policies and practices and service delivery. The assessment will include a three-part process. 1) Gather information: Information gathering will be employed to make appropriate decisions regarding identified needs. A TA form will be created to collect identified needs. 2) Analyze information: After gathering the information, SPF-SIG Management Team staff and CAPT will analyze it, interpret it, and draw conclusions from the information received. 3) Create a TA plan: After analyzing and interpreting information and offering conclusions, the information becomes the basis for a training plan which proposes how to

resolve the identified deficiency. Through the T/TA component, the ability of the community-level grantees and program providers to continue sound data collection, planning, programming, implementation and evaluation practices after SAMHSA CSAP funding has ended, will be sustained.

Table 3. Training Timeline

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
Introduction to SPF-SIG -This training will serve as an overview of the SPF-SIG.	Training length: 2hrs Target delivery date: December 2012 Estimate development time: TBD hours of adaptation, already developed Developer: SPF-SIG Coordinator	This training should be implemented in the SPF-SIG orientation meeting.	SPF-SIG Staff Prevention Consultants
Environmental Strategies - Interactive session which will explain structural interventions as aiming to modify social, economic, and political structures and systems in which we live. These interventions may affect legislation, media, health care, marketplace and more. This session will introduce core concepts for SPF-SIG.	Training length: 8hrs Target delivery date: December 2012 Estimate Development time: 80 hours Developer: CAPT	This training could be implemented during SPF-SIG orientation meeting, if the meeting is a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by CAPT, or, use a train the trainer model where the prevention consultants are trained and in turn they implement the training with communities.
Needs Assessment -This training will provide participants with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan. It will also include data interpretation strategies.	Training length: 2hrs Target delivery date: December 2012 Estimate Development time: 40 hours Developer: AEW/Epidemiologist/Evaluator	This training will be implemented during the SPF-SIG orientation meeting.	AEOW Epidemiologist Evaluator
Program Evaluation -This training will introduce participants to the basic principles of process and outcome evaluation and its applicability to the implementation of their local strategic plan, best practice intervention and cross site evaluation.	2hr training Target delivery date: December 2012 & monthly TA sessions Estimate Development time: Developer: Evaluator	An introductory session could be delivered at orientation meeting , Follow-up by individualized technical assistance and training	Evaluator
Decision Making Models -This training will provide participants with skills to establish healthy leadership models at their local coalition.	Training length: 4 hrs Target delivery date: July 2013 Estimate Development time: 40 hours Developer: CAPT	During the first year (months 3-6)	This training could be conducted by the CAPT during a designated sub-recipient meeting, or, a train-the-trainer model could be employed with Prevention Consultants

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
			and training could be conducted at Individual monthly TA sessions
Strategic Planning -This training will introduce the strategic planning model. It will include the required planning phases for SPF-SIG.	Training length:2hrs Target delivery date: October 2013 Estimate Development time: 80 hours Developer: CAPT/AEOW/ Epidemiologist/Evaluator	This training should be implemented both individually and with all funded groups. The training with sub-recipients must occur within month 6-8 of the first funding year.	This training could be conducted by CAPT, or, the use of a train the trainer model where the SPF-SIG Team and Prevention Consultants are trained and in turn they implement the training with communities.
Logic Modeling -This workshop will provide participants with skills to develop logic models that will illustrate the strategies local coalitions want to implement.	Training length: 4hrs Target delivery date: October 2013 Estimate Development time: 20 hours Developer: CAPT	This training should be implemented both individually and with all funded groups. The training with sub-recipients program must occur within month 6-8 of the first year.	This training could be conducted by CAPT if done as a training with all funded programs
Best Practices in Evidence Based Program for Substance Abuse Prevention	Training length TBD Target delivery date: TBD Estimate Development time: TBD Developer: TBD	Months 10-12 of the first funding year.	TBD
TRAINING/SUSTAINABILITY	DEVELOPMENT	TIMELINE	TRAINER
Organizational/Partnership/Leadership Development - Help coalition members examine their organization and partnerships and assess their organizational readiness to begin the task at hand. It will also orient them as to the essential elements of an efficient organization, as well as effective partnerships, leadership identification, and guide them towards the redesign or the strengthening of their organization, partnerships, leadership and coalition through an action plan.	Training length: 12 hrs Target delivery date: January 2013 4 three-hour sessions Estimate Development time: 40 hours Developer: SPF-SIG Management Team	During first year of funding	These trainings will be conducted by SPF-SIG Management Team. The first session will occur during the orientation meeting. Subsequent sessions will take place either during individual monthly TA session or during other sub-recipients meetings.
Cultural Competence -This training will provide participants with awareness, knowledge and strategies to foster a culturally competent environment in their local coalitions.	Training length: 4 hr initial training with ongoing increments of 3hrs Target delivery date: TBD Estimate Development time: 80 hours	First Year of funding	This training could be conducted by SPF-SIG Project Coordinator and CAPT if done as a training with all funded

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
	Developer: CAPT/SPF SIG Coordinator		programs or regionally OR At individual monthly TA sessions
Youth Involvement- This training will provide participants with guiding principles and strategies to create meaningful partnerships between adults and young people.	Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: TBD	Second Year of Funding	This training could be conducted by CAPT if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies
COMMUNICATION STRATEGIES Advocacy- This workshop would introduce participants to basic advocacy principles and strategies that could be use to further the structural changes local coalitions will implement. Media- This workshop will provide participants with basic skills to engage the media in their efforts to implement structural change.	Developer: Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: TBD	Second Year of funding	This training could be conducted by CAPT if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies
Grant Writing/Funding- This workshop will provide participants with basic information regarding strategies to secure long-term funding for the coalition's activities	Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: CAPT/SPF SIG Coordinator	Second Year of funding	This training could be conducted by SPF-SIG Project Coordinator and CAPT if done as a training with all funded programs or regionally

C. Role of the AEW

The role of the AEW will continue its role of assessment and analysis of consumption and consequences of ATOD in Alabama. From the beginning, efforts have worked to sustain these efforts. However, there are areas where capacity needs development. With TA from the CAPT, the AEW will work 1) to increase the ability to collect new data across multiple data gaps; 2) to achieve greater diversification of data-dissemination products; and 3) to expand the membership to build collaborative relationships with organizations and/or individuals that possess desirable but previously unfilled knowledge sets within the workgroup.

First, the AEW recognizes data gaps exist and need to be addressed to best present a complete picture of ATOD and implement evidence-based interventions (refer to page 27, Data Collection for more information on the state's data collection gaps). The AEW will examine the data gaps, prioritize them to determine which data gaps will have the greatest impact when addressed, and develop action steps to fill the gaps. Secondly, there is a need for the data that is collected to be accessible to individuals and organizations. Currently, the Epi Profile is

available as an electronic PDF which can be emailed to interested entities. The Epi Profile provides a full picture of ATOD, but could be disseminated in a more compact form. The AEW will work to disseminate data sheets starting with the most critical ATOD issues. Also, the AEW will work towards providing the Epi Profile, data sheets, and other relevant data on the website in a location that is easily accessible to everyone. Third, the AEW will continue to expand its membership by inviting agencies with the intention of gaining an increased ability to address AEW identified data gaps. Also, a guidance document will be developed to ensure new and old members understand the role and objectives to the workgroup. Additionally, the AEW will continue to update epidemiological data and establish electronic access to partnering agencies. Through the continued collection, analysis and updating of state agency data, local and state level prevention needs assessment and planning will be enhanced.

III. Planning

A. State Planning Model for Allocating Funds

On January 13, 2012 during a combined SPAB/AEW meeting, members conducted an in-depth discussion of the substance abuse consequences and consumption epidemiological data. The epidemiological data discussed would be used to determine the priority and the allocation model. The allocation model information was referenced during the discussion solely as a point of information for next steps. Because of the consistent flow of communication amongst SPAB/AEW members during our quarterly combined meetings beginning with the January 13, 2012 meeting, no conflict of interest was recognized for the selection of the priority and allocation model. Those members present conducted in-depth discussions of the substance abuse consequences and consumption patterns using epidemiological data. The epidemiologist, Catina James, was available during this period to explain the data being that most SPAB/AEW members were unaware of the epidemiological background. This breakdown alone provided members with the assurance that Alabama was headed in the right direction of the SPF-SIG process.

The allocation model was communicated to all members on March 7, 2012 via survey monkey. A brief description of each of the four allocation models was provided at the top of the survey to assist in the voting process. Considerations led Alabama to select the highest need model, which did not pose conflict for members. Following the integrity of the process, everything is discussed and/or communicated with all SPAB/AEW members; therefore members were aware of the selection of the allocation model.

The priorities, based on the rank order of voting, were provided along with a description of the allocation models and instructions on voting for preferred model. These communications, along with the survey are provided in Appendix 15. Members who anticipated making application for the SPF-SIG funds were asked to reclude themselves from the voting process and thus did not vote.

The AEW and SPAB met on July 13, 2012 to discuss the SAMHSA/CSAP Project Officer's initial review of the strategic plan. Both the AEW and SPAB were provided revisions prior to the meeting to discuss. During the meeting, SPAB members agreed with the AEW, that an additional review of the Epidemiological Profile data was warranted to revise the assessment and priorities of the plan. A subsequent date for the AEW to meet to review and revise the Epi profile was to be determined.

Following the feedback from the SAMHSA/CSAP Project Officer's initial review of the Strategic Plan it was necessary to enhance the plan. On July 24th and 25th of 2012, the CAPT provided face-to-face TA to the SPF SIG Management Team and invited AEW members on enhancing the Epidemiological Profile and Assessment and Priority sections of the Strategic Plan. Following the TA, the State Epidemiologist led the enhancement process of the aforementioned sections. As a result of these enhancements, the AEW met on August 22, 2012 to discuss revisions to the Assessment and Priority sections of the plan as well as revisions to the Epidemiological Profile. All AEW members were provided the enhanced Epidemiological Profile for review prior to the meeting to allow members an opportunity to review the information individually. As a group, during the August 22nd meeting, the AEW reviewed the Epi Profile to ensure data analysis used was clear and consistent throughout the process. All members were on one accord with the methodology that was taken to develop the Epi Profile and priority. The SPAB was also present at the August 22, 2012 meeting. Like the AEW, the SPAB met to review and discuss plan revisions. The forum was utilized as an opportunity for the SPAB to pose questions, comments, and/or concerns relative to the plan, as well as, the revisions of the SAMHSA/CSAP Project Officer. Consensus of plan approval was made.

Upon meeting on September 7, 2012 the SPAB unanimously approved the state planning model for prioritization and allocating funds. During this approval process, eleven of the twenty-four SPAB members were present for the voting process. The SPAB members that were unable to attend the meeting were called individually post the meeting to obtain documented vote, with the exclusion of the SAMHSA/CSAP Project Officer. Due to the SAMHSA/CSAP Project Officer residing as a federal reviewing representative of the state's plan and not an official member of the Alabama community, the one vote was not solicited for this purpose.

CSAP outlines four potential planning and allocation models. The four funding models are based on highest rate/need areas, highest-contributor, and equitable distribution across Alabama, or a hybrid model where two or more of these are blended.

1. The Equity Resource-Allocation Planning Model dictates that funds are distributed equitably across the all sub-State communities. This model is appropriate when the following two criteria are met: a) data indicate that the priority substance-use pattern or substance-related consequence is distributed evenly across the state and 2) the state has enough resources to fund each entity across the state at a level adequate to make changes in the targeted priority outcomes. Neither of these criteria was met. Equitable distribution was not chosen as there are not sufficient funds to create an effect on Alabama's 67 counties.

2. The Highest-Contributor Resource-Allocation Planning Model uses the state's overall number of priority problem cases as the metric for comparing sub-state entities. Using the number of cases, this model identifies and ranks problem areas that contribute the greatest number of cases to the overall state total in absolute numbers of the person affected, based on the available data. Funding highest-contributor could lead to the only the largest populations being funded for underage drinking and not give a funding opportunity for areas where the problem showed a higher per capita risk.

3. The Highest-Rate Resource-Allocation Planning Model directs funding to the communities or regions that have the highest rate of substance-use pattern or substance-related consequence. For Alabama, High-need was defined as areas with the highest rates within the state for underage drinking. This model would allow "hot-spots" to obtain funding where historically they

may have been underfunded to address the priority problem in their communities. The highest-need model will address areas that are acutely burden with the problem.

4. A Hybrid Resource-Allocation Planning Model will use a combination of the approaches described above. A hybrid model was not chosen to ensure that the mostly acutely burden areas were adequately funded in order to see substantial changes in the problem.

SPAB and AEOW members were sent a survey on March 7, 2012 through Survey Monkey via email so that each respective member could rank the funding allocation based on their thoughts, opinions, and expertise in the prevention field.

The considerations led Alabama to select the highest-need model which was voted on by the SPAB/AEOW utilizing Survey Monkey in order to rank the planning model choices. Ten (10) of the thirty-eight (38) members participated in the voting. After the initial email was sent providing members with the link to the Survey Monkey, the Epidemiologist and the CSAP fellow checked the participate rate within Survey Monkey Daily. In an effort to encourage and remind SPAB/AEOW members to participate, an email reminder was sent by the Epidemiologist. Each of the four mental health regions was represented in the response. In addition, members were reminded throughout the process at regularly scheduled quarterly meeting of the possibility of additional meeting, emails requiring their vote, and the importance of submitting their votes while Alabama was in the process of completing the state strategic plan.

Members who anticipated making application for the SPF-SIG funds were asked to reclude themselves from the voting process and thus did not vote. This resulted in three (3) members out of the thirty-eight (38) members not participating in the voting process because they represented agencies that might make application for the funds leaving thirty-five (35) members total eligible to vote. Ten (10) of the thirty-five (35) members who did not have to reclude themselves participated in the voting process. During the proposals review process, the capacity of applicants to affect change will be evaluated.

B. Community Based Activities

The SPF-SIG Management Team will conduct regional trainings around the state to explain, in detail, the SPF process and the RFP to prospective applicants. Each funded sub-recipient will be expected to adhere to the SPF model. Beginning fiscal year 2012 all contracted prevention providers in the state are required by prevention standard 580-9-47-.04 to utilize the SPF model. Sub-recipients are subject to adherence to these standards. To ensure adherence to these standards, staff of the Office of Prevention Services along with the Office of Certification conduct unannounced site visits to check compliance with the standards. Similarly, this standard requires providers to embed the SPF into their prevention plans that are submitted every two years and updated on a minimum of every year. These plans were submitted in June 2012 in preparation for FY13. To that end, sub-recipient plans will require the SPF model. This process will include the completion of a local needs assessment designed to identify local causal factors associated with the identified priority outcome of reduced underage drinking and driving.

Each funded community will follow a standardized procedure as set forth by the SPF-SIG Management Team for their local needs assessment and gather data to further examine the risk in their jurisdiction for underage drinking and driving. The latest consequence data available at the time the statewide needs assessment was conducted was in 2008; communities will be

expected to update this to include any current data available beyond 2008. In addition, consumption data will be gathered by multi-pronged methods to obtain valid, generalizable, local data for residents in the 15 to 20 year age group. Alabama issues restricted driving privileges to individuals starting at age 15. The age range for targeted efforts for underage drinking while driving is 15 to 20 years old. Additional data will be gathered to determine the presence of key risk and protective factors that affect the identified youth drinking and driving rate. Communities will be made well aware of data requirements through forums, e-mail notifications, trainings, etc. and will have data access via the ADMH website. Service Members, Veterans, and Their Families (SMVF) are special populations that sub recipients will be encouraged to find data on. If a sub recipient plans to identify the aforementioned populations, additional points will be granted.

A prerequisite for the success of the SPF is sub-recipient and non-sub recipient mobilization efforts. As a result of each sub-recipient conducting its own needs assessment, the following community level activities will be made available to assist this process. Various methods for mobilization will be used, including a SPF SIG forum and town meeting approaches. Town hall meetings allow for education and suggest the democratic process. During these open discussions a group of citizens are gathered, sharing a common vision, willing to work, supporting community goals, and seeking plan accomplishments. This shared vision and goal perspective will allow sub recipients and non sub recipients to identify as allies and link like-minded interests and needs. Furthermore, these meetings will provide an opportunity for networking and building relationships that could potentially encourage the growth and development of the LPCs. In addition, emerging leadership will be employed during this process. For example, mentor opportunities will be available. Emerging leaders will be connected with strengthened communities to ascertain community weaknesses, strengths, culture, political will, lessons learned, and how to effectively engage community stakeholders. Funded organizations will be required to develop a strategic plan that outlines the community-level factors identified and appropriate evidence-based practices they will implement. The EBP Workgroup will work with communities to ensure culturally-appropriate interventions are selected and implemented with fidelity. The local plans will also include steps to sustain the efforts when the grant funding ends. Included in the strategic plan will be a description of local evaluation efforts. As mentioned earlier, the LPCs, the AEW, the State Epidemiologist, and the State Evaluator will meet the TA needs requirements of each community-level sub- grantee to insure that the SPF process is implemented in its entirety.

The SE CAPT will provide the SPF-SIG Management Team on-going training based on the SPF steps at the state-level; included in the training will be the SPF-SIG Management Team, the SPAB, and LPCs.

C. Allocation Approach

According to the selected planning model, a Highest-Rate/Need Resource-Allocation Planning Model will direct funding to those communities or regions that have the highest rate of underage drinking. Through the assessment process, the AEW and SPAB determined that the unit of analysis would be counties. This decision was based on the fact that the SPF-SIG program encourages community-led planning activities. The AEW and SPAB also determined that the following indicators would best measure the state-priority, underage drinking: During the January meeting, members of the AEW/SPAB were provided hard copies of the Epi profile, that had been previously emailed to them in preparation of the meeting. Members of the SPF-SIG management team directed the members to work in small groups of 6-8 members following

a presentation on the information from the Epidemiologist and the Evaluator. Each small group was tasked to identify major areas of substance abuse concern. A subsequent meeting in August was used to explore the updated version of the Epi profile. During this meeting the topic of indicators was readdressed by the Epidemiologist. All AEW members were provided the enhanced Epidemiological Profile for review prior to the meeting to allow members an opportunity to review the information individually. As a group, during the August 22nd meeting, the AEW reviewed the Epi Profile to ensure data analysis used was clear and consistent throughout the process. All members were on one accord with the methodology that was taken to develop the Epi Profile and priority. The SPAB was also present at the August 22, 2012 meeting to comment, pose questions, concerns, approval and/or disapproval of priority selection.

Three criteria were examined to determine the allocation approach. They are discussed below.

1. The initial criterion indicator for funding determination was examination of the per capita rates of youth drinking and driving in the 15 to 20 year age group. The annualized rate of youth drinking and driving between the ages of 15 and 20 from 2009-2010 was examined by jurisdiction.
2. The second criterion indicator used to determine funding was the rate of youth who reported riding in a car with a driver who had been drinking alcohol, 2009-2010. As expected, the pattern of rate followed that of the population examined for the first criteria.
3. The third criterion indicator used was the rate of youth who reported binge drinking, 2009-2010. Again, the pattern of rate followed that of the population examined in the first two criteria.

Looking at these criteria will help to balance a need to intervene in areas of great need as indicated by high per capita rates, while decreasing the overall burden in the Alabama, as measured by sheer numbers. The sixty-seven (67) counties of Alabama were examined, but due to the amount of funding allocated to Alabama through the SPF-SIG, 20 counties were selected (Figure 3). Twenty (20) counties will allow for addressing both need and overall burden and it will help to ensure that interventions will affect enough people statewide to show a significant change in the statewide rate. To examine the distribution of the absolute magnitude of the underage drinking driving burden, the number of incidences, between 2009-2010, was examined by geographic distribution to review where they occurred.

Substance abuse (SA) needs for the identified communities will be further addressed through a comprehensive array of treatment services and supports from the currently established community mental health centers. Each county within the state has treatment resources that are due in-part to these community mental health centers as well as through stand-alone providers. The SPF-SIG will allow for the foundation of capacity building in the identified counties by established prevention providers partnering with established DFC's, coalitions, and/or tribes. Thirteen (13) of the identified counties do not currently have any prevention services so this provides an opportunity to build. Only one of the identified counties currently has a DFC and/or coalition. Capacity will be built by providing an opportunity for current prevention providers in neighboring counties to extend their borders into the currently underserved counties. Similarly, neighboring counties with coalitions will have an opportunity to expand their borders. When expansion is not a viable option, neighboring coalitions will have the opportunity to assist their neighbors in coalition building and serve as a mentor coalition to the community as the coalition is established and capacity is being built. SPF-SIG monies will

be allocated to support and build capacity based on the population for each county i.e. the amount of the sub-recipient award is based on the population size of the identified county. Support to these counties will be provided through ongoing T/TA. Additionally, a careful review of future potential funding will be done to see how monies can be provided post SPF SIG to continue to support coalition development and maintenance efforts. Counties will be eligible to submit a prevention plan proposal along with a prospective budget for consideration for future funding.

Counties were defined as high need if they ranked within the top twenty (20) with the highest rate of underage drinking and driving, riding in a car with a drinking driver, and rate of youth binge drinking. These areas will be identified as eligible to apply for SPF-SIG funding. Each county in Alabama was ranked by the three (3) rates separately to determine their standing within each rate category. Once their standing was determined in each rate category, their standings were averaged across each county to determine the overall county ranking for underage drinking. Averaging the standing across three different categories takes into account different factors for a complex problem. This data is further supported in the evidence that of the counties identified only one (1) has a coalition and only seven (7) have existing prevention providers, who do not currently have funded partnerships with DFC's, coalitions and/or tribes, clearly demonstrating high need and low capacity. Thirteen (13) of the identified counties currently do not have any prevention services nor coalitions. Thus, this initiative will allow for the expansion of prevention services, coalitions, and build capacity. Existing prevention service providers may choose to expand their geographic service area to cover these counties, while pairing with coalitions who can also expand their borders or act as a mentor coalition to the county as the county creates its own coalition. The incentive for being a mentor coalition is two-fold. The existing coalition will be able to share its knowledge, wisdom, experience and expertise while being compensated and benefitting from engagement in the SPF.

Figure 3. Map of Eligible Counties by Criteria



- Eligible Counties w/No Prevention Services/Coalitions
- ◆ Eligible Counties w/Existing Prevention Providers/Coalition

Table 4. Eligible Counties by Criteria

Rank	Region	County	% of Youth Drinking & Driving	Rate* of Youth Drinking & Driving	% Youth Riding w/ Someone who been Drinking	Rate* of Youth Riding w/ who been Drinking	% of Youth Binge Drinking	Rate* of Youth Binge Drinking
1	IV	WASHINGTON	12.20%	1220	28.60%	2860	26.50%	2650
2	II	COOSA	11.20%	1120	28.90%	2890	25.70%	2570
3	III	GREENE	11.80%	1180	32.50%	3250	22.60%	2260
4	III	PERRY	9.60%	960	32.70%	3270	24.00%	2400
5	III	SUMTER	10.90%	1090	28.00%	2800	22.70%	2270
6	II	PICKENS	9.40%	940	25.40%	2540	24.30%	2430
7	III	MARENGO	10.80%	1080	25.10%	2510	24.30%	2430
8	IV	ESCAMBIA	9.80%	980	30.80%	3080	19.90%	1990
9	IV	CLARKE	9.30%	930	23.20%	2320	24.30%	2430
10	III	WILCOX	10.60%	1060	28.70%	2870	17.00%	1700
11	III	LOWNDES	11.60%	1160	25.40%	2540	20.90%	2090
12	IV	MONROE	9.40%	940	24.00%	2400	22.90%	2290
13	IV	HENRY	9.30%	930	21.90%	2190	24.60%	2460
14	III	TALLAPOOSA	8.20%	820	24.10%	2410	23.10%	2310
15	IV	BALDWIN	7.67%	767	22.50%	2250	24.30%	2430
16	I	WALKER	6.77%	677	28.50%	2850	21.90%	2190
17	IV	DALE	7.62%	762	25.40%	2540	22.30%	2230
18	IV	GENEVA	9.10%	910	22.50%	2250	22.20%	2220
19	IV	HOUSTON	8.10%	810	21.60%	2160	23.50%	2350
20	IV	COVINGTON	7.71%	771	27.50%	2750	19.90%	1990

*Rate per 10,000, 6th-12th grades (PRIDE Data)

Capacity is the fourth criterion to be used in funding allocation. It is extremely important that a community demonstrates their ability to accept the dollars and successfully affect change within

the time allowed. Although the SPF-SIG dollars are expected to support capacity building, it is also imperative that interventions be implemented in a timely fashion with agencies and persons within communities working collaboratively to decrease the burden of alcohol misuse.

Funding allocation for the identified 20 highest need counties will be based on total county population. Table 5 displays the funding allocation. To ensure progression, population size was accounted for when determining allocation amount. The 20 highest need counties were proportioned based on 2010 census data for the funding amount of \$1.6 million per year. A baseline of \$40,000 and maximum of \$125,000 was set as the funding allocation amount to see an effective change based on capability and resources. All decisions were agreed upon by SPAB and the SPG-SIG Management Team.

Table 5. Funding Allocation

Total County Population	Allocation Amount
At least 10,000	\$40,000
10,001 – 25,000	\$65,000
25,001 – 50,000	\$85,000
Over 50,000	\$125,000

1. Element I - RFP Process

Section 41-16-20 of the Code of Alabama, Public Contracts, (as amended by Act 94 207) states that "All contracts of whatever nature for labor, services, work, or for the purchase or lease of materials, equipment, supplies or other personal property, involving seven thousand five hundred (\$7,500.00) or more, made by or on behalf of any state department, board, bureau, commission, committee, institution, corporation, authority, or office shall, except as otherwise provided in this article, be let by free and open competitive bidding, on sealed bids, to the lowest responsible bidder." Thus state agencies must comply with the competitive bid law. State-funded mental health facilities must comply with the competitive bidding process, even if they are considered to be "non-profit" organizations. The RFP process is utilized for this purpose. The RFP is a negotiated procurement that is announced through a public notice from a governmental unit which will administer the guaranteed energy cost savings contract requesting innovative solutions and proposals for energy conservation measures. The request for proposal shall include the following: (1) The name and address of the governmental unit. The name, address, title, and phone number of a contact person, (2) The date, time, and place where proposals must be received, (3) The evaluation criteria for assessing the proposals, and (4) Any other stipulations and clarifications the governmental unit may require. When such professional services are needed, the purchasing state entity shall solicit proposals from the professional service providers desiring to receive RFPs. The purchasing state entity shall select the professional service provider that best meets the needs of the purchasing entity as expressed in the RFP.

The Alabama SPF-SIG Management Team will write the RFP. The initial development of the RFP is slated for October 2012 and will be developed based an internal review of similar RFP's as well as external RFP's from SPF-SIG cohorts having completed a similar process.

The Alabama Building Capacity (ABC) initiative is designed to provide Alabama with a structured approach to substance abuse prevention planning and service delivery that utilizes state-of-the art prevention science to reach Alabama citizens at-risk or in need of substance abuse prevention services. ABC will be led by the SPF-SIG Management Team in conjunction with the SPAB, consisting of key statewide leaders who represent a culturally diverse section of government, business, faith-based entities, Native Americans, military families, health and education sectors. At the local levels, communities will be mobilized across the state to identify their local substance abuse problems, build local capacity, conduct strategic planning, implement evidence-based programs, policies and practices, and evaluate local efforts in coordination with the SPAB.

The ABC Initiative under the SPF-SIG seeks to accomplish the following goals through the RFP:

- Build prevention capacity and infrastructure at the State and community levels;
- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; and
- Reduce substance abuse-related problems.

Based on emerging alcohol and drug trends, ABC has identified the priority, underage drinking, that will be the focus of the RFP funding:

The RFP will be announced by the ADMH Office of Contracts and Purchasing (OCP) through multimedia to include but not limited to ADMH website and local newspapers. The RFP will be open for a minimum of two weeks yet typically for 30-45 days. The minimal criteria for submitting an RFP are outlined by the OCP. Prospective applicants must complete a vendor registration/application which can be found at <http://purchasing.alabama.gov/pages/vendors.aspx>.

To eliminate bias, the ADMH adheres to the competitive bidding process, providing an equal playing field established for community providers to make application for the funds. To ensure prospective applicants are knowledgeable about the SPF process, trainings will be made available prior to the deadline for the RFP submission. Randomly selected ADMH employees will review and score the applicants to further eliminate bias.

Applicants will follow the standard steps found in all RFPS:

1. Read the entire contract proposal document.
2. Proposal must be submitted in the format requested.
3. Proposals must be in ink or typed (pencil is unacceptable) and contain original signature.
4. Return proposal to:

Bertha M. Lawrence, Director
Office of Contracts & Purchasing
ADMH
100 North Union Street, Suite 570
Montgomery, AL 36104

Proposals may be returned via Express/Overnight Mail to the street address only or hand delivered by the closing date and time. Emailed or faxed responses are not accepted.

Applicants must apply by the designated application date/time and evidence specific responses listed in the Statement of Work section of the proposal. Selection shall be based on factors to be developed by the procuring state entity, which may include among others, the following:

1. Specialized expertise, capabilities, and technical competence, as demonstrated by the proposed approach and methodology to meet project requirements.
2. Resources available to perform the work, including any specialized services within the specified time limits for the project.
3. Record of past performance, quality of work, ability to meet schedules, cost control and contract administration.
4. Availability to and familiarity with the project locale.
5. Proposed project management techniques.
6. Ability and proven history in handling special project contracts.

The RFP will require applicants to demonstrate application of the SPF steps, staffing, and a proposed budget that aligns with affecting change with the identified priority for funding.

The ADMH will review each eligible proposal and, if selections are made, each will be made in accordance with the general criteria provided within the RFP. Failure of the applicant to provide information required in the RFP may result in disqualification of the proposal. The ADMH may elect to conduct interviews with applicants submitting eligible proposals. A comparative scoring process will be used to determine the degree to which each proposal meets the evaluation criteria contained within the RFP, with a maximum of 100 points possible. Each of these criteria shall be given relative weight value, which will be included within the RFP. The OCP randomly selects individuals outside of the division from which the RFP was developed to review and score the RFP's. The results of the score sheets are then provided to the office that developed the RFP for review and awarding of contract. Questions concerning the RFP's are fielded by the Office of Contracts & Purchasing.

The initial funding for the ABC initiative will be released in FY2012 and is anticipated to include roughly \$3.2 million dollars (YR1 & YR2 monies) disbursed throughout the state in the communities of greatest need based on the indicated priorities. Funding to the sub-grantee will follow the allocation approach that was collaboratively determined by the Alabama SPF-SIG Management Team, the AEW, and the SPAB. The funding will be based on highest-need stratified by capacity. Each year a RFP will be released for continuation funding utilizing similar criteria as the original RFP with a similar funding allocation process.

2. Element II – Selection of Criteria for Phase I Funding

The following criteria will be used by the RFP Workgroup to evaluate applications and select those for an award:

The following criteria will be used to evaluate the RFP's and select those for an award:

Criteria (100)		Points
A.	Cover Page	5
B.	Abstract	15
C.	Needs Assessment Approach	20
D.	Capacity	20

E.	Evaluation	20
F.	Budget	20
Total		100
An additional 10 points will be awarded to any applicant identifying SMVF population; Possible 110 point availability		10
		110

Initial funding for Phase I will support community needs assessments and the development of each community’s strategic plan. This plan will outline findings and identified interventions for implementation and will be reviewed and approved prior to actual execution in Phase II.

3. Phase II - Funding Allocation Approach

Continuation funding will be available to sub-grantee’s each year and based on the SPF steps 3 – 5 as detailed below:

SPF Step Three: Each SPF sub-grantee must develop a strategic plan that articulates a vision for local prevention activities. Local strategic plans must be based on documented needs, build on identified resources/strengths, set measurable goals and objectives, and include baseline data and performance measures against which progress will be monitored. Consequently, all sub-grantees’ plans must be adjusted as the result of their ongoing needs assessment and evaluation activities. Cultural competency, along with a program logic model, must be a central component of the local strategic plan both during the design and implementation phase. Finally, each sub-grantee’s local strategic plan must outline both short- and long-term sustainability strategies. DMHSAS will provide TA to assist sub-grantees with developing their strategic plans, as well as to ensure that local strategic plans resonate with the state-level strategic plan. Finally, at a minimum, local strategic plans should: 1) build upon the existing community resources so as not to create systems redundancies; the goal is to seek to uncover and utilize strengths within the community to sustain development. Several steps will be employed to ensure this process – the determination of skills and experience available; political will and organizational capacity. 2) parallel state-level processes; 3) address epidemiological profile data and systems gaps; 4) include a comprehensive plan for addressing underage drinking; 5) include cultural competency and environmental strategies; and 6) provide plan deliverables for accountability purposes. A final draft of the sub-grantee’s local strategic plan will be formally presented to its LPC for formal adoption. Sub-grantees will be required to submit their locally-approved strategic plan to SASD and the SPAB for review and approval. Once approved and implemented, the SASD prevention consultants will work to guide sub-grantees toward the successful completion of their local strategic plan goals and objectives.

SPF Step Four: Sub-grantees must use their local needs assessments findings to make data-driven decisions in the selection and implementation of their EBP. Likewise, sub-grantees will be required to provide detailed narrative discussion that identifies their selected EBP; discussion of the EBP’s scientific findings; and discussion of the selected population(s), including proof of

the EBP's cultural appropriateness for the selected target population(s). Sub-grantees will be required to utilize National Registry of Effective Programs and Practices (NREPP) programs. Likewise, sub-grantees will be required to provide a written assurance that they will employ EBPs by signing a memorandum of agreement (MOA). To ensure that core EBP elements are not sacrificed, all sub-grantees will be required to request prior approval before making any EBP adaptations; moreover, failure to adhere to this requirement may result in a loss or reduction of their sub-grant funds. Finally, ABC sub-grantees will be required to submit their local strategic prevention plans to the SPAB's EBP Workgroup for review and feedback.

SPF Step Five: Sub-grantees will be required to conduct program evaluation to support continued refinement of its strategic plan. DMHSAS will require sub grantees to submit performance data on a regular basis via Alabama Substance Abuse Information System (ASAIS) and Quarterly Progress Reports. Likewise, DMHSAS and the Alabama SPF Evaluation Team will, when necessary, assist sub grantees collect performance data by developing standardized pre- and post-test survey instruments, to include capacity measurement. The evaluation team will distribute these surveys to the SPF sub grantees using specially designed National Co-morbidity Survey (NCS) "Bubble Sheets." All sub grantees will be required to administer and return program surveys in a timely manner. The evaluation team will regularly monitor sub grantee survey activity, develop survey protocols, and provide regular sub grantee program performance feedback to ABC staff and the AEW. Data results will be used to monitor the need for changes in program implementation and to satisfy the Government Performance and Results Act (GPRA) and NOMs requirements. The Alabama SPF Evaluation Team will distribute evaluation results to sub grantees and prepare state level reports. Collectively, these strategies will help to ensure that all sub grantees comply with mandatory evaluation and performance reporting requirements.

Initial funding for Phase I will support community needs assessments and the development of each community's strategic plan. This plan will outline findings and identified interventions for implementation and will be reviewed and approved by the EBP Workgroup, the Management Team and the SPAB prior to actual execution in Phase II.

4. Maintenance of Effort - Allocation Approach

The contracts for Phase II will be based on the strategic plans developed by the communities during Phase I. Unlike the procedure used in Phase I, the assessment of the sub- grantee strategic plans will be made by the SPAB based on recommendations from the EBP Workgroup and the Management Team. In reviewing the strategic plans produced by the sub- grantees, they will ensure that: (1) evidence-based programs are used exclusively; (2) the evidence-based program chosen is appropriate for the conditions identified by the sub-grantee's process as contributing to binge drinking, underage drinking and subsequent motor vehicle crashes; and (3) the evidence-based program is appropriate for the population targeted by the intervention.

The Management Team and the LPCs will work with the EBP Workgroup and SE CAPT to provide training to funded sub-grantees in selecting best fit evidence-based programs. The EBP Workgroup will be provided the SAMHSA publication "Identifying and Selecting Evidence-Based Interventions"; sub-grantees will also be given a copy of this SAMHSA publication, in addition to the guidance document detailing bench marks for assessing the programmatic and cultural appropriateness of evidence-based programs compiled by the EBP Workgroup. It is expected that all of the SPF-SIG sub-grantees will be restricted to EBPs unless there is not one that is appropriate for their specific sub- population. In the latter case, the EBP Workgroup will serve as the panel of informed prevention experts outlined in the SAMHSA CSAP publication.

The guidance document provided to sub-grantees will outline the specific steps and documentation needed to gain approval for a specific program, practice or policy from the EBP Workgroup.

The EBP Workgroup will review the local strategic plans, as will the Management Team; the two groups will then meet to discuss scoring. Their joint report, and the strategic plans, will then go to the SPAB for further review, acceptance or rejection. If a strategic plan is rejected, the Management Team will respond to the sub-grantee with the nature of the SPAB's concerns and potential remedies.

During Phase I, communities will be awarded up to the full amount for which they are eligible based on the size of their county population. Funding will be distributed via reimbursement requests. It is expected that many, if not all, coalitions will hire external trained evaluators to assist them in compiling their formal data-driven needs assessments and strategic plans, i.e., holding focus groups, etc.; these services will not be needed once the strategic plan is approved and the evidence-based programs and practices need to be implemented in Phase II. Thus, the funding amount per year will remain the same; the distribution of funds per award will be spent on different activities, i.e. strategic plan vs. programming. Coalitions will not be able to expend any funding on running programming until their strategic plan has been approved.

D. Implications of the Planning Model and Allocation Approach

1. Implications of Alabama Supporting the Sub-Grantees Increase the Efficiency of Prevention Funding in Alabama by:

- Utilizing a bidding process allows communities to define themselves within a geographic region, encouraging development and collaboration among coalitions and/or tribes.
- Ensuring low and high capacity counties have equal opportunity for funding.
- Increasing the capacity of sub-grantees to fully enact all five steps of the SPF.
- Increasing the effectiveness of programs and policies by utilizing evidence-based practices and encouraging sub-grantees to use their SPF-SIG grants for environmental programs.
- Continuing to promote state and local agency collaboration and coordination.

This is the first time all funded sub-grantees across the state have been able to focus on the same target. The ADMH will also take this systemic approach and apply it to the SAPT BG system. The sustainability assistance process will help community initiatives plan and implement efforts for the long haul in various ways. When communities engage in the process of sustainability, they will develop the necessary commitment, capacity, and resources within their communities (e.g., funds, community leaders, and organizations) to ensure (a) that there are commonly shared values and ideas among stakeholders, (b) continuity of established relationships/partnerships (c) policies and practices become the community norm, and (d) the security of human and financial resources for the long-term.

Step one of the SPF is assessment; and counties with readiness and experience will be able to conduct their needs assessment more quickly than counties without those capabilities.

Therefore, they should be able to move to writing their strategic plan and planning their implementation sooner than those communities needing more assistance to conduct their needs assessment will likely need to spend more time initially, building capacity to conduct the needs assessment and to move forward. This means that there is likely to be considerable variation by county in their progress towards reduction of underage drinking.

The bidding process allows for all interested parties to apply, without limiting the RFP process to a particular subset of applicants based on selected criteria. However, Alabama has selected to weight need more by assigning extra points to applications from areas where need is greatest. For example, Alabama will award additional points for some criteria to ensure that its resource-allocation planning model disperses resources to critical-need population groups (10 points), specifically the SMVF population.

By using a highest rate/need resource allocation model, Alabama has identified counties with varying levels of capacity. This approach will lead to a diversity of counties, which should add value to the evaluation process. By including small, medium and large counties, Alabama will be able to examine the population-level impact on groups of interest.

Need-Based Allocation Challenges

However, need-based allocation is not without challenges. In using this approach, you may expect to achieve measurable outcomes at the county level (specific to improvements in the indicators). However, seeing state-level change is unlikely because of use of the highest-need model.

The main challenge the state faces is in meeting varying needs of all its counties. This will make the coordination of T/TA more complicated because the T/TA will need to fit a wide audience and either take into consideration all audience needs when developing a training, or the T/TA will need to be customized to meet the needs specific to each county, which may require more resources and time. To meet this particular challenge, the SPF-SIG Management Team will collaborate with the CAPT on specialized trainings. The execution of a Train-the-Trainers program to broaden the SPF-SIG Management Team and Prevention Consultants ability to conduct trainings will also meet challenge needs. Regionalized trainings will be customized to meet particular needs of the respective areas and with Alabama divided into four regions, regional trainings will assist in maximizing time and effort.

2. Non-SPF-SIG Resources to be used to Support the Strategic Plan

The ACPTSA, as designated in Executive Order 23, is comprised of various state agencies with prevention objectives. This has been the foundation for the current ADMH prevention infrastructure. Cross-state agency collaboration has been, and will continue to be, an integral component of the SPF-SIG process. Resources have been leveraged toward mutual, cross-agency initiatives i.e., Synar Program, PRIDE data surveys, and the AEW. Once the SPF-SIG Strategic Plan is underway, it is likely that continuity practices of the state agencies will be enhanced to leverage sources to address various aspects of underage and binge drinking by 15 to 20 year olds and drinking and driving that result.

In addition, Alabama has many strong, active, community-based prevention coalitions, many of which are DFC-funded. Alabama's valuable prevention resources; DFCs, coalitions, and providers will be tapped to expand and strengthen the infrastructure. While the target of any

given DFC may not be underage drinking and driving of youth 15–20 years of age, it is expected that adding an additional funded goal to a strong existing DFC, coalition, and provider network will be a more efficient use of funds in gaining the measurable outcome.

IV. Implementation

A. RFP Process for Sub-Grantees

The Alabama SPF-SIG Management Team will develop the RFP with input from the RFP Workgroup and the EBP Workgroup. The initial development of the RFP is slated for April 2012 and will be developed based on internal review of similar RFP's as well as external RFP's from SPF-SIG cohorts having completed a similar process. The RFP will be published on the ADMH website and all certified prevention providers and vendors will receive a notification of the RFP. Additionally, the RFP will be advertised through print media in the dominant local newspapers for the identified counties. ADMH will also partner with agencies representative of the SPAB and AEW and utilize additional publications and websites for notification. Members of the SPAB, DFC's/coalitions, and a tribal representative from the state level will receive notification of the posting of the RFP. To ensure prospective applicants are knowledgeable about the SPF process, T/TA will be made available prior to the deadline for the RFP submission. T/TA notification will be made available utilizing the same medium, i.e. dominant newspapers, and websites.

RFP specific questions will be fielded by the OCP. Based on need, SPF SIG workshops will be available to prospective applicants. SPF-SIG Workshops will be conducted by the Management Team.

The initial RFP will provide funding to sub-recipients to complete their local strategic plans; the first three steps and the planning for Step 5 of the SPF (Assessment, Capacity, Planning and Evaluation). The main focus of the application will be to ascertain the capacity of the jurisdiction/coalition/group to implement all five steps of the SPF process.

The RFP will be open to the counties representing the highest need for each of the priorities. The RFP process is a competitive process. Allocations to each county will be based upon the allocation model.

The ADMH OCP designates the reviewers for the RFP. Proposals will be evaluated and scored in accordance with Alabama Bid Laws. The Management Team and the RFP Workgroup, comprised of SPAB members or their proxies, will review the recommendations from the score sheet for final approval. The ADMH OCP notifies the applicants as to whether or not their application has been selected for funding. A meeting will be convened with the applicants selected for funding to outline reporting expectations and products, including due dates and deadlines for each and will become sub-contractors of the ADMH. Funding will be distributed on a reimbursement basis up to twice a month.

Once initial grants are in place, approval of community-level strategic plans will drive decisions regarding continuation of funding. Once funded, each sub-recipient will work in tandem with the DFC's and/or community coalition with which they have a MOA to maximize successful implementation. Post sub-recipient award, immersion training will occur. During this immersion training, sub-recipients will identify their additional training needs at that time. The immersion training will provide sub recipients with the essentials of the SPF components and the applicable

approaches within their existing systems. Sub recipients will be immersed into the SPF process, will hear presentations relative to the SPF, and review expectations. The immersion will ensure sub recipients are better equipped to implement SPF, post-award, and gain a better understanding of the relevancy and importance of the model. Post evaluation surveys will be utilized post at trainings to determine successes and opportunities for enhancement.

The EBP Workgroup will review each local-level strategic plan and the programs, policies and practices being proposed for implementation, and will make recommendations for improvement. The EBP Workgroup will also make recommendations to the SPAB regarding continuation funding for the implementation of evidence-based policies, programs and practices by each community coalition to enact their local strategic plan.

The following timeline (Table 6) has been established for the initial phases of the Alabama SPF-SIG:

Table 6. Grant Timeline

Task	Target Timeline	Responsible Party
Sub-recipient RFP released (posted on ADMH website, sent to providers, vendors, newspapers, SPAB, DFC's, and tribe representative)	2 weeks post CSAP approval of RFP	Office of Contracts and Purchasing
RFP Workshops (held in Montgomery, Dothan, & Birmingham)	3 weeks post release	Beverly Johnson
RFP due	8 weeks post workshop	Prospective Sub-recipients
RFP review process (randomly selected ADMH reviewers review and score RFP responses and score sheet forwarded to Office of Prevention)	3 weeks	Office of Contracts and Purchasing
Awards made (Sub-recipients notified of award and next steps to receive funds)	1 week post review	Maranda Brown in collaboration with Office of Contracts
Implementation Workshop held (Location to be determined; however, embedding workshop into an existing training venue is preferred option i.e. Gulf Coast conference)	2 weeks post award	Beverly Johnson
Local needs assessment begin	ASAP post-award	Sub-recipients
Sub-grantees submit strategic plans for approval	9 months post award	Sub-recipients
Begin implementation of evidence-based programs, policies, and practices	9 months post award	Sub-recipients

Sections B and C below focus on the approach Alabama will take to implement state-level capacity and infrastructure activities, the approach for supporting the implementation of community-level evidence-based strategies to address the SPF-SIG priority, and Alabama's

strategy for assuring that new dollars do not supplant existing initiatives.

Alabama will initiate a two-step SPF implementation process. These steps include:

- State-level implementation to include educational programs designed to strengthen and build capacity within State systems and statewide prevention networks to support the goals of the SPF. This step is described in Section B.
- Establish community level implementation supports and mechanisms in which funded communities receive continuous and consistent support from the Alabama prevention network. This step is described in Section C.

B. Planned State-Level Implementation Activities

State level activities to support SPF implementation include:

- Provide educational programs related to the SPF process for the entire workforce;
- Provide training and technical assistance for each SPF-funded community;
- Develop workgroups related to each step of the SPF process to provide guidance and support for SPF implementation at both the state and community level.
- Monitor state-level epidemiological data surrounding substances of abuse, as well as changes in the underage drinking. This will be a task of the AEW.
- Conduct an in-depth assessment of state infrastructure (including prevention certification, data collection requirements, program requirements, laws and state policies, and training systems) with the goal of better coordination among all state prevention agencies.
- Improve communication between the state and sub-grantees by hosting sub-grantee meetings, as well as obtaining feedback from the Prevention Consultants. Quarterly meetings will serve as the basis for improved communication between the state and sub-grantees. Hosted by the SPF-SIG Management Team, this will allow opportunity for information dissemination and awareness of resources and availability of resources.

The first three activities are described in deeper detail below.

Education and Training: In order to consistently and comprehensively support community-level SPF implementation, state prevention networks and workforce must have the capacity and readiness to do so. A key component of the state-level activities to support SPF-SIG communities will be to provide SPF-related education and training for state prevention networks and workforce. Educational programs will be offered to build capacity throughout the prevention network in the state.

Two goals will drive the education and training process. They are:

- Goal 1: Work in partnership with state and community entities to co-create an environment supportive of growth and grounded in change management.
- Goal 2: Provide knowledge and skill development related to the five steps of the SPF process and consultant roles.

Regional education and immersion training will be held in each of the four Alabama mental health regions. Topics for the education and training will include the SPF model, needs

assessment, strategic planning, cultural competency, sustainability, and data collection and evaluation strategies. The educational opportunities will also serve to build supportive communities that can foster positive growth founded upon change theory and the public health model.

Training and Technical Assistance: The SPF Management Team developed two strategies to provide training and technical assistance for each SPF-funded community. They are:

- Identify T/TA needs and develop and present T/TA programs to meet those needs.
- Initiate workgroups to provide continuous and consistent T/TA to state and community level partners across the lifespan of the SPF Process.

To address the first implementation strategy, Alabama formed a partnership with the SE CAPT to assist in the design and implementation of training and technical assistance offerings. In addition to extensive T/TA opportunities for the entire workforce, the SPF Management Team, the State Epidemiologist, the State Evaluator, and the Prevention Consultants will provide on-going training, technical assistance, and support to SPF-SIG funded communities. Please see training timetable, page 48.

Site visits are another tool that the SPF-SIG Management Team and Prevention Consultants will use to gauge T/TA needs. SPF-SIG Management Team and Prevention Consultants will be expected to schedule a site visit with each sub recipient Coordinator at least once per month in the months leading up to implementation, and also in the first 12 months of implementation. Based on needs expressed through telephone or e-mail communications, a Management Team member or Prevention Consultant may choose to meet on-site with a sub-recipient Coordinator more frequently.

To address the second implementation strategy, Alabama plans to develop five workgroups related to the steps of the SPF process. The workgroups will include representation from existing infrastructure partners, internal ADMH staff members, and the SPF-SIG Management Team. Design The State Evaluator and workgroup chairs will provide oversight and coordination of the workgroup efforts. Each workgroup will be tasked to develop and implement specific content and deliverables, and to ensure that processes are consistent with the individual and environmental strategies being created and implemented across the prevention network. In addition they will be asked to closely examine the resources that exist and identify additional needs. Workgroups will also explore capacity and its relevance. An integral part of the assistance will be enhanced sub recipient ability to implement SPF, enhanced community ability to implement SPF and the establishment and/or re-establishment of a cohesive community culture to sustain SPF. Each work group will focus on infusing cultural competency and sustainability into work plans and products to be applied throughout the statewide prevention network. Workgroups will assist sub recipients through scheduled meetings, forums and workshops. Table 7 below lists the planned workgroups and their primary responsibilities.

Table 7. Alabama SPF Workgroups and Responsibilities

Workgroup	Primary Responsibilities
T/TA	<ul style="list-style-type: none"> • Identify workforce and community T/TA needs • Collaborate with SE CAPT, SPF Management Team, Epidemiologist, and prevention specialists to design and implement T/TA offerings • Develop and conduct T/TA pre-post assessments • Conduct scheduled assessments to confirm effectiveness of T/TA offerings
Project Management	<ul style="list-style-type: none"> • Adopt a common community planning framework • Create a logic model to support the planning frame work • Determine project management strategies • Identify tools for management and monitoring
Evidence-Based Programs, Practices, and Policies	<ul style="list-style-type: none"> • Define evidence based programs, practices and policies • Provide guidance and parameters regarding evidence based programs, practices and policies • Identify infrastructure supports need to ensure implementation of evidence based programs, practices and policies, to include both direct and indirect services
Monitoring and Evaluation	<ul style="list-style-type: none"> • Develop processes for monitoring the success of T/TA efforts • Develop processes for monitoring SPF process implementation • Develop mechanisms and protocols for documentation and data collection • Develop resources and tools for documentation and data collection • Monitor annual state- and community-level data submission requirements
Technology Support	<ul style="list-style-type: none"> • Create recommendations regarding website content, features, and automated functions • Identify other technology supports needed

C. How Alabama Will Support SPF-SIG Communities

Support for local-level implementation will begin during the application process. The completion of a web-based Key Leader Survey and a Community Capacity Worksheet developed by the State Evaluator with input from the SPF-SIG Management Team and prevention consultants will be a pre-application requirement. This will process will allow the SPF-SIG Management Team to determine the following:

- The level of community readiness to address the underage drinking priority;
- Community capacity to engage in an intensive strategic planning process;
- SPF funds do not fund duplicative sub-state anti-drug coalition initiatives, such as those already functioning and funded by other sources such as DFC’s, etc;
- The depth and breadth of training and technical assistance needed for communities to successfully implement the SPF process.

Continued emphasis on community readiness and capacity will be placed once recipient funds have been awarded. Once sub-recipient awards from the State are in place, community readiness will be explored further as part of the assessment process. Community readiness will be assessed using the Tri- Ethnic Center model to allow communities to delve deeper into their readiness, level of knowledge, and current resources available to support the SPF process. This deeper assessment will allow the State to gain a more precise assessment of community-level consulting and TA needs and help plan content and processes to enhance relevancy of targeted community learning events.

The proposed two-phased implementation process will ensure that adequate capacity exists at all levels: the State, the workforce, and at the community. On-going assessment and enhancement of these processes across all levels will continue as the SPF process is infused into prevention efforts throughout Alabama. In the event a sub recipient lacks capacity to implement, substantial measures will be incorporated to assess the plan and identify gaps and seek appropriate resolution. Actions taken will be individualized and based on the sub recipient adjustment needs.

Emphasis will be placed on a comprehensive prevention approach. The importance of the capability and knowledge to assess community needs, involve the community and response to cultural issues, will be continually stressed. See Cultural Competence page 76. Both individual and environmental strategies will be employed to focus on public education, professional training, public policy, supportive services and advocacy. Also, understanding that indirect services are as valuable as direct services in program effectiveness, emphasis will be placed on the criticality of both throughout the state, as well as communities. Indirect services will focus more on channeling resources to the problem rather than working directly with an individual who may need the service. Indirect services will not come in contact with the people they serve, but rather incorporate an environmental component. Direct service activities are those that require personal contact with people in need, agencies, organizations and partnerships. Both invaluable resources will be an integral component to communities.

D. Community-Level Implementation Monitoring

The Management Team, including the LPCs, will monitor community level implementation progress of our sub-grantees. Sub-grantees will submit quarterly progress reports, including updated data pertaining to the NOMs, as well as invoices for cost reimbursement. Sub-grantees will also submit information into the Prevention Management Reporting and Training System (MRT-CLI) three times a year, and into the Participant Level Instrument (PLI) as needed. State-level checks of data input into the MRT will be conducted three times a year.

The Monitoring and Evaluation Workgroup will work with each individual sub-grantee to assure that the requirement for annual data submission will be met by initiating a data review process three months prior to data submission date to confirm that data are submitted properly and on time. The State Evaluator will oversee and coordinate Monitoring and Evaluation Workgroup activities related to annual data submission requirements.

V. Evaluation

This section provides a brief, preliminary narrative of state-level surveillance, monitoring, and evaluation activities. It describes what the Alabama SPF-SIG Project expects to track, how tracking will be managed and accomplished, and expected change as a result of the SPF-SIG process.

Evaluation of the Alabama SPF-SIG will include assessment of the process, the outcomes, and the long-term impacts of SPF implementation at both the state and community levels. The State Evaluator will design the state evaluation plan and develop an evaluation and sustainability plan to increase state and community level capacity for effective evaluation. The SPF-SIG Management Team will provide the State Evaluator with continuous feedback during the design and development process to assure fidelity to the SPF process, the state grant application, and state strategic plan. The NOMs data collection will help guide the evaluation design at required and appropriate levels.

As necessary, the SPF-SIG Management Team will collaborate with CSAP in regular cross-site evaluations to maintain and uphold data collection and goal timelines. The State Evaluator, along with other SPF-SIG Management Team members, will implement the evaluation plan.

A. Target for Change

As a part of the SPF assessment process using data gathered by the AEW and the DMHSAS and reported Alabama epi profiles, the AEW and the SPAB identified underage drinking as the State priority. This priority will be measured by reduced instances of underage drinking. The State Evaluator and the SPF-SIG Management Team, in collaboration with the AEW and the SPAB, will plan, coordinate, and manage evaluation processes. Evaluation components will include:

- Collection of required outcome data;
- Process evaluation;
- Outcome evaluation;
- Review of policy, program, and practice effectiveness; and
- Development of recommendations for program improvement.

B. The Process Evaluation

Process evaluation progress reports will serve to document the SPF-SIG process in Alabama, as well as the completion of state and community milestones embedded within each step of the SPF process. As communities work through the five SPF steps, their activities progress will be documented in quarterly reports submitted to the State Evaluator and the SPF-SIG Management Team. Reports will be monitored for fidelity and timeliness, and constructive feedback and recommendations will be offered to assure continuous program improvement. The State Evaluator will conduct the process evaluation to answer the major process evaluation question:

- To what degree was the Alabama SPF effectively implemented?

This question will be addressed through collection and analysis of a variety of data sources,

including the Grantee-Level Instrument (GLI), the CLI, the Management Reporting Tool (MRT), state and community-level assessments to be developed by the evaluation team, interviews, site visits, and training and technical assistance evaluation surveys. This array of required and appropriate data sources will provide a robust collection of data designed to collect qualitative and quantitative data relevant to five sub-questions:

1. Did the implementation of the SPF match the plan?
2. What types of deviations from the plan occurred?
3. What led to the deviations?
4. What impact did the deviations have on the intervention(s) and outcome(s)?
5. Who provided what services to whom in what context and at what cost?

The State Evaluator and the SPF-SIG Management Team will input information into the MRT for the GLI and will monitor community-level data entry into the CLI.

Program functioning, effectiveness, and impacts will be evaluated as a part of the process evaluation. The State Evaluator will design, distribute, and evaluate project-specific evaluation instruments, conduct interviews and site visits, as well as review state-level documents to collect data to respond to the following sub-grantee level process data points:

1. The extent to which increased capacity is observed as measured by the number of agency clients served with respect to age, gender, race, and ethnicity;
2. Increased retention in interventions for underage drinking and driving as measured by the total number of evidence-based programs administered by agencies for prevention purposes and the percent of clients exposed to prevention messages;
3. Increased social supports and social connectedness, including more frequent family discussions around alcohol use;
4. Cost effectiveness, evidenced by the increased provision of services within cost bands as determined by provider expenditures reported to the State;
5. Use of evidence-based practices, as measured by the number of evidence-based programs and strategies employed by providers throughout the State; and
6. Program fidelity, ensured through periodic site visits and evaluation instruments.

C. The Outcome Evaluation

State level outcomes will be monitored for increases in capacity building and strengthening of the substance abuse prevention system with an emphasis on cultural competency and sustainability of prevention efforts beyond SPF funding. In addition, with the availability of online resources, training and technical assistance, and evaluation tools, Alabama expects to see an increase in the use and usefulness of technology.

State level outcomes will be collected from two data sources, to allow for a balance of both quantitative and qualitative outcome data. 1) *Stakeholder Interviews*. The evaluation team will conduct bi-annual stakeholder interviews with state-level project partners to track progress with state prevention system capacity building. Baseline data collected from the State-Level SPF-SIG Prevention System Assessment survey with respect to state-level capacity and readiness will serve as the basis for interview protocol development and to track longitudinal movement

toward higher capacity. Additionally, the interviews will be organized around the SPF steps and will place a particular emphasis on documenting and assessing project capacity-building activities and enhancements that correspond to the five steps (e.g., improvements in needs assessment and strategic planning capacities). 2.) *National Outcome Measures*. State-level outcome measures will include collecting data with respect to the following NOMs:

- 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

Changes in substance use behavior, attitudes, frequency, and other related consequences are expected at the community level, specifically a reduction in underage drinking and driving. Quantitative and qualitative data collected through the evaluation process will be utilized to measure these changes. The PRIDE student survey may provide additional community level outcome data for monitoring and evaluation, if communities chose to distribute the surveys. The PRIDE survey is no longer distributed by the State Department of Education to local school jurisdictions due to cuts in funding. Communities may choose to use the PRIDE survey, and sub-grantees may use SPF-SIG funds to pay for survey distribution and analysis. The State Evaluator and SPF-SIG Management Team will coordinate collection and submission of required community level NOMs data. A proposed NOMs reporting plan will be developed and reviewed by the SPAB, and provided to the State's CSAP Project Officer for review and approval to ensure that all requirements are fulfilled. Community awards will be contingent upon compliance with NOMs data collection procedures to ensure high quality data collection, reporting, and accountability. In addition to developing instruments and data collection processes that support federal and state needs, the State Evaluator will assist local evaluators to ensure required information is accurately and reliability collected and reported.

Pre-, post- and 60-day exit program surveys will be administered to program participants to determine changes in substance use behavior, attitudes, and related consequences as a result of program implementation. Required program level NOMs will be collected through program surveys and will be submitted to CSAP through the State Evaluator.

The AEW and State Evaluator will collaborate to conduct the outcome evaluation to answer three primary questions:

- Were substance use and its related problems, especially those in the NOMs, prevented or reduced?
- Did Alabama achieve the outcome objective of reduced underage drinking and driving?
- Was prevention capacity and infrastructure at the state- and sub-grantee-levels improved?

The first two questions will be addressed through collection and analysis of quantitative data; the third through a multi-method approach. All data will be relevant to three outcome sub-questions that cut across the state, coalition, and program level outcomes in terms of systems-, individual-, and environmental-change. The three outcome sub-questions include:

1. What was the effect of the SPF-SIG on service capacity and other system outcomes?

2. Did the SPF-SIG project achieve the intended project goals?
3. What program/contextual factors were associated with the outcomes?

D. Variables to Be Tracked

National Outcome Measures: Program variables to be tracked include all of the National Outcome Measures (NOMs) listed below. Most of the state-level NOMs will be pre-populated by SAMHSA using a variety of national data sources including NSDUH, FARS, UCR and NCES.

1. Abstinence from Drug Use/Alcohol Abuse

- Alcohol use within the past 30 days;
- Age at first substance use;
- Perception of disapproval/attitude;
- Perceived risk and harm of alcohol use;

2. Return to/Stay in School Perceptions of workplace drug policies;

- Substance abuse-related suspensions and expulsions
- School attendance and enrollment (measured separately)

3. Decreased Criminal Justice Involvement

- Alcohol-related car crashes and injuries
- Alcohol and drug related crime

The data for three additional NOMs will be gathered and aggregated from the CLIs. These NOMs are: 1) number of persons served, by age, gender, race, and ethnicity, 2) total number of evidence-based programs and strategies employed, and 3) service costs per participant. The Monitoring and Evaluation and the EBP Workgroups will work closely with the SPF Team and the communities to ensure that the aggregate information is available in a timely manner for the reporting of state-level NOMs.

Additional Outcome Measures. In addition to the NOMs, seven additional consumption, consequence, and risk factor outcome measures will be tracked, depending on the specific nature and focus of the community-level interventions. They are:

- Consumption outcome measures
 - Current Binge Drinking
 - Current Heavy Drinking
- Consequence outcome measures
 - Alcohol-related Mortality
 - Motor Vehicle Crashes
 - Crime: Underage DUI
- Risk and Protective Factors
 - Drinking and Driving
 - Riding with Drinking Driver

With regards to alcohol consumption among adults and youth, data regarding binge and heavy alcohol use and binge drinking may be collected both from the Youth Risk Behavior Survey

(YRBS), as well as the Behavioral Risk Factor Surveillance System (BRFSS). Alcohol consequence indicators data sources may include alcohol-related mortality and motor vehicle accidents data derived from the National Vital Statistics System-Mortality (MVSS-M) and Alcohol Related Disease Impact (ARDI) respectively. Risk and protective data will be drawn from PRIDE surveys and YRBS. Alcohol-related arrest data will be collected from the Alabama Criminal Justice Information Center (ACJIC).

The Monitoring and Evaluation Workgroup, the SPF epidemiologist, and the state evaluator will work actively with the AEW as well as in communication with many of the state data analysts; thus, acquiring and compiling data from the MVSS-M, ARDI, and ACJIC, PRIDE, the YRBS/BRFSS systems will be efficient.

Program effectiveness will be established to the extent that the following patterns are observed over time in all measurement levels; i.e. a decline in alcohol use, an increase in first use, an increased perception is disapproval, and increased perception of risk and harm, and decreases in the rates of the additional outcomes measures listed above. Effectiveness outcomes related to staying in school will be defined as: diminished AOD-related suspensions and expulsions, and increased school attendance and enrollment. Effectiveness measures for crime will indicate a reduction in alcohol-related mortality and motor vehicle crashes. Data related to the measures will be collected at the state level, sub-state level (counties, intrastate regions), program level (agency), and individual level (participant). State and county-level data will be provided by state agencies through administrative and secondary survey data (e.g. NSDUH, PRIDE), and program and individual level data will be gathered through primary surveys from NOMs-based pre-and post-tests.

E. Evaluation Activities

The State Evaluator will be assisted by the SPF-SIG Management Team in tracking occurrences of underage drinking and driving at the state, county, and community level. The breadth of information collected by CSAP's MRT, in the GLI and parts 1 and 2 of the CLI, will be the main collection method for processing outcome data collection. In addition, the MRTs will keep track of T/TA requests and how requests were met in the GLI. LPCs and the Management Team will also collect observational notes, records and archives of products developed, including each community-level strategic plan.

The SPF-SIG Epidemiologist and AEW will monitor the key outcome measures on an annual basis. Per the SPF-SIG charge, the Epidemiologist and AEW will also continue annual monitoring of the same data assessed for the Epi Profile (Appendix 8) to see if any other issues arise over the course of this project.

Funded communities will be required to gather NOMS data from 8, 10 & 12 graders annually. The State Evaluator and Epidemiologist will continue to work with the SECAPT and other states to ascertain the most efficient and reliable method of gaining community-level consumption data from 12-20 year olds.

The evaluation plan and methodology is designed to support ongoing monitoring and assessment of SPF-SIG processes, activities, and outcomes. The evaluation plan will document efforts to increase state capacity for evaluation by providing training and technical assistance regarding evaluation of performance measures to sub-recipient communities and prevention providers. As a result, at the state and community level, needs assessment data will be integrated into a framework that builds and sustains capacity to assess effectiveness. The

evaluation plan supports coordination across multiple data sets and sources; ensures service delivery with fidelity and cultural competence; identifies areas for improvement; and promotes sustainability of effective programs, policies, and practices. The evaluation plan will serve as a tool to guide the process of adjusting implementation plans at the state and community level based on timely feedback that results from monitoring and evaluation activities.

VI. Cross-Cutting Components and Challenges

A. Cultural Competence in State and Sub-Grantee Processes

Cultural competence will be ever-present to improve the effectiveness and the quality of Alabama's programs, policies and practices. It has been suggested that developing 'competence' implies demonstrable mastery of a finite body of knowledge. However, cultural competence is best defined as a commitment and active engagement in a life-long process. Some have suggested the term 'cultural humility' as a more apt term to describe the on-going processes of professionals to continually engage in self-reflection, self-critique in building and maintaining respectful and dynamic relationships with others (Tervalon & Murray-Garcia, 1998). Cultural humility will be practiced at all levels throughout this project by all professionals, including lay-professionals, involved.

The cultural make-up of Alabama, as well as each funded community, is very diverse and will be an on-going focus regarding appropriate inclusion and representation on the SPAB, as well as local coalitions and workgroups. Representation of individuals who are in the 12 to 20 year-old targeted age range will be required. The EBP Workgroup will develop guidelines assisting the funded coalitions to ensure their composition is representative of the community and to develop their plan in a culturally competent manner. The Management Team and Prevention Consultants will also provide T/TA on issues related to cultural competence to the funded coalitions.

The cultural composition of any targeted sub-population will be a key issue considered in identifying and matching evidence-based programs with data-driven decision making. Priority will be given to evidence-based programs that have been tested in multiple ethnic or racial groups. When such programs are not available, other programs will be selected and adapted, taking care to ensure that in the adaptation process the core program components are not eliminated or overshadowed by efforts to adapt the model to meet the cultural needs.

CSAP defines cultural competency as "a set of academic and a set of interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and in between groups. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable persons of and from the community in developing focused interventions communications and other supports."

Multiple strategies will be used to ensure that funded activities are culturally competent, culturally proficient, and culturally inclusive. These issues will be addressed through both the community readiness and capacity assessments, and will also be a focus of the phase one SPF Planning Grants community strategic plan development and grant provisions. The following

considerations will be used in assessing organizational cultural competence, which includes assessing (based on similar SPF cultural competence considerations developed in Kentucky and Kansas):

Organizational Considerations

- Extent to which the coalition and/or its leading members and staff have a documented history of positive programmatic involvement with the population to be served.
- Extent to which staff participated in training that focused on the values, traditions, culture of the target population.
- Extent to which staff familiar with, or are themselves members of, the population on which the intervention will be focused.
- If the focus of the intervention will include people who do not speak English fluently, extent to which bilingual staff are available or the coalition and/or staff have realistic suggestions for addressing issues related to language.

Strategic Planning Considerations

- Extent to which the plan assesses the needs and intervening variables associated with the population to be served.
- Extent to which the plan takes the needs and intervening variables of the population to be influenced into consideration in determining the prevention strategies.
- Extent to which the plan includes a strategy for involving individuals who are knowledgeable about the values, traditions, and culture of the target population(s). This could include the recruitment or retention of culturally competent staff, advisory council members, and/or board members.
- Extent to which the plan addresses the issue of making audio-visual and print materials appropriate and specific for the population/community to be served in terms of gender, age, culture, and linguistics.

Grant Assurances

- Extent to which the prevention strategies implemented as part of the sub-recipients' funding takes into consideration the culture of the population to be served.
- Extent to which written and audiovisual materials produced as part of this project are linguistically and culturally appropriate to the population to be influenced.
- Extent to which individuals who directly identify with the history, traditions and culture of the target population have meaningful opportunities to guide the work of the project, either as staff, board members or advisors/consultants.

Additionally, the resources of the AEOW, the SPAB, and the SPF-SIG Management Team will be made available to the target communities to assist them in identifying subgroups within their community that are at particular risk for substance abuse and its consequences. A review of processes to ensure that SPF-SIG implementation proceeds in a culturally competent and inclusive manner will be completed annually by members of the SPAB. The guidance to ensure the inclusion of cultural competence will be guided by the Community Anti-Drug Coalitions of America (CADCA) Cultural Competence Primer. The primer will serve as the reference in providing targeted communities with a basic understanding of cultural competence and its importance in achieving substance abuse reduction that is both effective and sustainable.

The ultimate goal is to eliminate service and participation disparities for people of diverse racial, ethnic, and linguistic populations, as well as consideration of gender, disability and sexual orientation.

B. Sustainability

1. Assessment

The SPF Assessment is the first step of Alabama's SPF process. The assessment step provides guidance questions to get a clearer understanding of the problems, needs, resources and readiness of Alabama's communities to address community problems. During this process, community capacity and readiness is determined to utilize the necessary resources to address the problems in ways that can be sustained over time. This process will be heightened by mobilizing community leaders and other key stakeholders across disciplines and communities. The establishment and identification of data sources and partnerships will enhance sustainability beyond SPF.

2. Capacity

SPF Capacity is the second step of Alabama's SPF process. Capacity is the ability to mobilize the community and resources to address the needs identified through the assessment. By building an inclusive multi-sector partnership, establishing a culture of commitment, educating key stakeholders and identifying and securing resources, Alabama's capacity will extend beyond SPF. The ultimate goal is to not create an environment of burnout of a few people, but rather active engagement of various sectors creating steady, sustained efforts over time.

3. Planning

Planning is the third step of Alabama's SPF process. This step involves creating a logical, data-driven plan. Understanding that many funding sources are short-term in nature, specific strategies will be employed to develop an action plan to help ensure long-term sustainability. Resources and competencies to include financial, political, administrative, and managerial will be considered in attaining long-term goals. Adaptability to changing conditions in funding and policy environments will also play an integral planning role regarding long-term sustenance.

4. Implementation

SPF Implementation is the fourth step of Alabama's SPF process – putting Alabama's plan into practice. Monitoring will be incorporated to review documentation of sub recipients implementation processes. Monitoring will involve the review of any changes and/or adaptations along the way. Monitoring features will include action plans, outcome measurements, target populations, collaborative partnerships, problem identification and fidelity. The state Evaluator will be involved in this process to ensure appropriate tools are utilized to gather the required information. As no one can predict the future and with the awareness that situations and circumstances change, the on-going monitoring process and the employment of adaptability will help ensure sustainability efforts.

5. Evaluation

Evaluation is the final step of Alabama's SPF process. The evaluation component is crucial because it tells us what works, what doesn't work, what to improve and how to improve it. Evaluation will be accomplished by collecting and analyzing evaluation data as delineated in evaluation plan, writing an evaluation report and providing recommendation on quality improvements based on evaluation data. Increasingly understanding the significance and demands for tracking and reporting outcomes data, the evaluation component will be an integral sustainability element for communities beyond SPF.

The guidelines developed by the EBP Workgroup will also address sustainability. Focus on sustainability will occur from the beginning, as it will be reiterated to respective communities. Emphasis will be on sustaining outcomes in communities, not programs. Fact sheets will be developed by the EBP Workgroup that list steps a coalition may take to sustain their efforts beyond the grant funding. It is expected that through T/TA, the ability of the community-level sub-grantees and service providers to continue sound data collection, planning, programming, implementation and evaluation practices after the grant funding has ended, will be sustained. Prevention efforts and outcomes will be sustained by making prevention everyone's job. Evidence for cultural competence and sustainability will be considered in the scoring of the local RFP applications for funding.

Leveraging and aligning resources is one of the state-level strategies identified to sustain the impact of reducing underage drinking in Alabama. The ADMH, as the administrative agency for the SPF-SIG, is organizing its existing prevention efforts around the five steps of the SPF. Internal efforts by ADMH include the SAPT BG, SPF-SIG, and an agency-wide initiative to infuse prevention into all agency programs, policies, practices, and planning. ADMH Technology supports, capacity enhancement, and learning partnerships have aligned processes to the five steps of the SPF. This infusion into internal agency operations will be combined with external partnerships with other state agencies who share responsibility for allocation of prevention resources.

As stated in the proposed SPF-SIG goals outlined by the State, Alabama will focus significant resources to build the capacity of the prevention workforce fielded to support community-based processes. With a coordinated and intentional effort to empower state and community workforce partners, Alabama will articulate a direction and established structures that connect key stakeholders across the state. State advisory councils with reporting structures that inform top government leaders coupled with community-based teams comprised of representatives of multiple sectors are a traditional approach to align systems to effect change. With the additional component of supporting learning through communities of practice within key sectors, Alabama holds the expectation that strategies will emerge to guide systems development and infusion of effective prevention programs, policies, and practices into each key sector that can be carried beyond the targeted geographic areas funded specifically by SPF-SIG funds. In this way, communities of practice will be a key component of SPF sustainment at both the state and community level.

C. Challenges

1. System Challenges

Although the ADMH has statutory responsibility for substance abuse services and codified

standards for providing the services, prevention in our state still has little structure. To further complicate matters, state-level planning and implementation efforts have historically focused on the management of our provider network rather than the management of our prevention service system as a whole. This challenge could potentially lend way to inertia within the provider network and disconnect of the remaining prevention system. Consequently, in Alabama, comprehensive, strategic prevention services such as those espoused by the SPF are sporadic, at best. The following are system issues that we have and/or continue to wrestle in Alabama, and are clear indicators of our need to enhance our infrastructure.

State and local level services tend to overlap resulting in redundancies;

Alabama prevention providers often fail to engage in activities that focus on community change. Critical activities such as community mobilization, capacity building, and environmental strategies are not given adequate chance to succeed;

Funding streams are not coordinated and often lead to service redundancies;

There is a need for increased evaluation and monitoring so that more reliable program participation reporting methods are developed;

There is a need to increase the number of programs that target economically disadvantaged populations. For example, some providers under serve rural (isolated populations), urban (inner city) populations, and economically disadvantaged youth and adults;

Since SPF encourages addressing prevention across life spans, we need to begin efforts to reach college and pre-school students, which traditionally are two of our larger underserved populations;

Gender specific programs should be utilized where appropriate;

Many of our service providers only began using EBPs in 2003 during our SIG project period, thus, there is a need for ongoing training and TA to ensure EBPs institutionalization;

The continuum of services should be expanded to include children under age five and the elderly. Both populations are underserved and are at risk of developing substance abuse problems; and

Local planners should examine the ethnic makeup of their programs and compare them to the ethnic makeup of their target community. Programs should perform additional outreach and needs assessment among these ethnic groups to understand how they can better meet their prevention needs.

Thus, one of the primary goals for the SPF-SIG is to build prevention capacity and infrastructure at the State and community levels. Increased capacity will allow Alabama to support effective substance abuse prevention services at both the state and local levels.

2. Technical Assistance Challenges

Notably, T/TA is critical to many of the aforementioned needs. Based on responses to the state prevention system assessment survey, identified training needs topics include SPF-SIG processes, evidence based programs and polices related to the priority, local evaluation

strategies, and CLI data collection. Other identified training needs include workforce development and retention. TA will be an integral component of sustaining implementation. Without the necessary skill sets and resources to employ, successful implementation will not come to pass. It is anticipated that after technical assistance is received, the Prevention Consultants will be integral in providing targeted TA services statewide. As such the Prevention Consultants are an existing training resource within the state. Additionally, training can be replicated and delivered through current semi-annual training efforts. At present, this office has a longstanding history of participating in two of the largest conferences (ACCMHB and ASADS) attended by community providers and coalitions. Potential obstacles and barriers to the aforementioned training opportunities are funding, travel, staffing and availability. Due to state funding shortages and the allocation of systems improvement funds, future opportunities of the prevention community to attend such conferences may be threatened. In addition to funding of conference participation, travel and workforce capacity has to be taken into consideration. Week long conferences may pose an inconvenience to an already limited staff program. As addressed earlier, virtual technical assistance and regional meetings/workshops may alleviate or reduce the funding, travel, and/or staffing issues.

3. Data-Driven Decision Making Challenges

Data-driven decision making process is largely unfamiliar in Alabama communities which lead to challenges in implementation of the process. A major challenge is data accessibility even though there are a number of data sources. There is not a central location where an individual can gather data on their community. Substance abuse data is gathered from many different agencies making ability to monitor substance abuse trends for the state difficult. The availability of county level data poses a challenge due to data sources not collecting data to that level. State level data sources that do collect county level data are concerned with confidentiality and are hesitant in release statistics at that level. Lastly, personnel in the communities usually do not have the related skill set related to developing a data-driven decision making process. Since allocation of funds has been primarily based upon historical funding, this process is new to many of the communities. The communities must learn new skills and language pertaining to the usage of data. Through the implementation of the SPF-SIG, the community will have the ability to building their capacity to utilize a data-driven process.

4. Implementation Challenges

A major grant initiative such as the SPF-SIG requires significant resources to ensure an organized and clearly articulated direction. The timeframe required to move fiscal resources through federal and state systems to communities is substantial and forces a need to coordinate within existing operating procedures. Positioning of multiple leverage points across state and community partnerships to effectively support the SPF also increases the magnitude and complexity of implementation. Because the Alabama prevention system has little structure, as discussed in the system challenges above, the infusion of new ideas (specifically the SPF model) will be challenging. As Alabama strengthens its prevention system through the SPF process, it is foreseen that innovative approaches will emerge and change management strategies will be applied with and by the individuals and systems that serve as change agents within the existing system. Understanding that the change process can generate concern within systems, the Alabama SPF-SIG Management Team sees the pending changes as a unique opportunity to be seized. Prevention resources and structures must converge in Alabama in ways that produce favorable conditions to advance prevention programs, policies, practices, and planning across multiple disciplines, cultures, and geographies. Enhancing systems and

networks to stimulate substantial growth to a scale in which effective prevention can occur poses an exciting challenge to the Alabama prevention network.

Alabama spans more than 52,000 square miles with varied geography and cultures. With target sites yet to be identified through the competitive grant process, the distance anticipated between state, communities, and prevention consultants will require substantial travel time and expense. The SPF-SIG Management Team is exploring ways to host virtual meetings for its SPF stakeholders. However, in terms of implementation challenges, new web-based systems and ways of operating may pose difficulties for stakeholders who did not grow up with today's technology, or have no access to such.

Although there is recognition of various challenges, the identification and implementation of strategic solutions cited above will enhance the effectiveness of the implementation of the SPF-SIG. Thus, positioning Alabama to successfully accomplish its three over-arching goals through this project; preventing the onset and reducing the progression of substance use, including underage drinking; reducing substance-related problems in Alabama communities; and building prevention capacity and infrastructure at the state and community levels.

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Appendix 1.

Management Team Members

Dr. Maranda Brown, Director of Prevention Services

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Beverly Johnson, SPF/SIG Coordinator

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Brandon Folks, Prevention Associate

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Lauren Blanding, CSAP Fellow

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Dr. Katherine Whiteley, Evaluator

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Appendix 1b.

The Prevention Director, Maranda Brown, holds a Doctor of Philosophy in Counselor Education and Supervision. She has more than 10 years of experience in the substance abuse and mental health field. In addition, she is an active duty member of the Alabama Air National Guard. Dr. Brown has vast experience in working with vulnerable populations prior to employment with DMH.

The SPF-SIG Coordinator, Beverly Johnson, holds a Master in Public Administration. She has proven strengths in substance abuse advocacy, prevention education, coalition building, coalition member sustainability and interpersonal relations. She has certifications from the Alabama Alcohol and Drug Abuse Association, Crisis Prevention Institute et al. In addition, she has worked with the AEOW, SPAB, and evaluation contractor to provide resources and technical assistance to communities in Alabama. Ms. Johnson also has vast experience in community programs, overseeing and implementing the Drug-Free Communities program, prior to employment with DMH.

The SPF-SIG Evaluator, Dr. Katherine Whiteley, holds a Doctor of Philosophy in Instructional Design and Development. She is a program evaluator and improvement consultant with expertise in all phases of program evaluation design, implementation, and dissemination. She offers services change management, strategic and business planning, implementation and assessment, grants research, writing, and management.

The Epidemiologist, Catina James, holds a Master of Public Health in Epidemiology. She has performed data analysis using SAS, Microsoft Excel, and Microsoft Access to develop data summaries and reports on the request of public health staff, private citizens and the press. Ms. James has provided expert and technical assistance to various professional and technical groups, community-based organizations, media and general public. In addition, she assumed final responsibility for statewide HIV/AIDS Surveillance data management including the collection, storage, analysis and presentation.

The Prevention Associate, Brandon Folks, holds a Master of Science in Management. He has worked with the Office of Prevention Services since 2008. Mr. Folks' has participated in numerous trainings including National Association of State Alcohol/Drug Abuse Directors (NASADAD), National Prevention Network (NPN), Community Anti-Drug Coalitions of America (CADCA), Center for Disease Control (CDC) National Conference on Health Communication, Marketing and Media et al. In addition, He has assisted in statewide trainings on CSAP strategies and ATOD.

The CSAP Fellow, Lauren Blanding, holds a Master of Public Health with a concentration in Epidemiology and Biostatistics. Prior to the current fellowship, Lauren interned with the Mississippi State Department of Health, District VIII, in Hattiesburg, MS where she studied and researched the incidence of premature birth and infant mortality and its effect on women in the United States; examined public health records of women in the Hattiesburg, MS and surrounding areas to determine factors associated with premature births; determined public health measures that need to be implemented to assist in better health outcomes and a decrease in infant mortality rates for the state of Mississippi.

Epidemiologist

The role of the Epidemiologist is to:

- Research additional data sources and add to the Alabama Community and State Profiles document;
- Interpret data and facilitate a comparative analysis;
- Summarize the data sources for each document and specify each data element for alcohol, tobacco and other drugs;
- Analyze all data and assess the significance of the overall differences in the Alabama profile data for both community and state level sources. The data will be assessed for statistical significance;
- Facilitate data formatting to enhance, update and create figures, tables and footnotes to adequately explain all data elements and sources that are reflected in all figures, tables and text;
- Provide general oversight and assistance on all aspects of the Epidemiological workgroup;
- Promote data-driven decision-making at all stages in the Strategic Prevention Framework;
- Promote cross systems planning, implementation, and monitoring efforts;
- Provide core support to the Prevention Systems Committee (SPF Advisory Council).

State Evaluator

The role of the State Evaluator is to:

- Develop appropriate evaluation designs (e.g., experimental, quasi- experimental) based on meaningful evaluation questions;
- Evaluate the technical characteristics of assessment instruments and protocols and help staff select appropriate instruments;
- Develop valid and reliable surveys, interview protocols, or other desired instruments;
- Implement the collection and management of evaluation data;
- Analyze quantitative and qualitative data;
- Write evaluation reports and communicate findings to diverse audiences; and translate findings into specific program recommendations;
- Attend all required meetings (grantee meetings, conferences, Center for the Application of Technologies meetings, State office meetings as other deemed necessary to fulfill the obligations of the grant);
- Assist with the Implementation process with community providers;
- Review “Lessons Learned” from other Cohort Evaluation methods;
- Attain technical assistance from the CAPT Evaluator and Programmatic staff members;
- Review the literature and develop a document on the chosen “drug” from the State Plan;
- Develop a Guidance Document for local and state stakeholders on Evaluation methods and informal tips;
- Develop tips for key informants, community stakeholders, focus groups and other community and state officials on methods to collect evaluation requirements;
- Monitor progress at the state and community level ongoing basis;
- Train local data collection experts to fulfill the obligation of the grant requirements;
- File quarterly and annual progress reports in accordance with SAMHSA and the Dept of Mental Health guidelines;
- Complete an annual site visits to all communities allocated funding through the SPF-SIG;
- Assist with training to community providers on facilitating system changes in the community;
- Assist the local SPF-SIG Coordinators via telephone, e-mail as appropriate;

- Assist the state Project Director and SPF-SIG Coordinator at the Department of Mental Health;
- Keep state office informed of all aspects of community stakeholder's progress, barriers and strengths.

Management Team – Prevention Director, SPF-SIG Project Director/Coordinator, Evaluator, Epidemiologist, Prevention Associate

The roles of the members of the Management Team are as follows:

Prevention Director

- Provide leadership and guidance to the work of the Epidemiological Workgroup;
- Provide leadership and guidance to the work of the SPF/SIG Project;
- Build community coalitions/community partnerships.

SPF/SIG Project Director/Coordinator

- Monitoring, coordinating, collaborating, and facilitating the mobilization efforts for Underage Drinking and other Alcohol, Tobacco, and Other Drugs (ATOD) issues in rural communities;
- Monitor the planning, implementation, and evaluation of coalition programs and services;
- Facilitating the Strategic Prevention Framework and ensuring that programs and services supported by the coalition are consistent with the coalition mission;
- Collaborate with community coalitions at community activities to enhance the community profile and will assist with the development of strategizing on Environmental outcomes, evidenced based practices and outreach initiatives;
- Work with the Alabama Epidemiological Outcomes Workgroup to assist the Evaluation Team to provide resources and technical assistance in the respective communities across Alabama and will submit reports, plans, and overall recommendations for contractual obligations to community service providers for reports to the Center for Substance Abuse Prevention (CSAP).

Prevention Associate

- Maintain an up-to-date list of AEW members and activities;
- Schedule and coordinate logistical arrangements for AEW meetings and related activities;
- Take minutes at all AEW meetings and distributing the minutes to members in a timely manner;
- Track and monitor the AEW's deliverable schedule and ensuring timely submission of deliverables;
- Assist the Epidemiologist in the preparation and dissemination of AEW activity reports and related documents;
- Enter data and assisting the Epidemiologist as needed with programming code and statistical analysis;
- Compile data from multiple sources and maintaining a database of available variables and data sources; and
- Correspond with federal agencies for technical assistance and/or regarding comments about AEW activities and deliverables.

CSAP Fellow – Center for Substance Abuse Prevention

The role of the CSAP Fellow is to:

- Assist the Prevention Director, SPF-SIG Coordinator, Epidemiologist, and Evaluator with strategic planning;

- Review epidemiological profile data and provide input on the relativity of the data and served populations;
- Interpret and utilize epidemiological data to determine if prevention programs are having desired results;
- Participate in continuing education opportunities as recommended and/or suggested by SPF-SIG Coordinator and/or Prevention Director;
- Facilitate and/or assist with Alabama Epidemiological Outcomes Workgroup Meetings, State Prevention Advisory Board Meetings and Evidence-based Practices Workgroup Meetings;
- Consult with prevention staff and advisory workgroups on ideas regarding the utilization of social media in prevention, such as Facebook, twitter, texting, mobile applications, etc.;
- Assist the Epidemiologist and Evaluator with needs assessments/evaluations, as needed;
- Contact current advisory group members, as well as recruit new members;
- Review SPF-SIG Model, SPF-SIG Advisory groups, Functions of the SPF-SIG Advisory Groups;
- Assist Alabama Epidemiological Outcomes Workgroup and State Prevention Advisory Board with SPF-SIG-related activities; and
- Assist SPF-SIG Coordinator with daily functions of SPF-SIG

CAPT – Collaborative for the Application of Prevention Technologies

The role of the CAPT is to:

- Provide Capacity-building training and Technical Assistance
 - Smash’s Strategic Prevention Framework
 - Use data to inform strategic planning
 - Select and implement evidence-based interventions

Types of T/TA provided

- Customized technical assistance to include facilitated group planning and resource sharing;
- In-person training to include statewide workshops/conferences; and
- Online events such as webinars and web-mediated teleconferences

Appendix 2.

Alabama Epidemiological Outcomes Workgroup (AEOW)
Members
2012

Name	Agency Affiliation	Sector	Region Representation
1. Brown, Maranda	<i>Director of Prevention Services</i> Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
2. Burks, Henry	<i>Chief Drug Inspector</i> Alabama Board of Pharmacy	State Partner	II
3. Burleson, Erin	<i>Prevention Consultant</i> South Regional Information Clearinghouse, Drug Education Council, Inc.	State Partner	III
4. Castaldo, Lisa	<i>Deputy Director</i> Governor's Office, Faith- Based and Community Initiatives	State Partner	III
5. Deavers, Penny	<i>President</i> Southern Prevention Associates, LLC	State-level Substance Abuse Prevention Partner	II
6. Douglass, Charon	<i>Prevention Consultant</i> North Regional Information Clearinghouse, Agency for Substance Abuse Prevention	State Partner	II
7. Gamble, Tomy	<i>Representative</i> Administrative Office of Courts	State Partner	III
8. Johnson, Beverly	<i>SPF-SIG Coordinator</i> Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
9. Leary, Joan	<i>Project Manager</i> Addiction Technology Transfer Center (ATTC)	State-level Substance Abuse Prevention Partner	II

Name	Agency Affiliation	Sector	Region Representation
10. Lewis, Marilyn	<i>Representative</i> Prevention and Support Services Section, Alabama State Department of Education	State Partner	III
11. Means, Cesily	<i>Outreach Specialist</i> Governor's Office, Faith-Based and Community Initiatives	State Partner	III
12. Nelson, Loretta	<i>Representative</i> Department of Revenue	State Partner	III
13. Oakes, Robert	<i>Assistant Executive Director</i> Pardons and Parole	State Partner	III
14. Pendergast, Pat	<i>Screening and Placement Coordinator</i> Department of Youth Services	State Partner	III
15. Quinn, Michael	<i>Program Coordinator</i> Department of Rehabilitation	State Partner	III
16. Reese, Sondra	<i>Representative</i> Department of Public Health	State Partner	III
17. Rogers, Shalandra	<i>Representative</i> Mothers against Drunk Driving (MADD), Non-profit	State-level Substance Abuse Prevention Partner	III
18. Shanks, Bill	<i>(Resource Provider)</i> Department of Public Safety	State Partner	III
19. Winningham, Janet	<i>Representative</i> Department of Human Resources	State Partner	III
20. Wright, Bennet	<i>Representative</i> Sentencing Commission	State Partner	III

Appendix 3.

ALABAMA EPIDEMIOLOGICAL OUTCOMES WORKGROUP CHARTER

A. OFFICIAL DESIGNATION

The name of this body shall be the Alabama Epidemiological Outcomes Workgroup (AEOW).

B. AUTHORITY

The AEOW shall operate under the authority of the Alabama Department of Mental Health and Mental Retardation (DMH/MR) as established by Alabama Acts 1965, No. 881, Section 22-50-2, and in conformance with Executive Order Number 23 signed by the Governor of Alabama on September 29, 2004 to establish the Alabama Commission for the Prevention and Treatment of Substance Abuse (ACPTSA). DMH/MR's Associate Commissioner for Substance Abuse Services serves as Chairperson of ACPTSA, as designated by the Executive Order, and is responsible for reports to the Governor's Office.

The AEOW was established on April 11, 2006 by authorization of ACPTSA and the DMH/MR Associate Commissioner for Substance Abuse Services and shall function as a permanent subcommittee of ACPTSA.

C. MISSION

The mission of the AEOW shall be to support state and community efforts to prevent substance abuse, dependency, and related problems by identifying, collecting, analyzing, and disseminating data that describes the prevalence, consumption, and consequences of alcohol, tobacco, and other drug (ATOD) use in Alabama.

D. OBJECTIVES

The objectives of the AEOW shall be to:

1. Provide ongoing surveillance, assessment, and analysis of the consumption and consequences of ATOD use throughout the State of Alabama.
2. Establish a process for collecting and reporting ATOD use and related data that is inclusive of all relevant data systems within and available to the State of Alabama.
3. Monitor state and community ATOD data needs and assist in the development of strategies to address those needs.
4. Collaborate with ACPTSA's Prevention Planning Committee to assist in planning efforts for unification of the ATOD prevention services system and implementation of the Strategic Prevention Framework.

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

E. ACTIVITIES

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

1. Establish and maintain an adequate membership base to support its mission.
2. Develop and maintain operational and reporting procedures for continued assessment, surveillance, analysis, and reporting of ATOD use/abuse and related problems throughout Alabama.
3. Identify ATOD consumption and consequence variables and the quality and validity of the data sources.
4. Collect and analyze qualitative and quantitative ATOD data.
5. Develop an annual State Epidemiological Profile that provides a description of the burden of substance abuse in the State of Alabama, including patterns of ATOD use, emerging trends, sub-group differences, and social and health consequences.
6. Develop and disseminate periodic reports on emerging ATOD use patterns and consequences.
7. Establish priorities and parameters for ATOD needs assessments. Assist in conducting statewide and community needs assessments.
8. Collaborate with community organizations and provide technical assistance and support for local ATOD prevention planning efforts.
9. Serve as a resource for each ACPTSA member agency to encourage and support the use of ATOD epidemiological data in the development and implementation of related public policy and funding strategies.
10. Submit timely reports of work, findings, and progress to DMH/MR, SAMHSA, ACPTSA, and the Governor's Office.
11. Establish collaborative partnerships with state and local universities and colleges to encourage the study, collection, and use of ATOD epidemiological information.
12. Comply with all state and federal reporting requirements.

F. COMPOSITION AND TERMS OF MEMBERSHIP

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

1. Each ACPTSA member agency will have the opportunity to appoint an organizational representative to the AEOW, who shall be selected on the basis of recognized data competence and interest in ATOD epidemiology. Appointing state and community organizations include:
 - Administrative Office of Courts;
 - Alabama Alcohol and Drug Association;
 - Alabama Association of Addiction Counselors;
 - Alabama Council of Community Mental Health Boards;
 - Alabama Faces and Voices of Recovery;
 - Alcoholic Beverage Control Board;

- Board of Pardons and Paroles;
- Department of Children’s Affairs;
- Department of Corrections;
- Department of Economic and Community Affairs;
- Department of Education;
- Department of Human Resources;
- DMH/MR Division of Mental Illness;
- DMH/MR Division of Mental Retardation;
- Department of Public Health;
- Department of Public Safety;
- Department of Rehabilitation;
- Department of Senior Services;
- Department of Youth Services;
- Governor’s Office of Faith-Based and Community Initiatives;
- Medicaid Agency;
- Office of the Attorney General;
- Office of the Governor;
- State House of Representatives; and the
- State Senate.

2.

DMH/MR’s Substance Abuse Services Division will appoint the following employees as members of the AEOW:

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

3.

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

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

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

G. OFFICERS

1. Officers of the AEW shall consist of a Chairperson and a Co-Chairperson. The AEW Chairperson, as designated by ACPTSA, shall be the Director of Prevention Services/NPN from the Substance Abuse Services Division. During a calendar year that ends in an even number, the Epidemiologist from the Substance Abuse Services Division shall serve as Co-Chairperson. During a calendar year that ends in an odd number, the Co-Chairperson shall be elected during the last quarter of the preceding calendar year by AEW members. A quorum is required for election of officers.
2. A quorum for the AEW shall consist of one-half of the active membership, with active being defined as attending at least one formal AEW meeting during the preceding year.
3. Chairpersons of permanent subcommittees shall be elected by the specific subcommittee's membership for a period not to exceed one year.
4. Chairpersons of any ad-hoc subcommittees shall be appointed by the AEW Chairperson or Co-Chairperson for a period not to exceed one year.

H. COMMITTEES

1. Permanent subcommittees shall be established by majority vote of the AEW membership at any regular meeting when a quorum is met.
2. Ad-hoc subcommittees shall be established by the AEW Chairperson or Co-Chairperson, as needed, to assist the AEW in the performance of its duties and/or to carry out specific tasks.
3. Subcommittee members shall be members of the AEW whose major interests and expertise fall within the role and scope of the designated committee.
4. Nominations may be made by the AEW membership for non-AEW members to serve on a particular committee. Invitations for participation of non-AEW members shall be rendered by the AEW Chairperson or Co-Chairperson.

I. RELATIONSHIP TO THE STATE PREVENTION SERVICES SYSTEM

1. The Single State Agency (SSA) is the Substance Abuse Services Division of DMH/MR and has statutory authority to manage and monitor Alabama's public system of prevention services and is working collaboratively with the ACPTSA to establish a unified prevention services system based upon the Strategic Prevention Framework.
2. The SSA will assume primary responsibility for the continued operation of the AEW and shall provide administrative support consisting of fiscal management, personnel support, space, supplies, equipment, and training.

3. The designated Chairperson of the AEW shall be the Director of Prevention Services/NPN. The Chairperson shall preside at all AEW meetings and shall serve as the workgroup's liaison to ACPTSA's Prevention Planning Committee.

4. The Epidemiologist from the Substance Abuse Services Division will have primary responsibility for the management of the AEW. Working in collaboration with AEW members, the Epidemiologist will develop data collection processes and obtain data for use by the AEW from multiple archival, administrative, and survey databases kept by various governmental and other agencies.

5. The Executive Assistant to the Associate Commissioner of the SSA will evaluate the AEW with regard to attainment of its stated goals and objectives and will submit evaluations to the AEW Chairperson and the SSA Director.

6. The SSA's Associate Commissioner, in his role as Chairperson of the ACPTSA, will utilize reports on the activities and findings of the AEW, along with recommendations, to support prevention service planning in the State of Alabama and to inform the Governor's Office as part of the ACPTSA's reporting requirements.

J. TIMELINE

Designation of AEW as a standing committee of the Alabama April 2006
Commission

Recruit AEW members Ongoing

Provide progress reports to SEOW Administrator Ongoing

Include links to AEW reports and documents on DMH/MR website Not approved yet

Submit quarterly reports of AEW activities Ongoing

Meet regularly and communicate (e.g. email, newsletter) between Ongoing meetings

Monitor and evaluate AEW progress toward attainment of goals. Ongoing

Submit data gap plan September 2007

Submit Community-level Epidemiological Profile November 2007

Submit State Epidemiological Profile February 2008

Submit AEW Charter February 2008

Submit NOMs Report March 2008

K. EVALUATION METHODOLOGY

An annual evaluation report shall be completed in September to determine:

1. The extent to which activities of the AEW are performed and objectives are attained.

2. The use of AEW documents and available data to inform state and community ATOD policies.

3. The use of AEOW documents and available data to update the state's prevention services system.
4. Strengths and weaknesses in the AEOW's organizational structure and procedures.
5. Opportunities for enhancement of the role and function of the AEOW.

L. WORKGROUP SCHEDULE

1. The AEOW shall meet as frequently as necessary to accomplish its mission, with the provision that a minimum of one formal meeting be held quarterly.
2. Subcommittees of the AEOW shall meet as needed to accomplish their stated purpose.

M. TERMINATION DATE

The AEOW shall be a continuous workgroup, subject to dissolution only with rescinding of Executive Order Number 23.

N. PRIMARY CONTACT

The primary points of contact for the AEOW shall be the Director of Prevention Services/NPN or the Epidemiologist for the Substance Abuse Services Division.

Appendix 4.

State Prevention Advisory Board (SPAB)
Members
2012

Name	Membership Category	Sector
1. Culberson, Maura Judge	<i>Juvenile Judge</i> Elmore County Juvenile Court	State Partner
2. Deavers, Penny	<i>President</i> Southern Prevention Associates, LLC	State-level Substance Abuse Prevention Partner
3. Forbes, Laura	<i>Assistant Professor of Health Education</i> Department of Human Studies	State-level Substance Abuse Prevention Partner
4. Foster-Payne, Pamela, M.D.	<i>Deputy Director</i> Rural Health, University of Alabama-Tuscaloosa	State-level Substance Abuse Prevention Partner
5. Garrison, Ruby	<i>Human Resource Manager</i> Big Lots Distribution Center, Inc. (Retail)	State-level Substance Abuse Prevention Partner
6. Goodwin, Kathy	<i>Substance Abuse Director</i> 310 Board Representative	Prevention Provider
7. Jones, Anne-Marie	<i>Prevention Coordinator, Cherokee County Substance Abuse Council (Advocacy)</i>	Prevention Provider
8. Keith, Jamie	<i>Executive Director</i> Alabama Campaign to Prevent Teen Pregnancy	State-level Substance Abuse Prevention Partner
9. Kelly, Emily	<i>Community Projects Director</i> Alabama Coalition against Domestic Violence (ACADV)	State-level Substance Abuse Prevention Partner
10. Long-Cohen, Leigh	<i>Behavior Intervention Coordinator</i> Homewood City Schools	State-level Substance Abuse Prevention Partner

11. Myles, Lori	<i>Sheriff's Assistant for Public Affairs</i> Mobile County Sheriff's Office	State-level Substance Abuse Prevention Partner
12. Peterson, Dave CMSgt. AL ANG	Drug Demand Reduction Admin. Counter Drug Program, United States Armed Forces	State Partner
13. Pierre, Vandlyn	<i>Director</i> South Regional Clearinghouse, Drug Education Council, Inc.	Prevention Provider
14. Price, Kelly	<i>Director</i> North Regional Clearinghouse, Agency for Substance Abuse Prevention	Prevention Provider
15. Robertson, Tom	HIV Prevention Education	State Partner
16. Robinson-Cooper, Vickie	<i>Division Director</i> Department of Human Resources	State Partner
17. Schaffer, Tonia	CSAP	State Partner
18. Soule, Deborah	<i>Executive Director</i> Partnership for a Drug-free Community, Non-profit	State-level Substance Abuse Prevention Partner
19. Summerville, Curtis	<i>State Trooper</i> Department of Public Safety	State Partner
20. Thompson, James	<i>Executive Director</i> Alabama Association of Child Care Agencies (AACCA) Brewer-Porch Children's Center	State-level Substance Abuse Prevention Partner
21. Toney, Jim	<i>Education Specialist</i> Prevention and Support Services Section, Alabama State Department of Education	State Partner
22. Warren, Earl	<i>Director, Office of Institutional Development</i> Jacksonville State University	State-level Substance Abuse Prevention Partner
23. Watson, Gay	<i>Associate State Director of AARP in Alabama</i> Non-profit, Financial Agency	State-level Substance Abuse Prevention Partner
24. Wyckoff, Shelley	<i>(retired)</i> Professor of Social Work Alabama A&M University	State-level Substance Abuse Prevention Partner

Appendix 5.

Evidence-based Practice (EBP) Work Group
Members
2012

Name	Membership Category	Sector	Region Representation
1. Cheka, Rev. J Sandor III	<i>Executive Directive</i> The Addiction Coalition	State-level Substance Abuse Prevention Partner	II
2. Deavers, Penny	<i>President</i> Southern Prevention Associates, LLC	State-level Substance Abuse Prevention Partner	II
3. Hayes, Jenny	<i>Operations Director</i> The Addiction Coalition	State-level Substance Abuse Prevention Partner	II
4. Hooper, Gail	<i>Representative</i> Drug Education Council	Prevention Provider	IV
5. Lewis, Marilyn	<i>Representative</i> Prevention and Support Services Section, Alabama State Department of Education	State Partner	III
6. Mayo, Greg	<i>Representative</i> Mental Healthcare of Cullman	Prevention Provider	I
7. Short, Susan	<i>Executive Director</i> Covington County Children's Policy Council Coalition	State-level Substance Abuse Prevention Partner	IV

Appendix 6.

Alabama Certified Prevention Provider Network

Prevention Provider	County	Services Provided	Contracted w/ ADMH?	Under “auspices of the 310 Boards”?	Drug-Free Community Grantee?	Stand Alone?
Agency for Substance Abuse Prevention	Calhoun	Prevention	Yes	No	Yes	Yes
Alcoholism Recovery Services	Jefferson	Treatment and Prevention	Yes	Yes	No	No
Alethia House	Jefferson	Treatment and Prevention	Yes	No	No	No
Baldwin County Mental Health	Baldwin	Treatment and Prevention	Yes	Yes	No	No
Cahaba Center for Mental Health	Dallas	Treatment and Prevention	Yes	Yes	No	No
CED Mental Health Center	Etowah	Treatment and Prevention	Yes	Yes	No	No
Cheaha Mental Health Center	Talladega	Treatment and Prevention	Yes	Yes	No	No
Cherokee County Substance Abuse Council	Cherokee	Prevention	Yes	Yes	No	Yes
Chilton/Shelby Mental Health	Chilton	Treatment and Prevention	Yes	Yes	No	No
Council on Substance Abuse/NCADD	Montgomery	Prevention	Yes	No	Yes	Yes
Drug Education Council	Mobile	Prevention	Yes	No	No	Yes
East Alabama Mental Health Center	Lee	Treatment and Prevention	Yes	Yes	No	No
East Central Alabama Mental Health Center	Pike	Treatment and Prevention	Yes	Yes	No	No
Franklin Primary Health Center, Inc	Mobile	Treatment and Prevention	Yes	No	No	Yes
Gateway (Family & Child Services)	Jefferson	Prevention	Yes	No	No	Yes
Indian Rivers Mental Health Center	Tuscaloosa	Treatment and Prevention	Yes	Yes	No	No
JCCEO (Jefferson County Committee for Economic Opportunity)	Jefferson	Treatment and Prevention	Yes	No	No	No
Lighthouse Counseling Center, Inc.	Montgomery	Treatment and Prevention	Yes	No	No	Yes
Marshall-Jackson Mental Health Center	Marshall	Treatment and Prevention	Yes	Yes	No	No
Mental Healthcare of Cullman	Cullman	Treatment and Prevention	Yes	Yes	No	No
Mental Health Center of Madison County	Madison	Treatment and Prevention	Yes	Yes	No	No
Mental Health Center of North Central	Morgan	Treatment and Prevention	Yes	Yes	No	No
Northwest Alabama Mental Health Center	Walker	Treatment and Prevention	Yes	Yes	No	No
Oakmont Center	Jefferson	Treatment and Prevention	Yes	No	No	No
Riverbend Substance Abuse Services	Lauderdale	Treatment and Prevention	Yes	Yes	No	No

Prevention Provider	County	Services Provided	Contracted w/ ADMH?	Under "auspices of the 310 Boards"?	Drug-Free Community Grantee?	Stand Alone?
SAYNO of Montgomery, Inc.	Montgomery	Prevention	Yes	No	No	Yes
Southwest Alabama Mental Health Center	Monroe	Treatment and Prevention	Yes	Yes	No	No
SpectraCare (Wiregrass Mental Health Center)	Houston	Treatment and Prevention	Yes	Yes	Yes	No
St. Clair County Day Program	St. Clair	Prevention	No	No	No	Yes
TEARS (Teens Empowerment Awareness w/Resolutions, Inc.)	Russell	Prevention	No	No	No	Yes
UAB Substance Abuse Programs	Jefferson	Treatment and Prevention	Yes	Yes	No	No
West Alabama Mental Health Center	Demopolis	Treatment and Prevention	Yes	Yes	No	No

Appendix 7.

Alabama Prevention Coalitions

Selma-Dallas Prevention Collaborative Coalition		
Coalition Member	Role/Title	Responsibility
Coley Chestnut	Director	Manage Selma Dallas Prevention Collaborative (SDPC) affairs
Tracey Craig	Chairperson	Consults and directs SDPC meetings; supports SDPC events and decisions.
Robert Williams	Vice Chairperson	Conducts SDPC meetings in the absence of the chairperson
Dorothy Cowans	Treasurer	Serves in the responsibilities of SDPC finances
Joyce Kendricks	member	Supports SDPC functions
Callie Nelson	member	Supports SDPC functions
Frank Boggan	member	Supports SDPC functions
Tonya Chestnut	Secretary	Documents meeting minutes; assists with correspondences
Jeannie Ward	member	Directs youth meetings and functions
Jessica Chestnut	member	Grant writer; assists in reporting.
Joslyn Reddick	member	Selma City Schools representative
Carolyn Pickett	member	Supports SDPC functions
Karlynn Johnson	member	Supports SDPC functions
Pastor James Spicer	member	Supports SDPC functions
Corie Bowie	member	Supports SDPC functions
Dr. Kirit Chatpatwala	member	Supports SDPC functions
Barabara Brown	member	Supports SDPC functions
Ronald People	member	Supports SDPC functions
Dario Melton	member	State Representative
Montgomery Unified Prevention System Coalition		
Coalition Member	Role/Title	Responsibility
Tim Baker	Montgomery Public Schools	Provides PRIDE Survey data annually from 6th-12 grade public school students and helps get into schools for presentations

Lt. William Carson	ABC Compliance Officer	Provides alcohol and tobacco compliance check data monthly
Sheri Jones	Youth Advisory Board President	Serves as a link between youth, their schools, and City Council
Cindy Bisbee	Director of Montgomery Area Wellness Coalition	Provides up-to-date health care information for the coalition
LaKia Richardson	WCOV/FOX	Provides PSA's and media support for all grants and community events
Rev. Nettles	Pastor at Freewill Baptist Church	Provides church space, speaks at local events, and provides resources to the community.
Clare Watson	City of Montgomery	Provides a great connection to state, local, and government agencies
Shalandra Rogers	MADD	Provides up-to-date drunk driving statistics and serves on the MUPS Coalition as well as sub-committee's
Wesley Gallops	Greater Montgomery Home Builder's Association	Provides resources for the MUPS Coalition and the YouthBuild Montgomery and Generation Build Projects
Richard Jones	Parent	Helps with community events, reaching other parents, and providing MUPS with concerns parents have with substance abuse.
Kim Wasington	Director at E.D. Nixon	Provides the community center for community events and alternative activities, after school programs, and attends coalition meetings
Beth Malone	Director of CAP	Serves on the MUPS Coalition and CREST Steering Committee and offers recovery resources for the CREST Project
Elmore County Partnership for Children, Inc.		
Coalition Member	Role/Title	Responsibility
Judge Maura Culberson	Juvenile Judge	Chairman of Coalition, Ex-Officio member of Partnership
Dennis Hill	President	Elmore County Partnership for Children, Elmore Co Sheriff's Department
Delane Goggans	Sec/Tres	Elmore County Partnership for Children, Elmore Co Chief Juvenile Probation Officer
Amanda Golson	Sec	Elmore County Juvenile Court, Judicial Assistant

Jenny Hamilton	V-Pres	Elmore County Partnership for Children, Elmore Co District Attorney's Office
Vicky Bonner-Ward	Board Member	Elmore County Partnership for Children, Coordinator Juvenile Conference Committee
Cecelia Ball	Board Member	Elmore County Partnership for Children, Retired from DHR
Jody Waites	Board Member	Elmore County Partnership for Children, Retired from ADECA
Bill Franklin	Sheriff	Ex-Officio ECPFC, Sheriff Elmore County
Billy Womble	Director FSP	Retired ECBOE, Family Support Program
Louie Fryer	Senior Coordinator	Administrative Services Elmore County Board of Education
June Myers	Program Director	Elmore County Partnership for Children, SOAR Director, SOS
Pamela Johnson	Director Youth Prog	Elmore County Partnership for Children, SOS/UPS afterschool
Emma Bass	Program Staff	ECPFC Student Outreach Services At-Risk
Therisa Gilbert	Program Staff	ECPFC Student Outreach Services At-Risk
Lt Robert Johnson	Safety Committee	Millbrook PD, School Resource Officer
Officer Scott Beckam	Safety Committee	Tallassee PD, School Resource Officer
Michelle Wood	Child/Parent	Director Elmore Co DHR
Eloyse Seamon	Education	ECBOE Student Services Coordinator
Owen Duke	Safety Committee	Department of Youth Services
Angela Daniel	Child Parent Com	AllKids
Essie Woodson	Child/Parent Com	Medicaid
Tammy Coates		Department of Children's Affairs
Katrina Mitchell	Child/Parent Committee	Elmore County Extension
Alice Murphy		Counsel on Substance Abuse
Kim Adams		Alabama Power
Carolyn White		Poarch Creek Indians
Deborah Davis	Child/Parent Comm	Wetumpka Preschool
Bertha Brown		CIA-Kids Journey

Holly Christian		Elmore County Department of Human Resources
Jenny Story		Elmore County Department of Human Resources
Julia Rigsby		Elmore County Department of Human Resources
Joan Micelli		Mental Health
Doug Hall		Alabama Parent Education Center
Timberly Williams		Alabama 211
Shemiah Owens		Helping Family Initiative
Dr. Jeff Langham	Education Committee	Superintendent, Elmore County Board of Education
Emily Law		Director Elmore County Boys and Girls Club
Ssgt. Christopher Harris		Al. National Guard Counter Drug Program
Linda Church	Education Committee	Information Technology Services

Appendix 8.

Alabama Epidemiological Profile

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Appendix 9.

Prevention System Assessment

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Appendix 10.

Appendix 10 —Data sources Reviewed for the Epidemiological Profile for Alabama.						
Data Source	Availability	Validity	Consistency	Periodic Collection over at least 3-5 Yrs	Sensitivity	Limitations
National Data Sources Included in the Epi Profile						
Sales Data from the Alcohol Epidemiologic Data System (AEDS)	http://pubs.niaaa.nih.gov/publications/surveillance.htm ; Also available at Behavioral Health Indicator System (BHIS) http://204.52.186.105/	Total Sales of Ethanol per Year per Capita	A centralized, national repository of alcohol-related data sets. AEDS obtains annual alcoholic beverage sales data from Alabama. Sales data are believed to reflect actual consumption of alcoholic beverages more accurately than production and shipment data from beverage industry sources. Per capita consumption of absolute alcohol has been used historically as an indicator of overall drinking within a state and has been shown to be correlated with many types of alcohol problems.	1990-2008	Able to detect changes (with reservations due to the limitations) associated with substance use over time	Estimates may be inflated due to consumption by non-residents (e.g., tourists and other visitors). Untaxed alcohol (e.g., products that are smuggled or homemade) are not captured in this indicator.
Alcohol Related Disease Impact (ARDI)	http://apps.nccd.cdc.gov/ARDI/HomePage.aspx	Alcohol-Attributable Death, Years of Potential Life Lost, Alcohol-Attributable Fractions	An online application that provides national and state estimates of alcohol-related health impacts, including deaths and years of potential life lost (YPLL). These estimates are calculated for 54 acute and chronic causes using alcohol-attributable fractions, and are reported by age and sex.	Average for years 2001-2005	Unable to detect changes associated with substance use over time. Provides alcohol risk factor data	Survey subject to potential bias due to self-report, non-coverage (households without landlines), and non-response (refusal/no answer) Subject to underestimation because of potential bias due to self-report, nonresponse, recall and non-coverage (households without landlines). May miss former drinkers due to the use of past 30 day alcohol consumption
Behavioral Risk Factor Surveillance System (BRFSS)	http://www.cdc.gov/brfss/ ; Also available at Behavioral Health Indicator System (BHIS) http://204.52.186.105/	Binge Drinking, Current Alcohol Use, Drinking & Driving, Current Use of Cigarettes, Current Daily Use of Cigarettes	An annually conducted telephone health survey system, tracking health conditions and risk behaviors in the US.	1995-2010	Able to detect changes associated with substance use over time	Telephone survey subject to potential bias due to self-report, non-coverage (households without landlines), and non-response (refusal/no answer).

Fatality Analysis Reporting System (FARS)	http://www.nhtsa.dot.gov/pportal/site/nhtsa/menuitem.0efe59a360fbaad24ec86e10dba046a0/ ; Also available at Behavioral Health Indicator System (BHIS) http://204.52186.105/	Alcohol-related Vehicle Death Rate, Fatal Crashes among Alcohol-Involved Drivers, Fatal Crashes that are Alcohol-related	A annual nationwide census maintained by the National Highway Traffic Safety Administration containing data on fatal injuries suffered in motor vehicle traffic crashes.	1990-2009	Able to detect changes associated with substance use over time	The blood alcohol concentration (BAC) values for all drivers involved in fatal crashes were not complete so estimates were calculated for cases missing data.
National Survey on Drug Use and Health (NSDUH)	http://www.oas.samhsa.gov/states.htm ; Also available through SEDS at http://www.epidcc.samhsa.gov/default.asp	Alcohol Abuse or Dependence, Binge Drinking, Current Cigarette Smoking, Current Use of Alcohol, Current Use of Illicit Drugs other than Marijuana, Current Use of Marijuana, Drug Abuse or Dependence	A national survey designed to track changes in substance use patterns for US residents 12 years of age and older, asking respondents to report on past month, past year, and lifetime use of substances including alcohol, tobacco, marijuana, cocaine, and other illicit drugs. The survey also asks respondents whether they had received treatment for drug abuse or drug dependence during the past year.	2002-2008	Able to detect changes associated with substance use over time	The estimates are subject to bias due to self-report and non-response (refusal/no answer). There is usually a two-year delay between the time data are gathered and the time when data are made available to the public.
National Vital Statistics System Mortality (NVSS-M)	http://www.cdc.gov/nchs/deaths.htm	Chronic Liver Disease, Death due to Drug-Related Behavior, Death from all Drug-Related Poisonings, Homicide, Suicide	NVSS-M an annually collected data set generated from death certificate information collected through the National Vital Statistics System, an inter-governmental collaboration between the National Center for Health Statistics (NCHS) and the 50 States, two cities, and five territories. The NVSS-M data serve as the primary source of information on demographic, geographic, and cause-of-death information among persons dying in a given year. Variables include the following: year, month, and day of week of death; place of death; residence of decedent (State, county, city, population size, standard metropolitan statistical area, metropolitan and nonmetropolitan counties); State and county of occurrence; demographic information; underlying cause of death; and multiple causes of death.	1990-2006	Unable to detect changes associated with substance use over time	The stability of NVSS-M is directly related to the size of the population in which deaths occur. This creates the potential for unstable indicator(s) for less populated states and communities that have low numbers of annual deaths, especially when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death.

Sales Data for Tobacco Products	http://204.52.186.105/DataSource/DSalesT.aspx?Content=SalesT&menuID=4&ST1=TXT&ST2=TXT&font=	Cigarette Packs Taxed	Report per capita annual sales data of packs of cigarettes for the total population and the adult population (18 years or older) for the 50 States, the District of Columbia, and the United States as a whole.	1990-2007	Able to detect changes associated with substance use over time	Average consumption levels may not be sensitive in identifying areas with a high prevalence of heavy use where there are also high rates of abstinence. Estimates may be inflated due to consumption by non-residents (e.g., tourists and other visitors). Untaxed cigarettes (e.g., products that are smuggled or homemade) are not always captured.
Treatment Episode Data Set (TEDS)	http://www.dasis.samhsa.gov/webt/tedsweb/tab_year_choose_year?t_state=AL	Alcohol Abuse, Drug Abuse, Demographic and Substance Abuse Characteristics	A compilation of data on the demographic and substance abuse characteristics of admissions to substance abuse treatment. Designed to provide data on the number and characteristics of persons aged 12 or older admitted to public and private substance abuse treatment programs receiving public funding in all 50 States, the District of Columbia, and Puerto Rico.	1992-2010	Able to detect changes associated with substance use over time	Admissions do not represent individuals; TEDS is unable to follow individual clients through a sequence of treatment episodes. The number and client mix of TEDS admissions does not represent the total national demand for substance abuse treatment, nor the prevalence of substance abuse in the general population. The primary, secondary, and tertiary substances of abuse reported to TEDS are those substances which led to the treatment episode, and not necessarily a complete enumeration of all drugs used at the time of admission.
Uniform Crime Reports (UCR)	http://www.fbi.gov/ucr/ucr.htm ; Also available at Behavioral Health Indicator System (BHIS) http://204.52.186.105/	Drug-related Property Crime rates including burglary, larceny, and motor vehicle theft, Alcohol-related Violent Crime Rates including assaults and robberies	Law enforcement agencies that participate annually in the UCR Program forward crime data through Alabama's UCR Program. Property crimes frequently are committed in order to obtain money to purchase drugs. Drinking on the part of the victim or a perpetrator can increase the risk of	1994-2007	Able to detect changes (with reservations due to the limitations) associated with substance	Reported violent/property crimes are an under report of the total number of actual violent crimes. No perpetrator information is unavailable to determine if they have been drinking or using illicit drugs. Estimates of the percentage of crimes attributable to

			assaults and assault-related injuries.		use over time	alcohol/illicit drugs are derived primarily from self-reports of incarcerated perpetrators of the crimes.
Youth Risk Behavior Survey (YRBS)	http://www.cdc.gov/yrbss	Binge Drinking, Current Daily Use of Cigarettes, Current Use of Alcohol, Current Use of Cocaine, Current Use of Inhalants, Current Use of Marijuana, Current Use of Cigarettes, Current Use of Smokeless Tobacco, Drinking and Driving, Initiation of Alcohol Use, Initiation of Cigarette Use, Initiation of Marijuana Use	A national school-based survey conducted in odd years by the Centers for Disease Control and Prevention (CDC) designed to produce a nationally representative sample of students in grades 9 through 12. Key variables include unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; unhealthy dietary behaviors; and physical inactivity.	1991-2011	Able to detect changes associated with substance use over time	YRBS is a school-based survey, so students who have dropped out of school are not represented. It is also subject to bias due to self-report, non-coverage (refusal by selected schools to participate), and non-response (refusal/no answer). Not all states participate, and some participating states do not provide representative samples.
State Data Sources Included in the Epi Profile						
Alabama Criminal Justice Information Center (ACJIC)	http://www.acjic.alabama.gov/ ; http://acjic.state.al.us/crime.cfm	Crime Arrests by Age, Property Crime, Violent Crime, Homicide, Rape, Robbery, Assault, Burglary, Larceny, Motor Vehicle Theft, Arson, Liquor and Drug Abuse Arrests, Drug Sales and Possession Arrests	An annual Alabama crime publication of the ACJIC Statistical Analysis Center (SAC) intended to inform law enforcement officials and private citizens of criminal and law enforcement activity in the state. State law mandates that all crimes are reported from state, county and local law enforcement agencies, and the statistics presented in this report are compiled from these reports.	1977-2011	Able to detect changes associated with substance use over time (with reservations due to limitations)	Citizens or the media are cautioned against drawing conclusions by making direct comparisons between statistics submitted by cities or individual agencies, particularly when the increased reporting from previous years. It is important to note that there are unique conditions that affect each law enforcement jurisdiction, and valid assessments are only possible with careful study and analysis of the conditions that affect each law enforcement jurisdiction.
Pregnancy Risk Assessment Monitoring	http://www.adph.org/healthstats/index.asp?ID=1518 ; Also available at Behavioral Health	Alcohol Use By Pregnant Women, Smoking by Pregnant Women	An annual mail/telephone survey that collects information from new mothers about their behaviors and experiences before, during, and	1990 to 2010	Able to detect changes associated with	Survey subject to potential bias due to self-report, non-coverage (households without landlines), and

System (PRAMS)	Indicator System (BHIS) http://204.52.186.105/		after pregnancy.		substance use over time	non-response (refusal/no answer).
Alabama Pride Survey (PRIDE)	http://www.pridesurveys.com/Reports/index.html#state	Tobacco, alcohol, drug use data among students in Alabama	An annual survey 6th-12th grade public school students	2002-2003 to 2009-2010	Able to detect changes associated with substance use over time	Data not collected on students who do not attend public schools nor youth who are not attending school.
Alabama Youth Tobacco Survey (ALYTS)	http://www.adph.org/tobacco/assets/TobaccoBurdenReport2011.pdf ; http://www.adph.org/tobacco/Default.asp?id=1941	Cigarette Use, Smokeless Tobacco Use, Cigar Use, Pipe Use, Bidis Use, keteks Use, Knowledge and Attitude, Media and Advertising, Access and Enforcement, School Curriculum, Exposure to environmental Tobacco Smoke, Cessation	A bi-annual survey conducted by the Tobacco Prevention and Control Division of the Alabama Department of Public Health (ADPH), through a grant from the Office on Smoking and Health, Centers for Disease Control and Prevention (CDC). The survey is administered to Alabama middle school and high school students, grades 6-12, parallel with the National Youth Tobacco Survey (NYTS). Both surveys are designed to document tobacco-related knowledge, attitudes and behaviors among students. Those students that claim to have smoked cigarettes on one or more days in the past 30 days preceding the survey are considered current youth smokers.	2000-2010	Able to detect changes associated with substance use over time	The survey is based on self-report; therefore students can provide inaccurate information. Conducted every other year versus every year, and uses students only in grades 6th-12th. Not all schools participate in distribution of the survey.
Data Sources Excluded from the Epi Problem						
Alabama Accidents Summary	http://dps.alabama.gov/Home/wfContentTableItem.aspx?ID=10&PLH1=ADMINACCIDENTSUMMARY	Alcohol Involvement by Age	A document contains data related to motor vehicle accidents in Alabama. Data is collected by the Alabama Dept. of Public Safety annually.	2005-2008	Able to detect changes (with reservations due to the limitations) associated with substance use over time	Data only readily available for four years.

Automation of Reports and Consolidated Orders System (ARCOS)	www.deadiversion.usdoj.gov/arcos/index.html	Controlled Substances	An automated, comprehensive drug reporting system (registrants must report quarterly) which monitors the flow of DEA controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level - hospitals, retail pharmacies, practitioners, mid-level practitioners, and teaching institutions.	1997-2007	Unable to detect changes associated with substance use over time	Only 1,100 distributors and manufacturers report to ARCOS, but there are over 1,000,000 registrants in DEA's Controlled Substance Act database.
Centers for Disease Control and Prevention Wide-ranging OnLine Data for Epidemiologic Research (CDC Wonder)	http://wonder.cdc.gov/	Mortality	An online database administrated by Centers for Disease Control & Prevention (CDC) for the analysis of public health data. Annual data is made available	1999-2009	Able to detect changes associated with substance use over time	The database is an analysis tool for mortality gathered from the National Center of Health Statistics - NVSS-M
Federation of Tax Administrators (FTA)	http://www.taxadmin.org/fta/rate/tax_stru.html#Excise	State Income (individual and corporate) Tax, State Sales (food, drugs, vendor, and holiday) Tax, State Excise (motor fuel, cigarette, other tobacco products, distilled spirits, wine, and beer, estate) Tax,	An annual administration organized in 1937 to improve the quality of state tax administration by providing services to state tax authorities and administrators. These services include research and information exchange, training, and intergovernmental and interstate coordination. The Federation also represents the interests of state tax administrators before federal policymakers where appropriate.	2002-2012	Able to detect changes associated with substance use over time	FTA does not maintain historical tax rate data. This is only representative of tax dollars for the state, and not individual use and/or abuse.
Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)	http://apps.nccd.cdc.gov/sammecc/	Smoking-Attributable Mortality, Years of Potential Life Lost (YPLL), Smoking-Attributable Infant Mortality, Medical Expenditures	An online application that allows you to estimate the health and health-related economic consequences of smoking to adults and infants. The SAMMEC program contains two distinct Internet-based programs: the adult SAMMEC application provides	2000-2004	Able to detect changes associated with substance use over time	Since this is a Federal Government system, authorized users are only permitted to obtain information relative to smoking habits with infants and adults.

			users the ability to estimate Smoking-Attributable Mortality (SAM), YPLL, medical expenditures, productivity losses, SAM rate and YPLL rate. The Maternal and Child Health (MCH) SAMMEC application provides users the ability to estimate smoking-attributable infant deaths, YPLL and excess neonatal health care costs.			
State Health Facts - Alabama	http://www.statehealthfacts.org/profileind.jsp?ind=507&cat=11&rgn=2	AIDS Diagnoses by Exposure Category	A website conducted by the Henry J. Kaiser Family Foundation and is designed to provide free, up-to-date (annual), and easy-to-use health data for all 50 states.	From the beginning of the epidemic through 2010	Unable to detect changes associated with substance use over time	Data is total of number of cases over time; can not determine individual years
The Tax Burden on Tobacco	http://nocigtax.com/upload/file/148/Tax_Burden_on_Tobacco_vol_45_FY2010.pdf	Per Capita Sales of Tobacco	The annual document on tobacco revenue and industry statistics. Compiled of data from tobacco tax administrators, the U.S. Department of Treasury's Alcohol and Tobacco Tax Trade Bureau. Also, a data from an annual price survey of cigarette retailers.	1950-2009	Able to detect changes (with reservations due to the limitations) associated with substance use over time	Underestimates sales data due to self-reported bias. Some sales may go out of state; not all cigarettes purchased are actually smoked; smokers may round daily consumption down to the nearest half-pack.

Appendix 11.

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
Alcohol Consequences		
Alcohol-related mortality	# of alcoholic chronic liver disease deaths	NVSS-M
	Rate for alcohol suicide deaths	NVSS-M
	Years of potential life lost due to alcohol-related deaths	ARDI
	# of alcohol attributable deaths	ARDI
Motor vehicle crashes	Rate of deaths sustained in vehicle crashes that were alcohol-involved per 100,000 Population	FARS
	% of drivers involved in fatal crashes	FARS
	% of Drivers in Fatal Crashes Who Were Alcohol-positive	FARS
Crime	# of arrests for alcohol violations	ACJIC
	Rate of Aggravated Assaults per 1,000 Population	UCR
	Rate of Robberies per 1,000 Population	UCR
	Rate of Sexual Assaults per 1,000 Population	UCR
	Rate of violent crimes per 1,000 Population	UCR
	Rate for alcohol homicide deaths	NVSS-M
Treatment	% of total admissions reporting any use of alcohol	TEDS
	% of total admissions reporting alcohol as their primary substance of abuse	TEDS
Treatment Gap	% of persons aged 12 to 17 needing but not receiving treatment for alcohol use	NSDUH
	% of person age 18 to 25 needing but not receiving treatment for alcohol use	NSDUH
	% of person age 26 or older needing but not	NSDUH

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
	receiving treatment for alcohol use	
	% of persons ages 12 or older needing but not receiving treatment for alcohol use	NSDUH
Abuse or dependence	% of persons aged 12 or older reporting alcohol dependence/abuse	NSDUH
	% of persons aged 12 to 17 reporting alcohol dependence/abuse	NSDUH
	% of persons aged 18 to 25 reporting alcohol dependence/abuse	NSDUH
	% of persons aged 26 or older reporting alcohol dependence/abuse	NSDUH
Alcohol Consumption		
Age of Initial Use	% of youth in 9th-12th grades reporting first use of alcohol before age 13	YRBS
Current Use	% of youth in 9th-12th grades reporting use of alcohol in past 30 days	YRBS
	% of persons 12 and older reporting alcohol use in past 30 days	NSDUH
	% of persons age 12-17 reporting alcohol use in past 30 days	NSDUH
	% of persons age 18-25 reporting alcohol use in past 30 days	NSDUH
	% of persons age 26 or older reporting alcohol use in past 30 days	NSDUH
	% of persons age 12-20 reporting alcohol use in past 30 days	NSDUH
	% of students in grades 6-12 reporting use of alcohol during past month	PRIDE
	% of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS
Current Binge Drinking	% of persons 12 and older reporting binge drinking in past 30 days	NSDUH
	% of persons age 12-17 reporting binge drinking in past 30 days	NSDUH
	% of persons age 18-25 reporting binge drinking in past 30 days	NSDUH
	% of persons age 26 or older reporting binge drinking in past 30 days	NSDUH
	% of persons age 12-20 reporting binge drinking in past 30 days	NSDUH
	% of youth in 9th-12th grades reporting binge	YRBS

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
	drinking in past 30 days	
	% of students in grades 6- 12 reporting having 5 or more drinks within a few hours	PRIDE
	% of adults (aged 18 or older) reporting binge drinking in past 30 days	BRFSS
Current Heavy Drinking	% of adults (aged 18 and older) reporting heavy drinking in past 30 days	BRFSS
	% of adults (aged 18 and older) drinking/driving past 30 day use	BRFSS
Drinking and driving	% of students in 9th-12th grade who reported driving when they had been drinking alcohol	YRBS
	% of students in 6th-12th grade who reported driving when they had been drinking alcohol	PRIDE
Total ethanol consumption per capita	# of sales of ethanol per 10,000 population	AEDS
Alcohol Risk/Protective Factors		
Alcohol Use during Pregnancy	% of mothers who reported drinking before and during pregnancy	PRAMS
	% of students in 9th-12th grade who reported riding in a car driven by someone who had been drinking	YRBS
Riding with Drinking Driver	% of students in 6th-12th grade who reported riding in a car driven by someone who had been drinking	PRIDE
Tobacco Consequences		
Tobacco - Related Mortality	Rate of Lung Cancer Deaths per 100,000 Population	NVSS-M
	Rate of Lung Disease Deaths per 100,000 Population	NVSS-M
Tobacco Consumption		
Age of Initial Use	% of students in 9th-12th grade initiating tobacco use before age 13	YRBS
Current Use	% of persons aged 12 or older reporting smoked cigarettes in the past 30 days	NSDUH
	% of persons aged 12 to 17 reporting smoked cigarettes in the past 30 days	NSDUH
	% of persons aged 18 to 25 reporting smoked cigarettes in the past 30 days	NSDUH
	% of persons aged 26 or older reporting smoked cigarettes in the past 30 days	NSDUH
	% of youth in 9th-12th grades who smoked cigarettes on 1 or more of the past 30 days	YRBS

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
	% of youth in 9th-12th grades who smoked cigarettes on 20 or more of the past 30 days	YRBS
	% of students in 9th-12th grade reporting any use of smokeless tobacco in the past 30 days	YRBS
	% of adults 18 and older who smoke everyday	BRFSS
First time use	% of youth who have tried bidis/keteks	ALYTS
	% of adults ever using smokeless tobacco	BRFSS
Tobacco use during pregnancy	% of pregnant women who smoked during last 3 months of pregnancy	PRAMS
Total cigarette consumption per capita	# of packs of cigarettes sold at the wholesale level per capita aged 18 and older	Sales Data-Tobacco
Tobacco Risk/Protective Factor		
Friends Use	% of students in grades 6-12 reporting that friends use tobacco	PRIDE
Tobacco use during pregnancy	% of mothers smoking during pregnancy	PRAMS
Other Drug Consequences		
Abuse or dependence	% of persons 12 to 17 reporting illicit drug dependence/abuse	NSDUH
	% of persons 18 to 25 reporting illicit drug dependence/abuse	NSDUH
	% of persons 26 or older reporting illicit drug dependence/abuse	NSDUH
	% of persons 12 and older reporting illicit drug dependence/abuse	NSDUH
Drug related mortality	# of drug related behavior deaths	NVSS-M
	# of drug related overdose deaths	NVSS-M
Crime	# of arrests for drug possession or sale	ACJIC
	Rate of burglaries per 1,000 population	UCR
	Rate of larcenies per 1,000 population	UCR
	Rate of motor vehicle thefts per 1,000	UCR

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
	population	
	Rate of property crimes per 1,000 population	UCR
Treatment	% of total admissions reporting any use of cocaine	TEDS
	% of total admissions reporting any use of heroin	TEDS
	% of total admissions reporting any use of marijuana	TEDS
	% of total admissions reporting cocaine as their primary substance of abuse	TEDS
	% of total admissions reporting heroin as their primary substance of abuse	TEDS
	% of total admissions reporting marijuana as their primary substance of abuse	TEDS
	% of total admissions reporting stimulants as their primary substance of abuse	TEDS
	% of total Admissions Reporting any use of stimulants	TEDS
Treatment gap	% of persons aged 12 or older needing but not receiving treatment for illicit drug use	NSDUH
	% of persons youth ages 12-17 needing but not receiving treatment for illicit drug use	NSDUH
	% of persons youth ages 18-25 needing but not receiving treatment for illicit drug use	NSDUH
	% of persons youth ages 26 or older needing but not receiving treatment for illicit drug use	NSDUH
Other Drug Consumption		
Age of Initial Use	% of youth in 9th-12th grades who tried marijuana before age 13	YRBS
Current Use	% of persons aged 12 to 17 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH
	% of persons aged 18 to 25 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH
	% of persons aged 26 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH
	% of persons aged 12 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH
	% of persons 12 or older non-medical prescription pain reliever use in past year	NSDUH
	% of persons 12 to 17 non-medical prescription pain reliever use in past year	NSDUH

Appendix 11: Constructs and Indicators		
Constructs	Indicators	Sources
	% of persons 18 to 25 non-medical prescription pain reliever use in past year	NSDUH
	% of persons 26 or older non-medical prescription pain reliever use in past year	NSDUH
	% of persons 12 and older reporting marijuana use in past 30 days	NSDUH
	% of persons 12-17 reporting marijuana use in past 30 days	NSDUH
	% of persons 18-25 reporting marijuana use in past 30 days	NSDUH
	% of persons 26 or older reporting marijuana use in past 30 days	NSDUH
	% of youth in 9th-12th grades reporting any use of marijuana in the past 30 days	YRBS
	% of students in 9th-12th grade reporting any use of cocaine in the past 30 days	YRBS
	% of students in grades 6-12 reporting marijuana use during past month	PRIDE
	% of students in grades 6-12 reporting cocaine use during past month	PRIDE
	% of students in grades 6-12 reporting ecstasy use during past month	PRIDE
	% of students in grades 6-12 reporting inhalant use during past month	PRIDE
	% of students in grades 6-12 reporting hallucinogen use during past month	PRIDE
	% of students in grades 6-12 reporting methamphetamine use during past month	PRIDE
	% of students in grades 6-12 reporting non-medical use of prescription drugs in the past 30 days	PRIDE
Lifetime Use	% of students in 9th-12th grade reporting use of any drugs via injection in Their lifetime	YRBS
	% of students in 9th-12th grade reporting any use of cocaine in Their lifetime	YRBS
	% of students in 9th-12th grade reporting any use of heroin in Their lifetime	YRBS
	% of students in 9th-12th grade reporting any use of Inhalants in Their Lifetime	YRBS
	% of students in 9th-12th grade reporting any	YRBS

Appendix 11: Constructs and Indicators

Constructs	Indicators	Sources
	use of ecstasy (MDMA) in their lifetime	
	% of students in 9th-12th grade reporting any use of methamphetamine in their lifetime	YRBS
	% of students in 9th-12th grade reporting any use of steroids in their lifetime	YRBS

Appendix 12.

Alabama SPF-SIG Methodology for Prioritization

A. Epidemiological Dimensions

The following methodology is used to prioritize which construct/indicators should be addressed for SPF-SIG funding. The criteria chosen allowed the process to be methodical and objective. The following criteria were first used to rank the findings.

- Magnitude
- Relative Comparisons
- Trends over time
- Severity of consequences

Magnitude

Magnitude describes the number of individuals directly impacted by a particular indicator. It illustrates the occurrence of alcohol, tobacco, and other drugs (ATOD) in Alabama. Magnitude is described in terms or relative numbers (percentages). A 3-point scale is given to denote high, medium, or low. An indicator with '5' is given for percentages stating 40% or higher, '3' is given for percentages stating 20 -39%, and '1' is given for percentages stating 19% or less.

Magnitude Scale

1	3	5
19% or less	20% – 39%	40% or higher
Low	Medium	High

Relative Comparisons

Relative comparisons is the prevalence for ATOD consumption and related consequences in Alabama compared to those for the US during the same year to determine if Alabama was better or worse off than the rest of the country. The United States is a good benchmark because of the large and relatively stable population.

To compare these rates, ratios were computed. For example, the ratio indicates the percent difference in the rates with a RR greater than (>) '1' indicating the Alabama rate is higher than the US rate and a RR less than (<) '1' being the result when the Alabama rate is less. The ratios were categorized into three groups, labeled '1', '3', and '5' based on the percent difference in the rates and the direction of the difference with '1' given when an relative comparisons ratio was 0.95 or less and a '5' given when an relative comparisons ratio was 1.05 or more. Categories were determined as follows:

Comparison Scale

1	3	5
Ratio: 0.95 or less	Ratio: 0.96 – 1.04	Ratio: 1.05 or more
Below	Same	Above

Trends over Time

Trends over time in Alabama were examined to determine if prevalence were increasing (deteriorating) or decreasing (improving). Rates were compared as follows:

$$\text{Percent change} = [(T2-T1)/T1] \times 100 \text{ where } T1 = \text{time 1 and } T2 = \text{time 2}$$

Data for most of the Alabama indicators ranged from, T1=2004-2005 and T2=2007-2008. The same indicators used for comparison were examined for trends. The percent of change was ranked into three categories ('1', '3', and '5') based on the amount and direction of the change with '1' indicating improvement from a three to five year period and a '5' indicating deterioration.

Trends Scale

1	3	5
-5% or less	-4% - 4%	5% or more
Improvement	Steady	Deterioration

Severity

The consequences that were examined varied in severity from acute morbidity to death. To account for this, consequence rankings were weighted using a severity index. Again, a 3-point scale was utilized with '1' indicating acute morbidity, '3' indicating chronic morbidity, and '5' indicating death.

Severity Scale

1	3	5
Acute Morbidity	Chronic Morbidity	Death

An unweighted scoring approach is used to assess the problem by computing simple unweighted scores to create a numerically ranked list of problems. It is important to keep in mind that this scoring process is a device for compiling and assessing different information about problems. Thus, a problem that receives a score of 10 is not necessarily twice as important as problem with a score of 5. A score for each indicator is calculated by adding each of the criteria's score together. For example:

Indicator	Magnitude	Relative Comparison	Trends over Time	Severity	Score
% of Drivers in Fatal Crashes Who Were Alcohol-positive (FARS)	3	5	3	5	16

B. Additional Criteria

Additional criteria are applied to the top quartile of indicators after the four epidemiological criteria listed above. Applying the additional criteria after the epidemiological criteria allows for the epidemiological assessment to form the basis for prioritization, but still taking into account the broader social and political environment. The following criteria are examined to facilitate with final priority selection:

- Evaluability
- Changeability

Evaluability

Evaluability refers to the extent to which we can measure outcomes. Three factors are examined to determine the complexity of evaluating the changes in outcomes:

- Data readily available
- Access to data timely
- Defined clearly enough to measure

Aspects to consider include whether data are readily available at the community or state level for the measure of interest or whether primary data need to be collected. If data are already available, then we must consider whether data are available at two time points (i.e., pre-intervention [baseline] and post-intervention). Furthermore, access to the data must be timely; a delay of data to be released may cause a measure not to be evaluated for the year. Finally, outcome measures, or good proxies for the outcome, must exist. Furthermore, we must be able to define the measure clearly enough to measure it.

Changeability

Changeability refers to the feasibility of affecting significant change of the targeted problems within 5 years (the time frame of the SPF-SIG). Three factors were examined when determining if an indicator is changeable:

- Time
- Multiple Causal Factors

First, factor is time. The effect of interventions may not be seen for years to come with some outcomes. For example, cirrhosis deaths generally occur after years of drinking in a person's life. If we reduce drinking rates in the short term, it may take many years before we notice a drop in cirrhosis deaths. Next are multiple causal factors. Changing one of the indicators may or may not result in change at the outcome level.

Appendix 13.

Appendix 13: Constructs and Indicators Data											
Constructs	Indicators	Sources	Area	Year							
Alcohol Consequences				2004	2005	2006	2007	2008	2009	2010	
Alcohol-related mortality	# of alcoholic chronic liver disease deaths	NVSS-M	AL	141	145	145	156	—	—	—	
			US	—	—	—	—	—	—	—	
	Rate for alcohol suicide deaths	NVSS-M	AL	541	535	580	592	—	—	—	
			US	—	—	—	—	—	—	—	
	Years of potential life lost due to alcohol-related deaths	ARDI	AL	—	4043	—	—	—	—	—	
			US	—	—	—	—	—	—	—	
	# of alcohol attributable deaths	ARDI	AL	—	982	—	—	—	—	—	
			US	—	—	—	—	—	—	—	
Motor vehicle crashes	Rate of deaths sustained in vehicle crashes that were alcohol-involved per 100,000 Population	FARS	AL	9.5	9.8	10.4	10.4	8.6	—	—	
			US	5.8	5.9	5.9	5.6	5.1	—	—	
	% of fatal motor vehicle crashes that involved alcohol	FARS	AL	38.2	38.6	39.3	42.6	41.5	41.2	—	
			US	39.5	40.5	41.6	41.6	41.3	42	—	
	% of Drivers in Fatal Crashes Who Were Alcohol-positive	FARS	AL	25	24.6	25.6	28.3	26.8	—	—	
			US	24.5	25.2	26	25.9	25.9	—	—	

Crime	# of alcohol-related arrests	ACJIC	AL	—	—	—	—	—	29,291	—
			US	—	—	—	—	—	—	—
	Rate of Aggravated Assaults per 1,000 Population	UCR	AL	2.39	1.98	1.69	2.08	—	—	—
			US	2.81	2.81	2.78	2.75	—	—	—
	Rate of Robberies per 1,000 Population	UCR	AL	1.3	1.24	1.3	1.45	—	—	—
			US	1.34	1.38	1.46	1.45	—	—	—
	Rate of Sexual Assaults per 1,000 Population	UCR	AL	0.37	0.28	0.28	0.29	—	—	—
			US	0.3	0.3	0.29	0.28	—	—	—
	Rate of violent crimes per 1,000 Population	UCR	AL	4.07	3.5	3.27	3.82	—	—	—
			US	4.45	4.48	4.53	4.47	—	—	—
	Rate for alcohol homicide deaths	NVSS-M	AL	367	432	445	480	—	—	—
			US	—	—	—	—	—	—	—

Treatment	% of total admissions reporting any use of alcohol	TEDS	AL	53.1	52.7	50.9	—	—	51.2	—
	US		—	—	—	—	—	—	—	—
	% of total admissions reporting alcohol as their primary substance of abuse	TEDS	AL	30.3	29.6	30.1	—	—	35	—
			US	—	—	—	—	—	—	—
Treatment Gap	% of persons aged 12 to 17 needing but not receiving treatment for alcohol use	NSDUH	AL	—	5.1	4.9	4.5	4.3	—	—
			US	—	5.5	5.2	5.2	5	—	—
	% of person age 18 to 25 needing but not receiving treatment for alcohol use	NSDUH	AL	—	11.9	12	12.1	12.5	—	—
			US	—	16.9	17	16.7	16.4	—	—

	% of person age 26 or older needing but not receiving treatment for alcohol use	NSDUH	AL	—	5.2	5.3	5.1	4.9	—	—
			US	—	5.9	5.9	5.9	5.7	—	—
	% of persons ages 12 or older needing but not receiving treatment for alcohol use	NSDUH	AL	—	6.1	6.1	6	5.9	—	—
			US	—	7.4	7.3	7.2	7.1	—	—
Abuse or dependence	% of persons aged 12 or older reporting alcohol dependence/abuse	NSDUH	AL	—	6.6	6.5	6.3	6.3	—	—
			US	—	7.7	7.7	7.6	7.4	—	—
	% of persons aged 12 to 17 reporting alcohol dependence/abuse	NSDUH	AL	—	5.5	5.1	4.8	4.5	—	—
			US	—	5.8	5.5	5.4	5.1	—	—

	% of persons aged 18 to 25 reporting alcohol dependence/abuse	NSDUH	AL	—	12.7	12.9	13	13.1	—	—
			US	—	17.5	17.6	17.2	17	—	—
	% of persons aged 26 or older reporting alcohol dependence/abuse	NSDUH	AL	—	5.6	5.6	5.4	5.3	—	—
			US	—	6.3	6.2	6.2	6.1	—	—
Alcohol Consumption										
Age of Initial Use	% of youth in 9th-12th grades reporting first use of alcohol before age 13	YRBS	AL	—	30.9	—	—	—	22.8	—
			US	—	25.6	—	23.8	—	21.1	—
Current Use	% of youth in 9th-12th grades reporting use of alcohol in past 30 days	YRBS	AL	—	39.4	—	—	—	39.5	—
			US	—	43.3	—	44.7	—	41.8	—

% of persons 12 and older reporting alcohol use in past 30 days	NSDUH	AL	—	42.1	42.5	39.8	40.4	—	—
		US	—	51.1	51.4	51	51.4	—	—
% of persons age 12-17 reporting alcohol use in past 30 days	NSDUH	AL	16	16.1	14.9	13	—	—	—
		US	17.1	16.6	16.3	15.3	—	—	—
% of persons age 18-25 reporting alcohol use in past 30 days	NSDUH	AL	52.6	53.4	52.1	52.3	—	—	—
		US	60.7	61.4	61.6	61.2	—	—	—
% of persons age 26 or older reporting alcohol use in past 30 days	NSDUH	AL	43.7	44.1	41	41.9	—	—	—
		US	54	54.4	53.9	54.4	—	—	—

	% of persons age 12-20 reporting alcohol use in past 30 days	NSDUH	AL	—	—	25.5	24.8	22.7	23.6	—
			US	—	—	—	—	—	26.8	—
	% of students in grades 6-12 reporting use of alcohol during past month	PRIDE	AL	—	22.8	22	21.3	20.7	20.3	19.4
			US	—	—	—	21.1	19.5	19.6	18.9
	% of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS	AL	40.2	39.2	37	38.2	38.2	37.1	—
			US	56.9	55.6	55.2	54.7	53.9	53.9	—
Current Binge Drinking	% of persons 12 and older reporting binge drinking in past 30 days	NSDUH	AL	19.1	18.7	18.8	19.2	—	—	—
			US	22.7	22.8	23.2	23.3	—	—	—

	% of persons age 12-17 reporting binge drinking in past 30 days	NSDUH	AL	10	9.1	8.6	8	—	—	—
	US		10.5	10.1	10	9.3	—	—	—	
	% of persons age 18-25 reporting binge drinking in past 30 days	NSDUH	AL	33.6	33.8	33.1	33.9	—	—	—
	US		41.5	42	42	41.4	—	—	—	
	% of persons age 26 or older reporting binge drinking in past 30 days	NSDUH	AL	17.8	17.4	17.7	18.2	—	—	—
	US		21.1	21.2	21.7	22	—	—	—	
	% of persons age 12-20 reporting binge drinking in past 30 days	NSDUH	AL	—	—	15.5	15.2	14.3	14.6	—
	US		—	—	—	—	—	17.74	—	
% of youth in 9th-12th grades reporting binge drinking in past 30 days	YRBS	AL	—	23.8	—	—	—	23.1	—	
US		—	25.5	—	26	—	24.2	—		
% of students in grades 6- 12 reporting having 5 or more drinks within a few hours	PRIDE	AL		23	23.3	23.3	21.7	21.1	20.1	
US										
% of adults (aged 18 or older) reporting binge drinking in past 30 days	BRFSS	AL	12.7	10.4	11.2	11	12	10.7		
US		14.9	14.4	15.4	15.7	15.5	15.5			
Current Heavy Drinking	% of adults (aged 18 and older) reporting heavy drinking in past 30 days	BRFSS	AL	4	4.5	3.8	4	4.5	3.9	
			US	4.9	4.9	4.9	5.2	5.1	5.2	
Drinking and driving	% of adults (aged 18 and older) drinking/driving past 30 day use	BRFSS	AL	1.9		2.5		1.5		
			US	2		2.7		2.1		
	% of students in 9th-12th grade who reported driving when they had been drinking alcohol	YRBS	AL	—	11.1	—	—	—	12.3	—
			US	—	9.9	—	10.5	—	9.7	—
	% of students in 6th-12th grade who reported driving when they had been drinking alcohol	PRIDE	AL	—	—	—	—	8.3	8	7.4
			US	—	—	—	—	6.3	6.3	5.8
Total ethanol consumption per	# of sales of ethanol per 10,000 population	AEDS	AL	19,037	19,134	19,746	20,174	20,390	—	—
			US	22,283	22,340	22,747	23,073	23,154	—	—

capita												
Alcohol Risk/Protective Factors												
Alcohol Use during Pregnancy	% of mothers who reported drinking before and during pregnancy	PRAMS	AL	10.2	8.4	11.2	16.9					
			US	—	—	—	—	—	—	—	—	—
Riding with Drinking Driver	% of students in 9th-12th grade who reported riding in a car driven by someone who had been drinking	YRBS	AL	—	28.8	—	—	—	—	32	—	—
			US	—	28.5	—	29.1	—	—	—	—	—
	% of students in 6th-12th grade who reported riding in a car driven by someone who had been drinking	PRIDE	AL	—	—	—	—	22.4	22	20.2	—	—
			US	—	—	—	—	19.8	20.8	18.3	—	—
Tobacco Consequences												
Tobacco - Related Mortality	Rate of Lung Cancer Deaths per 100,000 Population	NVSS-M	AL	67.3	69	65.7	68.2	—	—	—	—	—
			US	53.8	53.7	53	52.6	—	—	—	—	—
	Rate of Lung Disease Deaths per 100,000 Population	NVSS-M	AL	50.2	51.2	48.9	53.6	—	—	—	—	—
			US	40.2	42.9	40.4	41.3	—	—	—	—	—
Tobacco Consumption												
Age of Initial Use	% of students in 9th-12th grade initiating tobacco use before age 13	YRBS	AL	—	21.2	—	—	—	—	—	—	—
			US	—	16	—	14.2	—	10.7	—	—	—
Current Use	% of persons aged 12 or older reporting smoked cigarettes in the past 30 days	NSDUH	AL	—	27.1	27.6	28.6	27.2	—	—	—	—
			US	—	24.9	25	24.6	24.1	—	—	—	—
	% of persons aged 12 to 17 reporting smoked cigarettes in the past 30 days	NSDUH	AL	—	12.4	11.7	12	11.3	—	—	—	—
			US	—	11.3	10.6	10.1	9.5	—	—	—	—
	% of persons aged 18 to 25 reporting smoked cigarettes in the past 30 days	NSDUH	AL	—	38.9	38.7	38.8	38.5	—	—	—	—
			US	—	39.3	38.7	37.3	35.9	—	—	—	—
	% of persons aged 26 or older reporting smoked cigarettes in the past 30 days	NSDUH	AL	—	26.9	27.8	29.1	27.3	—	—	—	—
			US	—	24.2	24.5	24.4	24	—	—	—	—

	% of youth in 9th-12th grades who smoked cigarettes on 1 or more of the past 30 days	YRBS	AL	—	24.4	—	—	—	20.8	—
			US	—	23	—	20	—	19.5	—
	% of youth in 9th-12th grades who smoked cigarettes on 20 or more of the past 30 days	YRBS	AL	—	10.2	—	—	—	8.6	—
			US	—	9.4	—	8.1	—	7.3	—
	% of students in 9th-12th grade reporting any use of smokeless tobacco in the past 30 days	YRBS	AL	—	14.1	—	—	—	12.4	—
			US	—	8	—	7.9	—	8.9	—
	% of adults 18 and older who smoke everyday	BRFSS	AL	18.7	18.8	17.6	16.5	17.3	16.5	15.6
			US	15.6	15.3	14.7	14.5	13.4	12.8	—
Lifetime Use	% of youth who have tried bidis/keteks	ALYTS	AL	—	—	11.1	—	10.2	—	—
			US	—	—	—	—	—	—	—
	% of adults ever using smokeless tobacco	BRFSS	AL	—	—	—	—	—	6.6	—
			US	—	—	—	—	—	—	—
Tobacco use during pregnancy	% of pregnant women who smoked during last 3 months of pregnancy	PRAMS	AL	—	—	—	—	—	—	—
			US	—	—	—	—	—	—	—
Total cigarette consumption per capita	# of packs of cigarettes sold at the wholesale level per capita aged 18 and older	Sales Data-Tobacco	AL	123	115	116	112	—	—	—
			US	92	89	86	83	—	—	—

Tobacco Risk/Protective Factor										
Friends Use	% of students in grades 6-12 reporting that friends use tobacco	PRIDE	AL	—	—	—	54.9	53.4	54.1	53.9
			US	—	—	—	—	—	—	—
Tobacco use during pregnancy	% of mothers smoking during pregnancy and giving birth to low birth weight baby	PRAMS	AL	17.5	25.2	22.8	13.5	15.6	15.8	
			US	—	—	—	—	—	—	—
	% of pregnant women who smoked during pregnancy	PRAMS	AL	—	25.2	22.8	13.5	15.6	15.8	—
			US	—	—	—	—	—	—	—
Other Drug Consequences										
Abuse or dependence	% of persons 12 to 17 reporting illicit drug dependence/abuse	NSDUH	AL	—	5	4	4	4.2	—	—
			US	—	5	4.7	4.5	4.5	—	—
	% of persons 18 to 25 reporting illicit drug dependence/abuse	NSDUH	AL	—	8.4	7.6	7.4	7.9	—	—
			US	—	8.4	8.1	7.9	7.9	—	—
	% of persons 26 or older reporting illicit drug dependence/abuse	NSDUH	AL	—	1.8	1.8	2.1	2.1	—	—
			US	—	1.7	1.7	1.7	1.7	—	—
	% of persons 12 and older reporting illicit drug dependence/abuse	NSDUH	AL	—	3	2.8	3	3.1	—	—
			US	—	2.9	2.8	2.8	2.8	—	—
Drug related mortality	# of drug related behavior deaths	NVSS-M	AL	0.8	1	1.4	0.9	—	—	—
			US	0.8	0.9	0.9	0.7	—	—	—
	# of drug related overdose deaths	NVSS-M	AL	6.2	6.2	8.7	11	—	—	—
			US	9.3	10.1	11.5	11.9	—	—	—
Crime	# of arrests for drug possession or sale	ACJIC	AL	—	—	—	—	—	17,126	—
			US	—	—	—	—	—	—	—
	Rate of burglaries per 1,000 population	UCR	AL	9.54	7.86	7.6	8.47	—	—	—
			US	6.98	6.95	6.98	6.93	—	—	—

	Rate of larcenies per 1,000 population	UCR	AL	26.3	21.4	20.4	23.3	—	—	—
			US	22.6	21.7	21	20.7	—	—	—
	Rate of motor vehicle thefts per 1,000 population	UCR	AL	3	2.37	2.59	2.69	—	—	—
			US	4.11	4.07	3.89	3.55	—	—	—
	Rate of property crimes per 1,000 population	UCR	AL	38.8	31.7	30.6	34.5	—	—	—
			US	33.7	32.8	31.8	31.2	—	—	—
Treatment	% of total admissions reporting any use of cocaine	TEDS	AL	35.9	35.1	33.4	—	—	23.5	—
			US	—	—	—	—	—	—	—
	% of total admissions reporting any use of heroin	TEDS	AL	1.6	1.3	0.5	—	—	1.7	—
			US	—	—	—	—	—	—	—
	% of total admissions reporting any use of marijuana	TEDS	AL	51.5	48.2	44.1	—	—	43.3	—
			US	—	—	—	—	—	—	—
	% of total admissions reporting cocaine as their primary substance of abuse	TEDS	AL	21.9	21.8	22.8	—	—	14.5	—

		US	—	—	—	—	—	—	—
% of total admissions reporting heroin as their primary substance of abuse	TEDS	AL	1	0.9	0.3	—	—	0.9	—
		US	—	—	—	—	—	—	—
% of total admissions reporting marijuana as their primary substance of abuse	TEDS	AL	27.9	27.6	28.4	—	—	28.5	—
		US	—	—	—	—	—	—	—
% of total admissions reporting stimulants as their primary substance of abuse	TEDS	AL	10	9.8	8.6	—	—	7.8	—
		US	—	—	—	—	—	—	—
% of total Admissions Reporting any use of stimulants	TEDS	AL	14.7	14.3	12.7	—	—	10.7	—
		US	—	—	—	—	—	—	—

Treatment gap	% of persons aged 12 or older needing but not receiving treatment for illicit drug use	NSDUH	AL	—	2.5	2.3	2.5	2.6	—	—
			US	—	2.7	2.5	2.5	2.5	—	—
	% of persons youth ages 12-17 needing but not receiving treatment for illicit drug use	NSDUH	AL	—	4.6	3.6	3.6	3.6	—	—
			US	—	4.7	4.3	4.1	4.2	—	—
	% of persons youth ages 18-25 needing but not receiving treatment for illicit drug use	NSDUH	AL	—	7.1	6.4	6.8	7.3	—	—
			US	—	7.7	7.5	7.4	7.3	—	—

	% of persons youth ages 26 or older needing but not receiving treatment for illicit drug use	NSDUH	AL	—	1.4	1.4	1.5	1.7	—	—
			US	—	1.5	1.4	1.4	1.5	—	—
Other Drug Consumption										
Age of Initial Use	% of youth in 9th-12th grades who tried marijuana before age 13	YRBS	AL	—	9.2	—	—	—	8	—
			US	—	8.7	—	8.3	—	7.5	—
Current Use	% of persons aged 12 to 17 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	AL	—	5.8	6	5.4	4.8	—	—
			US	—	5.1	4.9	4.8	4.5	—	—

% of persons aged 18 to 25 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	AL	—	9.9	9.8	8.6	8.5	—	—
		US	—	8.5	8.8	8.5	8	—	—
% of persons aged 26 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	AL	—	2.7	2.8	2.9	2.9	—	—
		US	—	2.5	2.8	2.9	2.7	—	—
% of persons aged 12 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	AL	—	4	4	3.9	3.8	—	—
		US	—	3.6	3.8	3.8	3.6	—	—

% of persons 12 or older non-medical prescription pain reliever use in past year	NSDUH	AL	—	5.1	5.6	—	—	—	—
		US	—	—	5	—	—	—	—
% of persons 12 to 17 non-medical prescription pain reliever use in past year	NSDUH	AL	—	8.9	8.9	7.3	—	—	—
		US	—	7	6.9	6.6	—	—	—
% of persons 18 to 25 non-medical prescription pain reliever use in past 30 year	NSDUH	AL	—	14.1	13.8	13.3	—	—	—
		US	—	12.4	12.3	12.1	—	—	—

% of persons 26 or older non-medical prescription pain reliever use in past year	NSDUH	AL	—	3.3	4.2	3.8	—	—	—
		US	—	3.4	3.6	3.4	—	—	—
% of persons 12 and older reporting marijuana use in past 30 days	NSDUH	AL	—	4.9	4.8	4.5	4.6	—	—
		US	—	6	6	5.9	6	—	—
% of persons 12-17 reporting marijuana use in past 30 days	NSDUH	AL	6.7	6.3	5.4	5.2	—	—	—
		US	7.2	6.7	6.7	6.7	—	—	—
% of persons 18-25 reporting marijuana use in past 30 days	NSDUH	AL	14	12.2	11.3	12.9	—	—	—
		US	16.4	16.4	16.3	16.5	—	—	—

% of persons 26 or older reporting marijuana use in past 30 days	NSDUH	AL	3.1	3.3	3.3	3.1	—	—	—
		US	4.1	4.1	4	4.1	—	—	—
% of students in 9th-12th grade reporting any use of cocaine in the past 30 days	YRBS	AL	—	3.5	—	—	—	2.6	—
		US	—	3.4	—	3.3	—	2.8	—
% of youth in 9th-12th grades reporting any use of marijuana in the past 30 days	YRBS	AL	—	18.5	—	—	—	16.2	—
		US	—	20.2	—	19.7	—	20.8	—

% of students in grades 6-12 reporting marijuana use during past month	PRIDE	AL	—	—	—	9.7	9.9	10.4	11
		US	—	—	—	10	9.8	10.2	10.7
% of students in grades 6-12 reporting cocaine use during past month	PRIDE	AL	—	—	—	3.2	3.2	3	3.1
		US	—	—	—	2.7	2.5	2.4	2.4
% of students in grades 6-12 reporting ecstasy use during past month	PRIDE	AL	—	—	—	3.2	3.1	3	3.1
		US	—	—	—	2.4	2.2	2.3	2.3

	% of students in grades 6-12 reporting inhalant use during past month	PRIDE	AL	—	—	—	3.7	3.8	3.8	3.8
			US	—	—	—	3.1	2.8	2.9	2.8
	% of students in grades 6-12 reporting hallucinogen use during past month	PRIDE	AL	—	—	—	3	3.1	3	3.2
			US	—	—	—	2.4	2.4	2.4	2.4
	% of students in grades 6-12 reporting methamphetamine use during past month	PRIDE	AL	—	—	—	2.9	2.8	2.7	2.7
			US	—	—	—	2.2	2	1.9	2.1

	% of students in grades 6-12 reporting non-medical use of prescription drugs in the past 30 days	PRIDE	AL	—	—	—	—	—	—	5.3
			US	—	—	—	—	—	—	—
Lifetime Use	% of students in 9th-12th grade reporting use of any drugs via injection in Their lifetime	YRBS	AL	—	4.1	—	—	—	3.4	—
			US	—	2.1	—	2	—	2.1	—
	% of students in 9th-12th grade reporting any use of cocaine in Their lifetime	YRBS	AL	—	7.5	—	—	—	6.1	—
			US	—	7.6	—	7.2	—	6.4	—

% of students in 9th-12th grade reporting any use of heroin in Their lifetime	YRBS	AL	—	5.3	—	—	—	3.7	—
		US	—	2.4	—	2.3	—	2.5	—
% of students in 9th-12th grade reporting any use of Inhalants in Their Lifetime	YRBS	AL	—	15.5	—	—	—	11.9	—
		US	—	12.4	—	13.3	—	11.7	—
% of students in 9th-12th grade reporting any use of ecstasy (MDMA) in their lifetime	YRBS	AL	—	8.4	—	—	—	7.1	—
		US	—	6.3	—	5.8	—	6.7	—

	% of students in 9th-12th grade reporting any use of methamphetamine in their lifetime	YRBS	AL	—	7.3	—	—	—	5.3	—
			US	—	6.2	—	4.4	—	4.1	—
	% of students in 9th-12th grade reporting any use of steroids in their lifetime	YRBS	AL	—	6.5	—	—	—	5.6	—
			US	—	4	—	3.9	—	3.3	—

Appendix 14.

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
Alcohol Consequences							
Alcohol-related mortality	# of alcoholic chronic liver disease deaths	NVSS-M	—	5	—	5	10
	Rate for alcohol suicide deaths	NVSS-M	—	5	—	5	10
	Years of potential life lost due to alcohol-related deaths	ARDI	—	—	—	5	5
	# of alcohol attributable deaths	ARDI	—	—	—	5	5
Motor vehicle crashes	Rate of deaths sustained in vehicle crashes that were alcohol-involved per 100,000 Population	FARS	1	1	5	5	12
	% of fatal motor vehicle crashes that involved alcohol	FARS	5	5	3	1	14
	% of Drivers in Fatal Crashes Who Were Alcohol-positive	FARS	3	5	3	1	12
Crime	# of alcohol-related arrests	ACJIC	—	—	—	1	1
	Rate of Aggravated Assaults per 1,000 Population	UCR	1	1	1	1	4
	Rate of Robberies per 1,000 Population	UCR	1	5	3	1	10
	Rate of Sexual Assaults per 1,000 Population	UCR	1	1	3	1	6

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	Rate of violent crimes per 1,000 Population	UCR	1	1	1	1	4
	Rate for alcohol homicide deaths	NVSS-M	—	5	—	5	10
Treatment	% of total admissions reporting any use of alcohol	TEDS	5	3	—	1	9
	% of total admissions reporting alcohol as their primary substance of abuse	TEDS	3	5	—	3	11
Treatment Gap	% of persons aged 12 to 17 needing but not receiving treatment for alcohol use	NSDUH	1	1	1	1	4
	% of person age 18 to 25 needing but not receiving treatment for alcohol use	NSDUH	1	5	1	1	8
	% of person age 26 or older needing but not receiving treatment for alcohol use	NSDUH	1	1	1	1	4
	% of persons ages 12 or older needing but not receiving treatment for alcohol use	NSDUH	1	3	1	1	6
Abuse or dependence	% of persons aged 12 or older reporting alcohol dependence/abuse	NSDUH	1	1	1	3	6
	% of persons aged 12 to 17 reporting alcohol dependence/abuse	NSDUH	1	1	1	3	6

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons aged 18 to 25 reporting alcohol dependence/abuse	NSDUH	1	3	1	3	8
	% of persons aged 26 or older reporting alcohol dependence/abuse	NSDUH	1	1	1	3	6
Alcohol Consumption							
Age of Initial Use	% of youth in 9th-12th grades reporting first use of alcohol before age 13	YRBS	3	1	5	1	10
Current Use	% of youth in 9th-12th grades reporting use of alcohol in past 30 days	YRBS	3	3	3	1	10
	% of persons 12 and older reporting alcohol use in past 30 days	NSDUH	5	3	1	1	10
	% of persons age 12-17 reporting alcohol use in past 30 days	NSDUH	1	1	1	1	4
	% of persons age 18-25 reporting alcohol use in past 30 days	NSDUH	5	1	1	1	8
	% of persons age 26 or older reporting alcohol use in past 30 days	NSDUH	5	3	1	1	10

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons age 12-20 reporting alcohol use in past 30 days	NSDUH	3	1	1	1	6
	% of students in grades 6-12 reporting use of alcohol during past month	PRIDE	1	1	3	1	6
	% of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS	3	1	1	1	6
Current Binge Drinking	% of persons 12 and older reporting binge drinking in past 30 days	NSDUH	1	3	1	1	6
	% of persons age 12-17 reporting binge drinking in past 30 days	NSDUH	1	1	1	1	4

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons age 18-25 reporting binge drinking in past 30 days	NSDUH	3	3	1	1	8
	% of persons age 26 or older reporting binge drinking in past 30 days	NSDUH	1	3	1	1	6
	% of persons age 12-20 reporting binge drinking in past 30 days	NSDUH	1	1	1	1	4
	% of youth in 9th-12th grades reporting binge drinking in past 30 days	YRBS	3	3	1	1	8
	% of students in grades 6- 12 reporting having 5 or more drinks within a few hours	PRIDE	3	1		1	5
	% of adults (aged 18 or older) reporting binge drinking in past 30 days	BRFSS	1	1	1	1	4

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
Current Heavy Drinking	% of adults (aged 18 and older) reporting heavy drinking in past 30 days	BRFSS	1	3	1	1	6
Drinking and driving	% of adults (aged 18 and older) drinking/driving past 30 day use	BRFSS	1	1	1	1	4
	% of students in 9th-12th grade who reported driving when they had been drinking alcohol	YRBS	1	5	5	1	12
	% of students in 6th-12th grade who reported driving when they had been drinking alcohol	PRIDE	1	1	5	1	8
Total ethanol consumption per capita	# of sales of ethanol per 10,000 population	AEDS	-	5	1	1	7
Alcohol Risk/Protective Factors							
Alcohol Use during Pregnancy	% of mothers who reported drinking before and during pregnancy	PRAMS	1	5	—	1	7
Riding with Drinking Driver	% of students in 9th-12th grade who reported riding in a car driven by someone who had been drinking	YRBS	2	5	3	1	11
	% of students in 6th-12th grade who reported riding in a car driven by someone who had been drinking	PRIDE	3	1	5	1	10
Tobacco Consequences							

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
Tobacco - Related Mortality	Rate of Lung Cancer Deaths per 100,000 Population	NVSS-M	5	3	5	5	18
	Rate of Lung Disease Deaths per 100,000 Population	NVSS-M	5	5	5	5	20
Tobacco Consumption							
Age of Initial Use	% of students in 9th-12th grade initiating tobacco use before age 13	YRBS	3		5	1	9
Current Use	% of persons aged 12 or older reporting smoked cigarettes in the past 30 days	NSDUH	3	3	5	1	12
	% of persons aged 12 to 17 reporting smoked cigarettes in the past 30 days	NSDUH	1	1	5	1	8
	% of persons aged 18 to 25 reporting smoked cigarettes in the past 30 days	NSDUH	3	3	5	1	12
	% of persons aged 26 or older reporting smoked cigarettes in the past 30 days	NSDUH	3	3	5	1	12
	% of youth in 9th-12th grades who smoked cigarettes on 1 or more of the past 30 days	YRBS	3	1	5	1	10
	% of youth in 9th-12th grades who smoked cigarettes on 20 or more of the past 30 days	YRBS	1	1	5	1	8
	% of students in 9th-12th grade reporting any use of smokeless tobacco in the past 30 days	YRBS	1	5	5	1	12

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of adults 18 and older who smoke everyday	BRFSS	1	1	—	1	3
First time use	% of youth who have tried bidis/keteks	ALYTS	1	1	—	1	3
	% of adults ever using smokeless tobacco	BRFSS	1	—	—	1	2
Tobacco use during pregnancy	% of pregnant women who smoked during last 3 months of pregnancy	PRAMS	—	—	—	—	0
Total cigarette consumption per capita	# of packs of cigarettes sold at the wholesale level per capita aged 18 and older	Sales Data-Tobacco		1	5	1	7
Tobacco Risk/Protective Factor							
Tobacco use during pregnancy	% of mothers smoking during pregnancy and giving birth to low birth weight baby	PRAMS	1	1	—	1	3
	% of pregnant women who smoked during pregnancy	PRAMS	1	1	—	1	3
Other Drug Consequences							
Abuse or dependence	% of persons 12 to 17 reporting illicit drug dependence/abuse	NSDUH	1	1	1	3	6
	% of persons 18 to 25 reporting illicit drug dependence/abuse	NSDUH	1	1	3	3	8

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons 26 or older reporting illicit drug dependence/abuse	NSDUH	1	5	5	3	14
	% of persons 12 and older reporting illicit drug dependence/abuse	NSDUH	1	3	5	3	12
Drug related mortality	# of drug related behavior deaths	NVSS-M	1	5	5	5	16
	# of drug related overdose deaths	NVSS-M	3	5	1	5	14
Crime	# of arrests for drug possession or sale	ACJIC	5	1		1	7
	Rate of burglaries per 1,000 population	UCR	1	1	5	1	8
	Rate of larcenies per 1,000 population	UCR	5	1	5	1	12
	Rate of motor vehicle thefts per 1,000 population	UCR	1	1	1	1	4
	Rate of property crimes per 1,000 population	UCR	5	1	5	1	12

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
Treatment	% of total admissions reporting any use of cocaine	TEDS	3	1	—	1	5
	% of total admissions reporting any use of heroin	TEDS	1	5	—	1	7
	% of total admissions reporting any use of marijuana	TEDS	5	1	—	1	7
	% of total admissions reporting cocaine as their primary substance of abuse	TEDS	1	1	—	3	5
	% of total admissions reporting heroin as their primary substance of abuse	TEDS	1	1	—	3	5
	% of total admissions reporting marijuana as their primary substance of abuse	TEDS	3	3	—	3	9
	% of total admissions reporting stimulants as their primary substance of abuse	TEDS	1	1	—	3	5
	% of total Admissions Reporting any use of stimulants	TEDS	1	1	—	1	3
	Treatment gap	% of persons aged 12 or older needing but not receiving treatment for illicit drug use	NSDUH	1	3	3	1

Appendix 14: Constructs and Indicators Scores							
Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons youth ages 12-17 needing but not receiving treatment for illicit drug use	NSDUH	1	1	1	1	4
	% of persons youth ages 18-25 needing but not receiving treatment for illicit drug use	NSDUH	1	3	3	1	8
	% of persons youth ages 26 or older needing but not receiving treatment for illicit drug use	NSDUH	1	5	5	1	12
Other Drug Consumption							
Age of Initial Use	% of youth in 9th-12th grades who tried marijuana before age 13	YRBS	1	1	5	1	8
Current Use	% of persons aged 12 to 17 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	1	1	5	1	8
	% of persons aged 18 to 25 reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	1	1	5	1	8
	% of persons aged 26 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	1	5	5	1	12
	% of persons aged 12 or older reporting illicit drug use (other than marijuana) in past 30 days	NSDUH	1	1	5	1	8
	% of persons 12 or older non-medical prescription pain reliever use in past year	NSDUH	1	5	5	1	12

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	% of persons 12 to 17 non-medical prescription pain reliever use in past year	NSDUH	1	1	5	1	8
	% of persons 18 to 25 non-medical prescription pain reliever use in past 30 year	NSDUH	1	1	5	1	8
	% of persons 26 or older non-medical prescription pain reliever use in past year	NSDUH	1	5	5	1	12
	% of persons 12 and older reporting marijuana use in past 30 days	NSDUH	1	1	1	1	4
	% of persons 12-17 reporting marijuana use in past 30 days	NSDUH	1	1	1	1	4
	% of persons 18-25 reporting marijuana use in past 30 days	NSDUH	1	1	1	1	4
	% of persons 26 or older reporting marijuana use in past 30 days	NSDUH	1	3	1	1	6
	% of students in 9th-12th grade reporting any use of cocaine in the past 30 days	YRBS	1	1	3	1	6
	% of youth in 9th-12th grades reporting any use of marijuana in the past 30 days	YRBS	1	1	1	1	4
	% of students in grades 6-12 reporting marijuana	PRIDE	1	5	3	1	10

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	use during past month						
	% of students in grades 6-12 reporting cocaine use during past month	PRIDE	1	3	5	1	10
	% of students in grades 6-12 reporting ecstasy use during past month	PRIDE	1	3	5	1	10
	% of students in grades 6-12 reporting inhalant use during past month	PRIDE	1	3	5	1	10
	% of students in grades 6-12 reporting hallucinogen use during past month	PRIDE	1	5	5	1	12
	% of students in grades 6-12 reporting methamphetamine use during past month	PRIDE	1	1	5	1	8
	% of students in grades 6-12 reporting non-medical use of prescription drugs in the past 30 days	PRIDE	5	—	—	1	6
Lifetime Use	% of students in 9th-12th grade reporting use of any drugs via injection in Their lifetime	YRBS	1	1	5	3	10
	% of students in 9th-12th grade reporting any use of cocaine in Their lifetime	YRBS	1	1	1	3	6
	% of students in 9th-12th grade reporting any use of heroin in Their lifetime	YRBS	1	1	5	3	10
	% of students in 9th-12th grade reporting any use	YRBS	1	1	3	3	7

Appendix 14: Constructs and Indicators Scores

Construct	Indicator	Sources	Magnitude	Trends Over Time	Relative Comparison	Severity	Total
	of Inhalants in Their Lifetime						
	% of students in 9th-12th grade reporting any use of ecstasy (MDMA) in their lifetime	YRBS	1	1	5	3	10
	% of students in 9th-12th grade reporting any use of methamphetamine in their lifetime	YRBS	1	1	5	3	10
	% of students in 9th-12th grade reporting any use of steroids in their lifetime	YRBS	1	1	5	3	10

Appendix 15.

Alabama SPF-SIG Resource Allocation Survey

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http://www.surveymonkey.com/MySurvey_EditPage.aspx?sm=JabH4%2fv22roM%2btpBRhoDfBMFQhC8u1nQtqXbVP%2f%2bTs54p8DlhftzCAaPZbbRcEC&TB_iframe=true&height=450&width=650

Below you will find a description of the four resource-allocation planning models adapted by SAMHSA/CSAP. The selected model will guide how funding is dispensed to address the priority targeted for intervention. Please read each description carefully, then continue to the next page to complete the survey based off of the descriptions given.

Equity- Dictates equitable distribution of funds across all sub-State communities. The same amount of money is awarded to each community without applying other criteria. For example, underage drinking levels being widely distributed across a State.

Highest-Contributor- Concentrates funding within a subset of communities or regions that contribute the highest number of cases to a State's total. For example, a State prioritizing substance abuse-related motor vehicle accidents (MVAs) to identify regions/communities with the highest number of MVA cases.

Highest-Need- Directs funding to those communities or regions that have the highest rate (e.g., 32.2 cases per 100,000) of substance-use pattern or substance-related consequence. For example, using county data from the PRIDE survey indicating the rate of youth reporting any drinking or binge drinking in the last 30 days compared to the rate on a Statewide basis.

Hybrid- Concentrates funding on "hot-spot" problem areas as defined by both prevalence numbers and rates. For example, combining the Highest-Contributor and Highest-Need models in an urban community within a State to address non-medical prescription use.

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http://www.surveymonkey.com/MySurvey_EditPage.aspx?sm=JabH4%2fv22roM%2btpBRhoDfBMFQhC8u1nQtqXbVP%2f%2bTs72drkPKU06kJ5CG6lb4HjD&TB_iframe=true&height=450&width=650

1. Select which group(s) you serve on for the SPF-SIG.

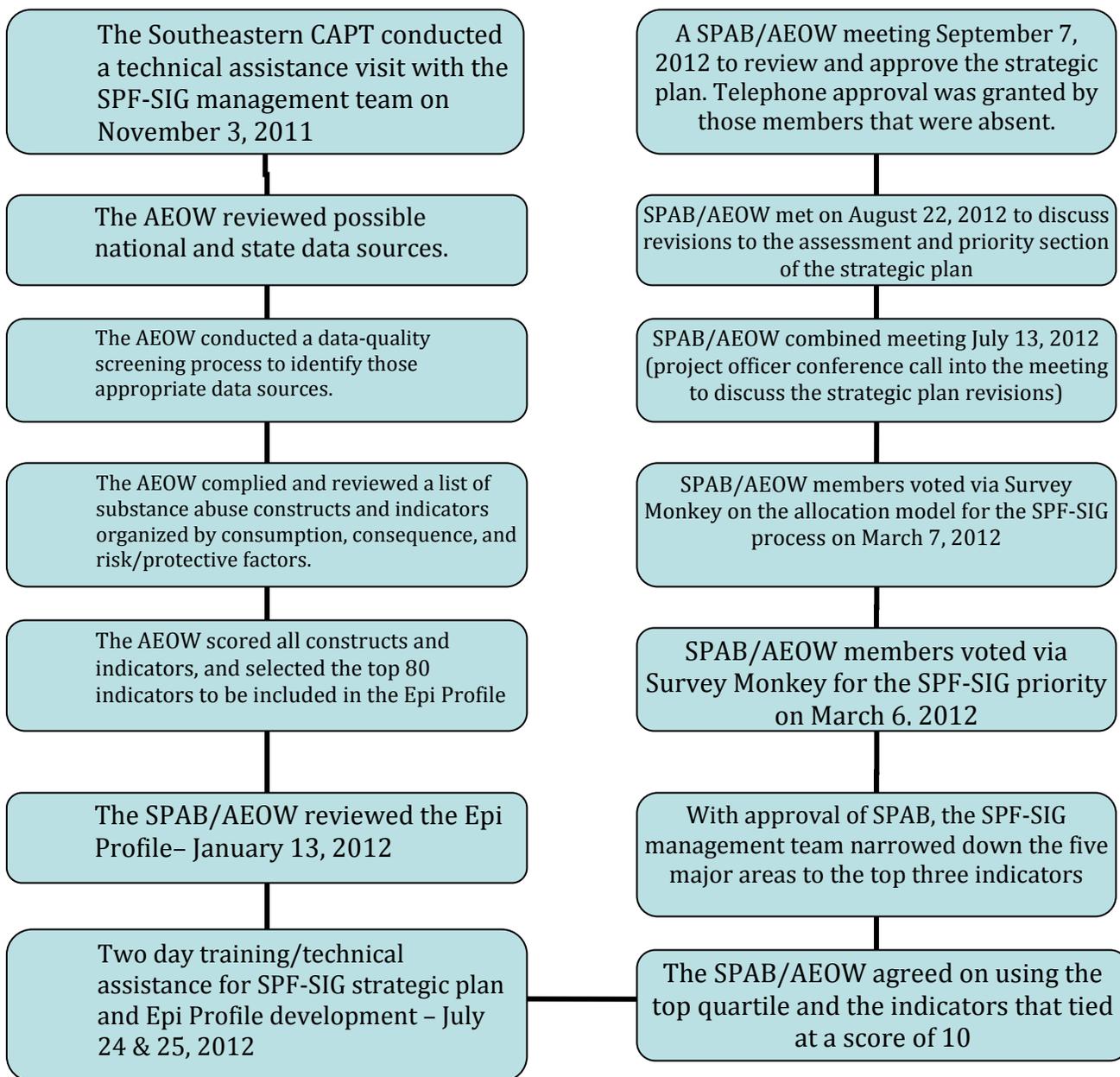
- SPAB (State Prevention Advisory Board)
- AEW (Alabama Epidemiological Outcomes Workgroup)
- Both

2. Rank the following resource-allocation planning models with first representing your primary choice.

	First	Second	Third	Fourth
Equity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highest-Contributor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highest-Need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hybrid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 16.

Prioritization Process Model



Appendix 17.

Project Timeline

Task	Target Timeline	Responsible Party
Strategic Plan Approval	November 16, 2012	SAMHSA/CSAP Project Officer; SAMHSA Delegates
SPAB/AEOW Approval Notification	November 26, 2012	Maranda Brown
SPF-SIG Prevention Management Team Briefing	November 26, 2012	Beverly Johnson
SPF SIG Orientation	December 2012	SPF SIG Management Team/CAPT
Sub-recipient RFP released (posted on ADMH website, sent to providers, vendors, newspapers, SPAB, DFC's, and tribe representative)	2 weeks post CSAP approval of RFP/December 2012	Office of Contracts and Purchasing
RFP Workshops (held in Montgomery, Dothan, & Birmingham)	3 weeks post release/January 2013	Beverly Johnson
RFP due	8 weeks post workshop/March 2013	Prospective Sub-recipients
RFP review process (randomly selected ADMH reviewers review and score RFP responses and score sheet forwarded to Office of Prevention)	3 weeks/March 2013	Office of Contracts and Purchasing
Awards made (Sub-recipients notified of award and next steps to receive funds)	1 week post review/April 2013	Maranda Brown in collaboration with Office of Contracts
Implementation Workshop held (Location to be determined; however, embedding workshop into an existing training venue is preferred option i.e. Gulf Coast conference)	2 weeks post award/April 2013	Beverly Johnson
Various Year 1 Trainings (See Training Timeline pg. 51)	April 2013	SPF SIG Management Team/CAPT/Prevention Consultants
Local needs assessment begin	ASAP post-award/April 2013	Sub-recipients
SPF-SIG Needs Assessment TA	ASAP post-award/April 2013	SPF-SIG Evaluator, Catina James/Lauren

		Blanding/AEOW
Sub-grantees submit strategic plans for approval	9 months post award/January 2014	Sub-recipients
Strategic Plan Approval Process	9 months post award/January 2014	SPAB/SPF-SIG Management Team
Begin implementation of evidence-based programs, policies, and practices	9 months post award/January 2014	Sub-recipients
Monitoring and Evaluation	April 2013 – October 2015	SPF-SIG Evaluator
Outcome Evaluation	April 2014/March 2015	SPF-SIG Evaluator
Sub recipient Outcome Review Process	April 2014/March 2015	SPAB/SPF-SIG Management Team
Year 2 Determination/Notification	April 2014	SPAB/SPF-SIG Management Team
Phase II begins	April 2014	Sub recipients
Various Trainings (See Training Timeline pg. 51)	TBD	SPF SIG Management Team/CAPT/Prevention Consultants